Adolescent Girls' Experiences in a Motivational Enhancement Support Group for Disordered Eating

By

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Abstract

Four girls participated in a study exploring their experience in an motivational enhancement support group for disordered eating. This research is based on qualitative accounts from the participants. The accounts were analyzed to determine common themes using a phenomenological research method. No study to date has examined adolescent girls experiences in this specific type of group. The research question for this study was: *What are adolescent girls common experiences in a motivational enhancement support group for disordered eating?*

The analysis of these data resulted in nine common themes: *Feeling Validated, Identification with Other Group Members, Comparisons with Other Eating Disorder Clients, Appreciation for Parental Component, Opportunity for Interaction with Other Group Members, Satisfaction of Helping Others Through Sharing Individual Experiences, Becoming Familiar with Professionals in the Program, Apprehension about Group Participation and Awareness of the Stages of Change.*

This study can be of benefit to counsellors and therapists working with this population as they are better able to understand the experiences which were identified as meaningful in their treatment. Through this understanding, practitioners will be able to tailor groups to meet the needs of this population and also better understand what is meaningful to adolescent girls in therapy. This study suggests that future research is needed in this area to further evaluate the treatment of eating disorders which allows the participants to have a voice in their experience. This preliminary study also indicates that further qualitative and quantitative research is needed in this area in order to increase our understanding of adolescent girls' experiences in treatment for eating disorders.
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Introduction

Disordered eating is a devastating illness which often arises during adolescent growth and maturation (Abraham & Llewellyn-Jones, 1992). Anorexia nervosa, one of the DSM-IV classifications of disordered eating, is the third most chronic condition amongst adolescent girls after obesity and asthma (Lucas, Beard, O'Fallon & Kurland, 1991). Although eating disorders often form in the adolescent years, much of the literature fails to consider the unique physiological, psychological and developmental issues of this population (Attie & Brooks-Gunn, 1989). The prevalence of eating disorders in adolescents has increased significantly over the past 50 years (Lucas et al., 1991). Prevalence rates for anorexia nervosa (AN) amongst girls, 15 to 19 years of age, range from 0.5 to 0.8 cases per 100 in the United States (Lucas et al., 1991). It is reported that the lifetime prevalence for anorexia nervosa among women is 0.5% for narrowly defined AN to 3.7% for broadly defined (APA, 2000). The lifetime prevalence for bulimia nervosa (BN) ranges from 1.1% to 4.2% (APA, 2000). According to Brown and Jasper (1993), a developmental perspective requires that we study disordered eating in the context of challenges confronting this population which include:

a) accommodations of the physical changes of puberty within a cultural milieu that values pre-pubertal body shape over a mature body shape, b) the striving for physical and psychological autonomy as the adolescent moves towards adulthood, and, c) the development of a stable and consistent personality structure. The increase in AN and BN is related to the strong emphasis contemporary society places on appearance, particularly body shape (Nagel & Jones, 1992). Unfortunately, changing contemporary society's emphasis on body image and appearance may be a near-impossible task. The change
needs to come from within those struggling with disordered eating. The decision to dispel the temptation to be defined by a culturally defined appearance ideal must come from within those who struggle. Although many treatments and programs continue to be developed, disordered eating amongst adolescents continues to escalate. This may be an indication that we need to further evaluate the participants' experiences in such programs and treatment regimes. Adolescent girls, in particular, deserve a voice regarding their struggle with this potentially fatal disease. This voice has not been acknowledged in the past and it greatly increases frustration and perceived lack of control which is such a pervasive factor in disordered eating (Zerbe, 1993). Therefore, this study will give a voice to adolescent girls struggling with disordered eating.

While disordered eating is often theorized to be a developmental disorder, few studies examine the normative data in populations at risk (Steiner, Sanders & Ryst, 1995). In a short-term study, Attie and Brooks-Gunn (1989), followed 193 girls from grade 7 to grade 10 for 2 years. They tested the hypothesis that the development of anorexia nervosa represents an accommodation to puberty. These researchers used physical status measures as well as questionnaires about body image, psychopathology, personality dimensions and family relationships. Multiple regressions confirmed that AN emerged in response to pubertal change. Girls who felt most negatively about their bodies at puberty were at increased risk of developing disordered eating. The conclusions from this study may indicate that pubertal changes, such as the rapid accumulation of body fat, may serve as a trigger for negative body image and result in an attempt to restrict caloric intake or absorption (Abraham & Llewellyn-Jones, 1992; Attie & Brooks-Gunn, 1989; Dolan & Gitzinger, 1994). Thus, intervention with adolescent
girls struggling with disordered eating must recognize these unique developmental factors.

Many educational groups prove effective, however, they do not always address the subjective, phenomenological experience of the participants. An educational group program aimed at improving body image, eating attitudes and behaviors conducted in Australia proved highly successful concurrently as well as one year following intervention (O'Dea & Abraham, 2000). This study showed that there are benefits of group experience but it seems necessary to conduct in-depth interviews of those participating in the group to get a sense of their experiences. Another intervention which is currently being used is the motivational enhancement model.

Due to their resistance to treatment, those struggling with disordered eating have been compared to people with substance abuse problems (Vitousek, Watson & Wilson, 1998). Both groups have been identified as unmotivated and reluctant to present for treatment. It may be useful to apply some of the motivational approaches used in the field of addictions to help those struggling with disordered eating. The term "Motivational Enhancement Therapy " (MET) has been assigned to such treatment specific to disordered eating. Incorporated into this model are other theoretical elements including aspects of developmental theory, cognitive behavioral therapy (C.B.T.), narrative approaches and feminist theory. The M.E.T. approach is based on the transtheoretical model of change (Prochaska & DiClemente, 1992). This approach will be explained in detail further in this paper. It was developed with the addictions field in mind in an attempt to understand how people change unwanted behaviors. With eating disorders, treatment refusal, lack of compliance and dropouts during treatment programs
are very common problems which would indicate that readiness to change would be important to address prior to treatment (Geller, 2002; Geller, Cockell & Drab, 2001; Rieger, Rouyuz, Schotte, Beumont, Russell, Clarke, Kohn & Griffiths, 2000). Motivational approaches are intended to promote change through increasing the client's sense of autonomy and responsibility for change (Geller, Hastings, Goodrich, Zaitsoff & Srikameswaran, 2001). One of the key focus points of this study will be the motivational model.

The purpose of this study is to determine adolescent girls' experiences in a motivational enhancement group for disordered eating. Motivational enhancement is based on a process of change which examines clients "readiness to change" based on their current stage of the change within Prochaska & DiClemente's model of the change process. Many adolescent girls struggling with disordered eating are very ambivalent about change and may even view their symptoms in a positive light (Freedman & Leichner, 2001). Thus it can be very challenging for practitioners working with this population. One of the main obstacles relates to the fact that it may be very difficult to create a therapeutic alliance. Freedman and Leichner (2001) suggest that a therapeutic alliance is created through the practitioners' display of trust, warmth and genuineness. It is also important to respect the client's concerns and convey an understanding of their beliefs in a non-confrontational manner. Thus, conducting research which will reinforce the client's "voice" in their treatment is an approach which is not only important for furthering our knowledge of treatment but it also empowers the adolescent client by fostering a feeling of "being heard".
Historically, there seems to be an absence of research focusing on female participants' experiences in support groups or efficacy of groups based on participant reports. Although there has been an increased emphasis on women's groups since the 1960's, efficacy based on self-reports have not yet been researched significantly.

This study investigated: "What are adolescent girls' common experiences in a motivational enhancement support group for disordered eating?" Through qualitative, open-ended questioning, I identified common themes or areas of significance which are of importance to girls. Awareness of the girls' phenomenological, subjective experience in the Motivational Enhancement group and how it affects the perception of "recovery" and their readiness to change will enhance our knowledge in the field of counselling those struggling with disordered eating.
Literature Review

It is estimated that 200,000 to 300,000 Canadian women aged 13 to 40 (.5% to 1%) have anorexia nervosa and twice as many struggle with bulimia nervosa (National Institute of Nutrition, 1993). Some studies which include broader definitions for eating disorders would show a lifetime prevalence of 3.7% for AN and 4.2% for BN (APA, 2000). As many as 10% to 50% of adolescent girls reportedly participate in occasional self-induced vomiting or binge eating (Fisher et al., 1995). Due to the rigid diagnostic criteria for disordered eating in the DSM-IV (APA, 1994), many adolescent girls do not necessarily meet diagnostic criteria for disordered eating, however, up to 20% of randomly selected adolescent girls score in the abnormal range on standardized tests of eating attitudes and behaviors (Fisher et al., 1995). Thus, this is a very severe and widespread problem which often begins in adolescence, when attitudes and beliefs are formed about body image, weight and appearance. Additionally, disordered eating can exist on a continuum and, therefore, many adolescent girls at risk may not even be diagnosed with an eating disorder but they are still at risk of developing unhealthy attitudes and behaviors around food, weight and body image.

Research

AN can be loosely defined as an intense fear of becoming obese resulting in reduced intake of food and severe weight loss. With BN, the key diagnostic factor is recurrent episodes of binge eating followed by compensatory behavior such as self-induced vomiting or laxative use to prevent weight gain. Literally, bulimia nervosa translates to "ox hunger" or voracious appetite. This historical definition fails to recognize the tragic psychological component of bingeing and purging. AN and BN
nervosa are diagnosed according to specific criteria defined by the American Psychiatric Association (1994) (See Appendix A).

DSM-IV also refers to "Eating Disorder Not Otherwise Specified" which I will not review at length for the purpose of this paper. Such diagnostic criteria allow for minor variance in the behaviors indicated as criteria for AN or BN.

Recent research suggests that the current diagnostic criteria are too restrictive (Garfinkel, Lin and Goering, 1996). It has also been suggested that the current DSM-IV criteria are not entirely applicable to an adolescent population. The DSM-IV criteria does not consider the unique developmental considerations of an adolescent population such as menstrual irregularities and the more extreme height and weight changes which may present at adolescence (Yager, Andersen, Devlin et al., 1993). Current research supports the importance of early recognition of disordered eating and that problems with eating can exist on a continuum. The use of strict criteria may exclude some adolescents from treatment when abnormal, and potentially dangerous, eating attitudes or behavior may be present (Fisher, Schneider, Pegler & Napolitano, 1991). Additionally, puberty is a time of greatly variable height and weight as well as a time when menstrual periods may be irregular. Psychological awareness of abstract concepts (such as distorted perception of weight or shape), which are included in the diagnostic criteria, may be difficult to assess in adolescents (Fisher, Golden, Katzman et al., 1995; Garfinkel et al., 1996; Kreipe, Golden, Katzman & Fisher, 1995; Yager et al., 1993). Although these definitions exist for diagnosis, practitioners must take such developmental factors into account when working with an adolescent population. Both AN and BN are very serious illnesses. The consequences of disordered eating during adolescence are particularly dangerous.
Recent research indicates that the most significant medical problems for adolescents are the potential for significant growth retardation, pubertal delay and peak bone mass reduction resulting in an increased risk for osteoporosis in adulthood (Fisher et al., 1995). Other consequences of disordered eating include potentially fatal conditions such as bradycardia or dysrythmia (Fisher et al., 1995). Estimates of mortality for AN are between 5% and 22%. Some of the deaths result from suicide indicating the serious psychological consequences and comorbidity concerns (Herzog, Sacks, Keller et al., 1993; Steinhausen, Rauss-Mason & Seidel, 1991; Sullivan et al., 1995; Herzog, Keller & Lavori, 1988). Approximately 50% of the patients with AN relapse after hospitalization. Five percent die as a direct result of self-starvation and those who have a relatively good outcome often continue to have difficulties with attitudes towards weight and eating (Yates, 1990). American Psychiatric Association (APA) (2000) reports that the percentage of individuals who fully recover from AN is modest. According to APA (2000), based on a review of a large number of follow-up studies with hospitalized or tertiary referral populations, at least 4 years after the onset, 44% of the patients could be rated as "good" (weight restored to within 15% of weight recommended for height); about 28% fell between those of the good and poor groups; and approximately 5% of the patients were early mortality. Overall, they report that approximately two-thirds of the patients continue to have enduring morbid food and weight preoccupation and up to 40% have bulimic symptoms. APA (2000) reports that in a long-term study of patients with BN, 6 years after treatment 60% of patients were rated as "good", 29% were of intermediate success, 10% were poor and 1% were deceased. APA also reports that the patients who function well and have milder symptoms at the start of treatment often have
better prognosis. Additionally, they note that patients' motivation as a preliminary measure prior to treatment has gained recent attention and has been show to impact the rapidity of response to care (Kaplan & Garfinkel, 1999; Tantillo, Bitter & Adams, 2001; Treasure et al., 1999; Geller, 2002; Geller, Cockell & Drab, 2001).

Additionally, disordered eating amongst adolescents must be examined closely. Although the statistics representing diagnosed eating disorders among adolescent girls are alarming, this does not even reflect the magnitude of adolescents affected by maladaptive, unhealthy beliefs and weight management practices. The fact that disordered eating exists on a continuum from unhealthy beliefs, attitudes and behavior to full-blown AN, BN or eating disorder not otherwise specified. The negative sociocultural and health implications as a result of public self-consciousness around weight and shape must be taken into consideration when working with adolescent girls (Levine & Smolak, 2001). In one study, more than half of the adolescents evaluated for eating disorders had subclinical disease but suffered a similar degree of psychological distress as those whom met strict diagnostic criteria. Included in this group were patients who did not meet the DSM-IV criteria for anorexia nervosa, bulimia nervosa or binge eating disorder. Some of the factors which may exclude them from the diagnostic criteria include: those who had not yet lost 15% of the expected weight for their age and height, those who purged but did not binge and those who were amenorrheic for less than 3 months (Bunnell et al., 1990). It is estimated that 50% of normal weight high school girls were on a diet and some were using compensatory measures, such as self-induced vomiting or laxatives, to lose weight. Such behaviors have been shown to frequently lead to the development of a clinical eating disorder (National Institute for Nutrition, 1993). Thus, one can see the
prevalence of eating disorders and the fact that weight and body image has become a
damaging preoccupation for female adolescents.

Sullivan, Bulik, Fear and Pickering (1998) studied the outcome of all female
patients referred to an eating disorder service between January 1, 1981 and December 1,
1984. In a 12-year follow up study, 70 of these women were contacted and agreed to
participate (86.4% of the original patients). They were compared to a group of 98
women representing a random community sample (screened to exclude any with anorexia
nervosa). Only patients referred for the first time during the above mentioned time frame
were included in the study. Approximately 12 years later, at the outcome interview,
15.7% of those in the anorexia nervosa group met the criteria for current anorexia
nervosa and more than 50% met the criteria for current bulimia nervosa. The authors also
reported high rates of comorbid major depression, alcohol dependence and cognitive
restraint. The women in the study group had a persistent focus on thinness and
maintained relatively low body weights. Body weight and shape concerns were much
more marked among the women in the anorexia group compared to those in the control
group. The two groups also had profound differences on all body mass index variables.
There were also marked differences between the groups on the Eating Disorder Inventory
(EDI) and the Three-Factor Eating Questionnaire (TFEQ). The most obvious differences
on the EDI were drive for thinness, perfectionism and cognitive restraint. The "lower
hunger" category showed the greatest difference on the TFEQ. The anorexic patients
also had a higher lifetime prevalence of alcohol dependence, mood, anxiety, panic
disorders, separation anxiety and over-anxious disorder than women in the control group.
Additionally, their Global Assessment of functioning scores were significantly lower than
those of the comparison group. Thus, even though they may not have met the criteria for anorexia nervosa, their low body weights, perfectionism and cognitive restraint persisted. The authors of this study stress that due to the onset of managed care/brief treatment era, patients may be at risk for receiving less care and outcomes with issues such as disordered eating cannot be expected to improve unless treatment is refined to ensure the greatest chance of recovery and efficient use of resources. Their findings also highlight the fact that treatment focused on weight gain with little attention being given to the underlying psychological issues or comorbidity may decrease the chances of sustained recovery from disordered eating.

Fairburn, Norman, Welch, O'Connor, Doll and Peveler (1995) indicate that the outcome of studies comparing various treatment approaches highlight the need to focus on interpersonal issues and cognitive awareness (through interpersonal therapy and cognitive behavioral therapy, respectively) in comparison to strictly behavioral interventions in the treatment of bulimia nervosa. Their study involved two different psychotherapy trials conducted in Oxford, England in the 1980's. There were 24 patients in the first trial and 74 patients in the second. The mean length of follow up was 5.8 years. The outcome study examined patients who received cognitive behavioral therapy (CBT) (n=35), behavioral therapy (BT) (n=22) and Focal Interpersonal Therapy (FIT), which is comparable to Interpersonal Therapy (IT) (n=32). Comparatively, a significantly poorer outcome was noted for patients who received BT only. Of the patients who received BT treatment, at follow-up 86% met DSM-IV eating disorder criteria. In comparison, those who received CBT and FIT, 37% and 28%, respectively, met criteria for an eating disorder according to DSM-IV criteria. There are some limitations to this
study including the fact that the follow up time ranged from 3 to 11 years. Although the mean follow up time was 5.8 years, this indicates a wide range. Additionally, this study examined data from two separate treatment trials and combined two different forms of FIT. The results, however, did not show a difference in outcome between the two similar treatments. There are several strengths to this study as well. The recruits for this study were consecutive referrals from a defined geographic area where there were no other competing treatment facilities. Thus it would represent a typical sample of individuals struggling with disordered eating without excluding anyone on the basis of choice in different treatment programs. Secondly, 90% of the original cohort was interviewed. This study shows the need to determine which treatments are most effective based on the reports of those struggling with disordered eating. Based on these findings, it is clear that treatment options must be carefully examined for adolescent girls in order to ensure that successful recovery is initiated at a crucial developmental stage.

Etiology

The factors contributing to the development of an eating disorder are complex and multifaceted. Each individual struggling with disordered eating is unique and their issues surrounding food, eating and body image must be explored in depth. In general, researchers concede that a mix of sociocultural factors, familial factors, personality characteristics, psychological vulnerability and genetics contribute to the causal factors.

Some theorists have suggested that eating disorders could be explained as predominantly a sociocultural phenomenon (Levine and Smolak, 1994). In general, many Western countries equate beauty with thinness. Gowen and Hayward (1999), found that the more acculturated Hispanic-American girls were more likely to be
diagnosed with disordered eating. Their study supported their hypothesis that higher levels of North American acculturation are related to disordered eating. Thus, one can conclude, with caution, that the higher level of acculturation is a result of exposure to Western culture through the media and other such forums. The media portrays a very unrealistic image of our bodies. The average female model weighs up to 25% less than the typical woman and maintains a weight at about 15 to 20 percent below what is considered healthy for her age and type. In addition, the images presented through the media are often altered before going to print. Thus, these images which portray “happiness” are absolutely unobtainable. Our society continues to foster attitudes around thinness and beauty being equated with happiness. Thus, in addition to being bombarded with media messages, family and peers continue to perpetuate unhealthy attitudes around appearance and body image. During early adolescence, girls in particular value the advice and support of peers about personal issues such as attractiveness and self-control (Berndt and Perry, 1990). Thus, one could conclude that the attitudes around body image or appearance are readily shared amongst peers furthering unhealthy views.

The family environment has been studied extensively in the literature. Haworth-Hoeppner (2000) identified significant pathways which seem common in much of the research done of family factors in the development of eating disorders: a critical family environment, particularly when it is focused on weight, a critical family environment and an atmosphere of coercive parental control and a main discourse on weight. Haworth-Hoeppner also suggest that these pathways are significant in addition to the ways families mediate cultural messages. Family dynamics are important and may be more significant for some individuals than others. The family processes take place in a larger cultural
context, in which thinness is valued, and families whom value achievement can create a very volatile mix. In our culture, achievement of a slender body is linked to qualities such as motivation (Hill and Lunskow, 1995), hard work (Sobal, 1995) and strong moral character (Bordo, 1993 as cited in Haworth-Hoepner). Therefore, one can see how the value of such qualities in a family environment which emphasizes achievement could create a “gateway” for disordered eating.

Research Related to Treatment Options

It is clear that there are many different treatment options for practitioners assisting those struggling with disordered eating. According to Oltmanns, Neale and Davison (1995), a survey conducted at the International Conference on Eating Disorders concluded that less than 50 percent of practitioners believed that there is consensus on the treatment of eating disorders. Since the time of their survey, practice guidelines, including those published by the American Psychiatric Association (APA) have provided, perhaps, a clearer direction for treatment. There are many different theories and approaches. Although this may be confusing for practitioners, it does allow for many options which will suit individual clients. As Geller (2002) emphasizes, based on the high cost of eating disorder treatment, appropriate treatment decisions which increase the likelihood for recovery are critical.

As noted by Mehler (2001), AN is often a protracted disorder. Based on the conclusions of several long-term outcome studies, he notes that the AN (in particular) is a problem which can have long-term, devastating effects. Zipfel, Lowe, Reas, Deter and Herzog (2000) show that 16% of patients diagnosed with AN continue to meet criteria for AN more than a decade after the initial diagnosis. Based on such findings, it seems
logical for the purpose of this study to examine the history of treatments which are showing such results.

Based on their 12-year follow-up study, Sullivan et al. (1998) show that practitioners must ensure that patients receive thorough care. In their long-term, case-control study they found that anorexia nervosa often persisted or many patients currently meet criteria for bulimia nervosa 12 years following treatment for their eating disorder. They also found high rates of comorbid major depression, alcohol dependence and cognitive restraint. Their study showed that this is particularly true when treatment is focused on weight gain and little attention is given to underlying psychological issues. Additionally, when there is underlying comorbidity such issues must also be addressed to ensure successful recovery.

Zerbe (1993) refers to the compilation of treatment modalities which were undertaken in 1993 by the American Psychiatric Association Work Group on Eating Disorders. The group established various guidelines for working with eating disorder patients while acknowledging the need for individuality in treatment options. The APA Work Group, as reported by Zerbe (1993), describes treatment in terms of three general modalities: medication, group therapy and individual therapy. Various models have been used within these treatment modalities, however, historically, the most common forms of treatment mentioned in the literature are behavioral therapy, CBT, Interpersonal Therapy (IPT), Family Therapy and Biomedical Approaches (e.g. hospitalization and medications).

There is an abundance of literature regarding the efficacy of various treatments and it is evident that it would be very difficult to determine whether or not one treatment
could be considered superior to another for a diverse range of clients struggling with disordered eating. Overall, the problem of identifying which treatment options may be most effective has to do with the limited number of well-controlled outcome studies which examine the long-term outcome of various treatments (Gore, Vander Wal & Thelen, 2001). They highlight the fact that few controlled studies of eating disorder treatments have been conducted with children and adolescents and this is a critical developmental stage in relation to disordered eating. Additionally, Gore et al. (2001) point out that although various treatments have been studied traditionally in the literature, comparisons of the effectiveness of the different components of treatment is needed. Despite such gaps in the research, practitioners are well guided by several key factors in treatment. With any eating disorder treatment, medical stabilization and weight restoration are paramount. As Anderson, Bowers and Evans (1997) indicate "restoration of a healthy body weight is best seen as a means, not an end, to comprehensive treatment" (p. 331). Thus, nutritional status and body weight are a necessary component of treatment and create a foundation for the multi-factored approach which must be developed individually for each client.

Overall, CBT has proven to be significantly effective (Wilson, Fairburn & Agras, 1997). CBT is based on the premise that extreme attitudes about eating and the body are modified through examination of the client's cognitive processes. The therapy is a combination of behavioral techniques, such as the self-monitoring of food, with strategies to combat cognitive distortions and dysfunctional thoughts. In the early stages of therapy, the approach is more behaviorally focused whereas it shifts to a greater emphasis on cognitive techniques in the mid and latter stages of treatment (Gore et al., 2001). They
suggest that CBT has been studied significantly for use in adult populations, however, developmental considerations such as cognitive ability must be examined when working with children or adults. CBT has proven effective in many different studies. Agras et al. (1989) showed that CBT was more effective in treating BN than supportive-expressive therapy (SET). One of the longest follow-up studies was conducted by Fairburn et al. (1995). They evaluated treatment outcome an average of 5.8 years following therapy. They found that the posttreatment-effects of CBT were maintained (an abstinence rate for purging or compensatory behavior of 48%). They had compared CBT to BT and IPT. In the post-treatment follow-up which was conducted one year following treatment, CBT showed the greatest promise of the three therapies for its effectiveness in reducing purging, dietary restraint and attitudes to shape and weight. This study highlights the fact that the treatment chosen can produce specific effects. The above study shows that the effects of CBT are consistent with its theoretical rationale as it showed the greatest difference in attitudes to shape and weight.

Behavioral therapy (BT) involves techniques such as exposure, relaxation, modeling, visualization and role playing in addition to various reinforcers which are linked to target weights or desired behaviors. Activities such as planned meals, often referred to as "meal support" in some treatment centres, is also a form of BT which is commonly used. APA (2000) recognizes BT as one component in the treatment milieu for both BN and AN. Thus, it does play a role in treatment, however it does not address the underlying beliefs and emotions which accompany disordered eating (Gore et al., 2001). It is clear that the underlying psychological issues are a core component in the treatment of eating disorders.
Interpersonal therapy (IPT) places the symptoms of the eating disorder in a larger interpersonal context. Rather than exploring cognitive processes, treatment involves exploring individual events, defining the client's expectations, developing alternative ways of coping with such events and practicing these behaviors (Gore et al., 2001). It has been noted that IPT is helpful for adolescent clients, particularly those struggling with BN (Gore et al. 2001). Fairburn et al. (1995) found that 52% of their clients participating in a long-term follow-up study which compared three different treatments for BN had remained maintained abstinent from bingeing and purging behaviors for an average of 5.8 years.

In addition to CBT, IPT and BT, family therapy is noted to be useful for symptom alleviation and resolution of problems which may be contributing to the maintenance of an eating disorder. As previously discussed in the etiology section, familial characteristics can be a contributing factor to an eating disorder and such patterns must be reconstructed and examined. Minuchin (1978) was one of the earliest supporters of the argument that families characterized as enmeshed, overprotective, rigid and limited in conflict resolution were at risk for children with an eating disorder. There now seems to be differences noted in family functioning between families with children who develop BN versus those who develop AN (Humphrey, 1994). Families characterized by chaos, hostility and less nurturance or empathy were often associated with BN and those who were rigid and dependent were often associated with AN. Thus, it is clear that various familial traits seem to be salient for adolescents struggling with either BN or AN and the importance of the role of the family in treatment is well supported. There is also a promising new family therapy treatment for adolescents struggling with AN. It
approaches the obsessive anorexic mindset as the villain rather than blaming the patient or family. This form of treatment involves the family in the therapeutic approach. One study reports that two-thirds of all patients reached a weight within a normal range for their height, showed striking improvements in psychological functioning and the parents become less critical of each other and their children by the end of treatment (DeAngelis, 2002).

Although there is an abundance of literature on family therapy in anorexia nervosa, there is very minimal outcome research on family therapy as applied to BN (Gore et al., 2001). The research does show that the clients who show the best outcome with family therapy are the younger clients with earlier onset of symptoms, particularly in the AN population (Russell, Szmukler, Dare and Eisler, 1987). This certainly makes sense from a developmental perspective as younger children tend to be closely tied to the family as opposed to the stronger peer orientation which occurs later in development.

Another treatment area in eating disorders is the use of pharmacotherapy. Although there is a lack of research on children and adolescents and outcome studies involving pharmacotherapy for disordered eating, the adult literature indicates that psychotropic medications are of benefit. The most commonly used medications to treat eating disorders are the Selective Serotonin Reuptake Inhibitors (SSRI's). The most familiar of these drugs would be Fluoxetine (Prozac), Sertraline (Zoloft) and Paroxetine (Paxil). According to the results of the Fluoxetine Bulimia Nervosa Collaborative Study Group (1993), fluoxetine (Prozac) has been promising and has shown fewer side effects than the previously used tri-cyclic antidepressants. This study included 387 participants. The treatment group was divided into three separate groups consisting of 129 participants...
each. One group was given 20 mg of Fluoxetine Hydrochloride (Prozac) per day, another group was given 60 mg Fluoxetine Hydrochloride per day and the third group was given a placebo. At the end point of the study (8 weeks) the group receiving 60 mg/day, 20/mg/day and placebo of Prozac has a 56%, 29%, 5%, respectively, median reduction of vomiting episodes and a reduction of 67%, 45% and 33%, respectively, in binge eating episodes. Thus, the fluoxetine administered at 60/mg per day showed to be significantly superior in decreasing undesirable bulimic behaviors. Although there was also an improvement for the group receiving 20/mg per day, the effects were not as robust. One of the limitations of this study is that it was based on self-reports of bingeing and purging behavior. This makes it somewhat difficult to assess the reliability of these self-reports as participants may feel shame about the actual number of bingeing and purging episodes when questioned for the purpose of the study. Another consideration is that the participants may have responded to factors other than the drug therapy. As they were selected from various treatment centres in the U.S. and Canada, they were generally receiving some other form of treatment such as group or individual counselling. It would, therefore, be difficult to attribute favorable results to the drug therapy alone.

As the use of fluoxetine and similar medications do show promise in the treatment of disordered eating, it may be useful to understand the physiological effects of the medication which reduces binge/purge behavior. Although the exact mechanism of action of fluoxetine in BN remains uncertain, it is believed that a SSRI can inhibit carbohydrate craving and hence binge eating. Some of the side effects which may occur with the use of such drugs include insomnia, nausea, asthenia, tremor, sweating, urinary frequency, palpitation, yawn, mydriasis and vasodilatation. There is caution against use
of such medications as the primary treatment for AN, but they are helpful for relapse prevention in weight-restored patients. It is suggested that antidepressants are quite effective, when used in conjunction with other treatments, to decrease binge and purge symptoms in patients with BN (APA, 2000). As the clients participating in this study will be involved in a treatment program, they may be receiving some medical or psychotropic treatments, therefore, it is important to be familiar with the range of customary treatment options.

In summary, APA Practice Guidelines (2000) support the presented literature that a combination of CBT, IBT, BT, family therapy, medical interventions (including the use of medications) and nutritional rehabilitation are all useful treatment interventions for practitioners treating clients struggling with disordered eating.

Research Related to Motivational Model

Group treatment for disordered eating is usually viewed as an adjunct to individual therapy, nutritional guidance and medical intervention. Gordon and Ahmed (1988) found group therapy in general to be beneficial for clients struggling with disordered eating. Researchers suggest that psycho-educational groups run in 8-week cycles independent of other treatment can be an effective agent for change, and with some clients may be the only intervention required (Olmsted, 1991). Support groups have proven effective for girls struggling with other issues such as sexual abuse and depression (Butler and Fontenelle, 1995; Lindon and Nourse, 1994). The phenomenon of "mutual recognition" in a support group for adolescents has been reported by participants as beneficial, and, in particular, led to enhanced self-esteem (Mishna, 1996). In a long-term follow-up study of women who had recovered from anorexia, Hsu, Crisp and Callender
(1992) examined the women's subjective experience 20 years following their initial treatment. They interviewed 6 clients who had been treated for AN between 1965 and 1973. From the 6 cases, they were able to operationally define common themes reported by the women based on their self-reports of factors contributing to recovery. They reported that "being understood" was one of the most important factors in sustained health. There are several limitations to this study, including the limited number of participants and the difficulty in determining that the terms used are defined the same way by different patients. However, the importance of consulting the client years later and determining which factors may seem most memorable in their recovery can certainly be considered with great interest. Additionally, one can conclude that a support group of peers experiencing similar challenges would prove very instrumental to "being understood". Thus, the group component of this study would likely prove highly effective.

One of the models currently being used in eating disorder treatment is the motivational model. The model describes the five stages through which people pass while trying to change. Each stage represents a motivational level of change. The stages are as follows (Prochaska and DiClemente, 1994):

1) Precontemplation: behavior is not recognized and there is not attempt to change.

2) Contemplation: recognition of the problem behavior, however, there is ambivalence about change.

3) Preparation: Person wants to change but does not know how or needs assistance.

4) Action: Person is in the process of changing behavior.
5) Maintenance: maintaining the change in behavior and avoiding regression to the problem behavior.

This model of change should be viewed as "spiral" as opposed to a linear progression. Clients may cycle back and forth between the stages (Feld et al., 2001). In a pilot study, motivational measures suggested that participant's motivation to change increased following M.E.T. intervention. A decrease in depressive symptoms and an increase in self-esteem measures were also reported (Feld et al., 2001).

The central component of the M.E.T. group is Prochaska's Process of Change Model (Prochaska et al., 1994). This frames the group experience within a model of change. Clients feel a sense of empowerment simply by coming to group (Tantillo, Bitter and Adams, 2001). It contributes to consciousness raising, social awareness and self-evaluation. The change model creates a more realistic set of expectations about just how change can be achieved with this particular client population. The group process is a very important impetus for change as denial and ambivalence can be a very debilitating factor in recovery from disordered eating. These factors can keep those struggling with disordered eating stuck in the early stages of change (Tantillo et al., 2001). When some group members are taking action, it may mobilize the defenses of those who are not ready to break free from disordered eating.

Vitousek et al. (1998) compare eating disorder patients with those struggling with substance abuse problems. Both populations are commonly described as ambivalent and unlikely to present for treatment willingly. Kaplan and Garfinkel (1999) also recognize the difficulty in treating these clients. They suggest that clinical factors such as comorbidity and patient resistance contribute to the challenge of working with eating
disorder clients. The trans-theoretical model of change has been suggested as a model for
treatment based on the rationale that treatment failures with such populations have
occurred due to the fact that the patient’s readiness for change does not match the
treatment approach (Prochaska, DiClemente & Norcross, 1992). Research has been
conducted to determine if the trans-theoretical model of change is applicable to people
struggling with eating disorders and the general conclusion is that it would be a useful
framework for intervention and treatment. (Ward, Troop, Todd & Treasure, 1996; Blake,
Turnbull & Treasure, 1997; Treasure et al., 1999).

Treasure et al. (1999) examined the transtheoretical model of change in treating
BN. In their study, 125 female participants were randomly assigned to one of three
groups. One group received 4 weeks of MET followed by 8 weeks of group CBT (n=48),
a second group received 4 weeks of individual CBT followed by 8 weeks of group CBT
(n=38) and the third group was given 4 weeks of MET followed by 8 weeks of individual
CBT (n=39). The two groups in which MET was administered for the first 4 weeks were
combined. Thus, 87 patients were allocated to the MET group and 38 to CBT. The
results of this study were based on the frequency of episodes of binge eating, vomiting
and laxative abuse. The stages of change were measured using the 24-item University of
Rhode Island Change Assessment Scale (URICA). This scale is not specific to BN, it
only refers to the "problem" behavior. The questionnaire provides scores on three scales
of precontemplation, contemplation and action as well as assigning patients to a
particular stage on the basis of the scale with the highest score. The study also assessed
therapeutic alliance using the Working Alliance Inventory (WAI). This 35-item
questionnaire assesses the quality of the patient-therapist "bond" and the degree to which
the patient and therapist agree on the tasks and goals of the therapeutic process. Both the client and therapist complete this questionnaire. There were not significant demographic differences between the two groups and the severity of their eating disorder behaviors. The study reflected a significant reduction in the frequency of binge eating, vomiting and laxative abuse over the first 4 weeks of treatment. There was not a significant difference between MET and CBT treatments in reducing symptoms. There were, however, significant differences in binge eating episodes between the participants who were in the action stage prior to treatment and those in the contemplation stage. Thus the results reflect that readiness to change is a significant factor influencing treatment outcome and motivational enhancement would be a helpful foundation for other facets of eating disorder treatment. On therapeutic alliance measures, the study did not reflect a significant correlation between bond and goal with the degree of improvement in any of the symptoms measured. However, therapist and patient ratings of task agreement were positively related to improvements in binge eating. Additionally, clients with higher pretreatment action scores perceived greater therapeutic alliance after four weeks. One of the difficulties with this study is the methodology of measuring the stages of change. As this can be a vague concept, it if difficult to measure accurately. Another limitation would be the limited number of participants. Ideally, a greater number of participants would be necessary to examine interaction effects. Overall, however, readiness change was a strong indicator of improvement and the development of a therapeutic alliance.

A recent study conducted by Pettersen and Rosenvinge (2002) with adult women struggling with disordered eating, showed that positive treatment experiences were related to timing and being in an action stage to change. Their study is particularly
relevant to the study presented herein as it presents the patient perspective on treatment. They selected 48 participants from patient organizations on eating disorders and from a hospital eating disorder unit. The mean age of the participants was 27.6 years. Forty-six (96%) of the participants were students or in stable jobs while two participants were living on sick-pension. On average, the participants had eating disorders for 11.1 years. Ten subjects reported current or previous history of AN, 10 of BN and the remaining had binge eating disorder or a mixture of AN and BN (n=8 and n=20, respectively). The general aspect of recovery was reported as the desire for a better life and all participants reported that admitting their eating disorder was the first step on the road to recovery. Pettersen and Rosenvinge (2002) report that treatment effects were related to a feeling of "being ready" or "motivated to change" (p. 66). They stressed the need for a positive therapeutic alliance which conveyed understanding, empathy, respect and seeing the individual "beyond the symptoms" (p. 66). The other effects which were reported by participants included the opportunity to meet with other sufferers in support groups, internet chat groups, meetings and courses. The third aspect involved the effects of positive life events and important persons. This included support from friends or family and positive life events (i.e. achieving educational goals or meeting a partner). Generally, they described some of these events as the last boost they needed to overcome their eating disorder. Through this exploratory study, a general aspect of recovery was determined which was "the desire for a better life" (p. 65). Thus, the results support the importance of the patient perspective and their feelings of control and decision around recovery. One of the major limitations of this study is the fact that normative data has not been collected from the general population to control for statistical variance in measuring
recovery. The researchers recognize that, as a result, the fallacy of "supernormalism" could create or "exacerbate negative perfectionism" and "unrealistic personal standards" for eating disorder clients (p. 70). Through the study I am proposing, I hope to further evaluate this process and gather information related to eating disorder clients' experiences in treatment. Through the generation of such information, practitioners in the field may gain greater insight into the most beneficial use of resources when treating those struggling with disordered eating.

The goal of the therapeutic style used in motivational enhancement is to assist clients in reaching a decision to change by shifting their intrinsic motivation. This is accomplished by increasing the client's recognition of incongruencies between present behavior and longer-term goals and values. Thus, the decision to change is reached by the client rather than being forced upon them by a therapist or other treatment professionals. (Feld et al., 2001).

Motivational enhancement therapy integrates the trans-theoretical model of change and the skills of motivational interviewing. An example of a comparative study from the addictions field utilizing Motivational Enhancement Therapy (MET) is the "Matching Alcoholism Treatments to Client Heterogeneity" (MATCH) Research Group (1997). The Project MATCH research group consisted of alcohol dependent clients who were randomly assigned to CBT, Motivational Enhancement Therapy (MET) and Twelve-Step Facilitation Therapy. The goal of this research was to determine whether specific client characteristics warranted greater strategies around triaging clients to appropriately matched treatments. Although this was not the goal of the study and did
not necessarily address the hypothesis, it was determined that four sessions of MET were as effective as 12 sessions of cognitive-behavioral therapy or 12-step facilitation therapy.

This study was very extensive and involved two parallel clinical trials. One with clients receiving outpatient therapy (n=952) and one with clients receiving aftercare therapy following an inpatient or day treatment hospital program (n=774). The treatments were administered over a 12-week period and the clients were monitored over a one-year post-treatment period.

There are several limitations to this study, including the fact that it is difficult to determine levels of life difficulty related to alcoholism and make such comparisons between participants. Additionally, a longer-term study would be even more informative. Although this study does not answer the research question specifically with regard to matching, it does support motivational enhancement therapy as a useful form of therapy which may certainly be useful in eating disorder treatment due to the parallels with the client population around ambivalence and readiness to change.

Perhaps more relevant to this study, Treasure et al. (as cited in Feld et al., 2001) conducted a study on people with BN nervosa in 1999 and found that MET is effective for the first phase of treatment. Feld et al. (2001) conducted a pilot study using MET on patients with eating disorders. In their study, nineteen individuals who were referred for eating disorder treatment participated in the study. All participants were 17 and older and met criteria of AN, BN or eating disorder not otherwise specified (EDNOS). The objective of the study was to develop and conduct a pilot evaluation of a pretreatment MET group for patients with eating disorders. The intervention was based on the existing literature from the addictions field and that which has been developed
specifically for eating disorders. A treatment manual was developed for this study. The measures used to study motivation included the University of Rhode Island Change Assessment (URICA), the Concerns and Change Scale (CCS), and three Likert motivation scales. The URICA provides scores for the stages of change including precontemplation, contemplation and action.

A significant increase was detected on the mean action stage subscale of the URICA. A significant increase occurred on all three of the Likert motivation scales. The three scales include: "How motivated are you to change?"; "If you decided to change how confident are you that you would succeed?"; "How ready are you to change?". A significant increase was noted from Session 1 to Session 4 on all three scales. Of the CCS subscales, "failure to recognize the irrationality of the problem" decreased significantly following the intervention, thus indicating a shift in the motivation to change.

It also showed a statistically significant decrease in the mean Beck Depression Inventory (BDI) in the post-intervention assessment compared with the pre-intervention assessment. Their results also showed that the participants viewed their behavior as much more of a problem following MET intervention. Additionally, the Eating Disorder Inventory showed a significant decrease in the "Interpersonal Distrust" category following MET intervention (Feld et al., 2001).

One of the limitations of this study is that of the 38 patients assessed for the study, only 27 entered the intervention and 19 completed the study protocol. Thus, one could conclude that this sample represented a group which was already showing readiness to change. These difficulties in recruitment, however, only further emphasize the need to
examine motivational factors as the degree of ambivalence is very high in this population. Feld et al. (2001) report that their findings are very promising for the future of eating disorder treatment.

Overall, the qualitative feedback was very positive and encouraging and they only suggested that the treatment should have been extended for a longer period of time. As this was a pilot study it certainly highlights the need for further research in this area. It would be particularly interesting to conduct such a study with follow-ups at various time intervals. Through the study I propose, I will gain the client perspective from the adolescent girls in this group. The current literature does not reflect this research area and it is a very important stage for intervention in eating disorder treatment.

Pettersen and Rosenvinge (2002) report their findings from a patient perspective. They found that all the patients in their study admitted that recognizing that their eating disorder was a problem and the desire for a better life was the first step toward recovery and could take years to reach that point. They report (Pettersen and Rosenvinge, 2002): "The overriding motives to recover were to prevent the eating disorder from dominating life, to evade negative medical, social or professional consequences of eating disorders were "fed-up" with having an eating disorder" (p. 65). Overall, these findings seem to provide some insight toward understanding the need to address readiness to change in the treatment of eating disorders.
Method

The goal of this research was to explore the experiences of adolescent girls in a motivational enhancement group for disordered eating. Specifically, I was interested in the common experiences of the participants in the therapeutic motivational enhancement group. In order to understand the experiences from the girls' perspectives, a phenomenological research methodology was used. A phenomenological study describes "the meaning of the lived experiences for several individuals about a concept or the phenomenon" (Creswell, 1998, p. 51). Marshall and Rossman (1999, p. 112) describe phenomenology as follows:

...the study of lived experiences and the ways we understand those experiences to develop a world view. It rests on an assumption that there is a structure and essence to shared experiences that can be narrated. The purpose of this type of interviewing is to describe the meaning of a concept or phenomenon that several individuals share. (p. 112)

In-depth interviews were conducted to extract thick, rich data which reflect the subjective view of the participants. In short, this study explored the lived experiences of the girls in the motivational enhancement group.

Theory of Phenomenological Method

Throughout my research, I maintained a phenomenological stance. Phenomenology is the study of the meaning of a concept or phenomenon that is shared by several individuals. This impacted the interviewing, recording and analysis of data. I incorporated what Creswell (1999) refers to as the sociological perspective and the psychological perspective of phenomenology. From a sociological perspective, this study
explored the experiences of the individuals within the motivational enhancement group and how the group impacted them. From a psychological perspective, it explored the meaning of individual experiences which are independent of group interaction but which have were influenced by the individual’s participation in the group. This research methodology is in-depth and allows readers to capture the essence of what is being reported by the participants (Creswell, 1999). Through the report of my research findings I have depicted, as accurately as possible, what the experience was like for the participants in this motivational enhancement group. As Rice and Ezzy (1999) describe, phenomenological inquiry to centre around the “life-world” of the participants (p. 15). This approach is an in-depth look into the core experiences and the meaning they attach to such experiences in the context of their individual life.

Researcher’s Involvement

Rice and Ezzy (1999) describe qualitative research as “reflexive.” They are able to reflect on the experience as the participants describe it and be aware of their personal beliefs and biases. By reflexive they are referring to the fact that the researcher is part of the setting, context and culture they are seeking to understand. Thus, in order to accurately analyze the data, the researcher must be aware and open about their role in the project. Cressman (1998) describes the researcher as an instrument of data collection with an awareness of preconceptions. Van Manen (1990) stresses the importance of being respectful of participants’ perspectives and reflect them as accurately as possible.

As the researcher in this study, I needed to carefully explore and become aware of my assumptions and biases. I also needed to identify what presuppositions I may have of the participants’ experiences. The process of making such assumptions, biases and
presuppositions known is referred to by Creswell (1998) as bracketing. It is suggested that by making them overt, the researcher is better able to discern how they may affect their interpretation of the data and thus ameliorate the possibility of shading the results with their own perception of the experience rather than that of the participants. In this study, I make my assumptions, biases and presuppositions known and will carefully analyse how they influenced the collection of data.

In my case, I come with several biases and assumptions. Due to my work in the field of eating disorder treatment, I believe that in order to recover fully, one must first be motivated to change. Thus, I believe that motivation for change is the impetus for recovery. Additionally, I believe that once a person struggling with disordered eating experiences a period of life free from their eating disorder they are able to progress upon their path to recovery and explore the underlying psychological issues. Once they are able to experience a life which is not inhibited by an eating disorder, their motivation to change will rapidly encourage a successful recovery. It has been my experience that many people struggling with disordered eating can become so entrenched in the disorder that they are not able to imagine life without an eating disorder. It seems to truly become a central part of their existence and, consequently, an important part of their identity. If they can reach a point when they are ready to shed this part of their identity, they can turn to alternate ways of being.

Secondly, I have had some very significant experiences as a counsellor with girls' struggling with disordered eating. These experiences have been some of the most rewarding and fulfilling. I have facilitated groups for girls struggling with disordered eating and I am always impressed by their ability to support each other through common
experiences. It seems that once they give themselves "permission" to accept each other, they are able to make significant insights based on their intimate ability to understand the challenges of being an adolescent girl in our society. I feel that this is a very core component to the motivational enhancement group as the participants will not only support each other but they will foster enhanced motivation due to group cohesion and identification.

This leads me to another area of significance with regard to my stance as a researcher. I may not be an adolescent girl in today's society, however, I can certainly relate to the pressures experienced by these girls. I feel that our society mandates a degree of perfection in appearance and performance which is felt across all generations. This is particularly significant as an adolescent as one is striving to achieve an identity and feel "special" or "outstanding" within a peer group. As an adolescent, I certainly experienced such pressures and, as a result, would identify this as one of the most difficult periods in my life to date. As a woman in today's society, I find that it is still a challenge to counter the messages we receive through the media about our appearance and the need to be "perfect" in every way. This is such a pervasive influence that it is not something we are even overtly aware of unless we remain critical of everything we experience. We are made to feel that everything in life will be perfect if we could obtain the unrealistic ideals which are portrayed in the media. As a result, change from something which may set us apart (i.e. being thin) may be difficult. It is my experience that it is always a relief when I can interact with others who challenge these ideals and represent acceptance of one's individuality. I think that this is a similar phenomenon, which can occur in support groups.
In terms of presuppositions, I would identify my belief that the motivational group would have a significant impact on the girls' and they would then feel they are ready to "accept" the other treatments they receive in the program. In other words, the motivational group would serve as a "launching pad" for their recovery. It was also my belief that the girls would share various themes or common experiences and these would serve a therapeutic purpose in their recovery from disordered eating.

I also held and continue to hold some assumptions with regard to the factors that contribute to the development of eating disorders. I believe that the factors which contribute to eating disorders are much like a complex puzzle which must be pieced together for each individual. I believe that eating disorders are a manifestation of much deeper issues and that these issues need to be explored. I also wish to emphasize, however, that the eating disorder behaviours must first be somewhat resolved and a certain level of nutrition and health must be achieved in order to successfully do the work necessary to explore such issues. Thus, it has been my belief that the motivational group provides a very important impetus for the emotional work which must be done to facilitate recovery.

I chose this particular therapeutic setting as it serves as a Tertiary Referral Program for disordered eating amongst the child and adolescent population in the province of British Columbia. It is also highly respected in the professional community and represents a high level of expertise and ethics in the field.

Although it is was not possible to completely set aside my biases and assumptions, I made the greatest effort possible to accurately record the experiences of the participants without my influence impacting the results. Self-awareness and making
my assumptions, biases and presuppositions known assisted me in accurate analysis of
the data gathered in this project.

Selection of Participants

The participants were adolescent girls (ages 14-18) struggling with disordered
eating who had been admitted to a multi-disciplinary eating disorder program. All girls
were from an urban area and were of Caucasian ethnicity. They had been referred to the
program by their primary care physician and assessed by various members of the
multidisciplinary team. All participants met current DSM-IV criteria for either anorexia
nervosa or bulimia nervosa. The group was a voluntary, closed group which comprised
one component of a hospital eating disorder program.

The participants were introduced to the opportunity to participate in the research
study following their participation in the group. The study participants were offered
incentive for their participation. The incentive consisted of a $20.00 gift certificate to a
popular music store. The parents and the participants were contacted regarding the option
to participate in the research project in the form of a letter from the program's Psychiatric
Director. The participants then made contact with the researcher if they wished to
participate in the study. At this time, the researcher provided a brief description of the
study and the requirements for participation were outlined. The participants were
required to complete a 30-minute screening interview at which time the researcher
described the study and determined their suitability for participation. At this point, a
parent/guardian was present to hear the details of the study and requirements for
participation and sign the parental consent form if they agreed with their daughter's
participation in the study. The participants were presented with a separate consent form.
Following the completion of the group, the girls were each interviewed for approximately one hour each to explore their experiences in the group.

Confidentiality and Consent

The supervisor of this thesis, Dr. Colleen Haney, served as a "gatekeeper" to ensure that ethics were observed with regard to confidentiality and consent. All participants and their parents signed consent forms (See Appendix C & D) which outlined the purpose of the study and their involvement. They were encouraged to notify myself or my supervisor, Dr. Colleen Haney, if they had any questions or concerns. Additionally, Dr. Pierre Leichner, the Psychiatric Director of the hospital program, was well informed at all stages of this project.

All data collected from this study was coded to maintain confidentiality, kept in a locked cabinet at University of British Columbia and any data on a computer required a password for access. All participants are reported under pseudonyms in order to maintain confidentiality. Additionally, all data was obscure so as to protect the possible identification of the participants based on potentially identifiable characteristics.

The participants and parents were informed that they could withdraw from the research at any time if they wished to do so.

Ethical Considerations

The Ethical Research Review Committee of the University of British Columbia and Children's and Women's Health Centre of B.C. both approved this study. The certificates of approval from each of these institutions are available by request.

Every effort was made to ensure that the participants were comfortable throughout their participation in the study. There was a possibility that the disclosure of
painful experiences may have led to emotional distress for the participants. As a researcher, if any type of distress was determined or communicated, I would have been prepared to refer the participant to appropriate resources or ensure that they received the support required from their practitioners in the program. This was not a concern with any of the participants. The participants were also advised of the limits to confidentiality which are standard to ethical counselling practice.

Data Collection

Interview Questions

The following interview questions were posed to the study participants:

1) “Can you tell me what it was like to participate in the motivational enhancement group?”

2) “Was there anything from the group or any session in particular which really stood out for you? What was it like?”

3) “When you think of this group in terms of your relationships with other participants, what was it like?”

From each of these questions, “probes” were used to encourage further elaboration. Rice and Ezzy (1999) suggest the use of the following probes which were utilised in the interview process:

a. Elaboration probes: asking for more detail on a response

b. Continuation probes: encourage the participant to keep talking

c. Clarification probes: aim to resolve ambiguities or confusion about participants’ meaning
d. Attention probes: indicate that the interviewer is paying attention and fully interested in what is being said.

e. Completion probes: encourage the participant to finish a particular line of thought.

**Audiotapes and Transcripts**

The interviews were audio taped and transcribed by the researcher. This allowed for thorough evaluation of the interviews and adequate analysis by the researcher. The audiotapes and transcripts were kept in a secure location, only to be utilized by the researcher and the research supervisor for the purposes of this study.

**Interpretation**

During the process of analyzing the data, I remained focused on the purpose of the study which is to extract the subjective view of the girls and determining the essence of the phenomenon. According to Creswell (1998), data analysis and representation in phenomenology can be broken down into the following categories: data managing, reading/memoing, describing, classifying, interpreting and representing or visualizing. Karlsson (1993) discusses the Empirical Phenomenological Psychological (EPP) Method. The goal of the EPP method is to describe the meaning structure as follows:

This method yields descriptive results, which disclose the intentional relationship between the subject and the object of experience. The data analyzed has the structure of a test, for instance, subjects' retrospectively written descriptions of their spontaneous experiences of the phenomenon in questions. (Karlsson, 1993, p. 78)
Karlsson (1993) then proposes a series of steps to follow for analysis according to the EPP method:

1) The first step consists of reading the protocol and gaining a good understanding of what the subject is conveying. The researcher must have a sufficient understanding to continue with the analysis of the next step.

2) Secondly, the meaning units (MU's) must be deciphered (Karlsson, 1993; Creswell, 1998). The MU's can be considered different themes which emerge from the interviews. Karlsson (1993) emphasises that a MU does not follow linguistic or grammatical rules. Rather, the researcher divides the text where a shift in meaning is determined. The division of MU's is a practical aid to begin the complex process of determining areas of significance in the research.

3) The third step is where the formal content analysis takes place. This is where MU's or codes are put together in a meaning framework. Specifically, each MU is interpreted and methodological comments are noted by the researcher. This is the step where the data moves from particular fact to its psychological meaning. Karlsson (1993) stresses that although the language may be transformed into the psychological meaning, the researcher should avoid using terms which are theory - laden. Instead, everyday language which depicts the meaning should be used.

4) In the fourth step, the researcher is able to transform the meaning units into a "situated structure" presented in the form of a synopsis. This could be defined as the experience of this phenomenon with this individual. Here the
researcher may omit or shift the meaning units" (Karlsson, 1993, p. 106). He suggests one of two approaches for presenting each synopsis. The noetic side of structure presentation, describes how the phenomenon is lived. The noemic side focuses on what the phenomenon is. Depending on the phenomenon and the data, the researcher must decide which approach to take.

5) The final step is to move from situated structure to general structure. This involves looking at the data from all subjects and identifying common experiences. Karlsson (1993) stresses the importance of carefully reading through the data once again to ensure that nothing of significance is missed. The results obtained in this step will be presented in terms of different themes (this will reflect the noemic side of the experience or what something is). A summary of the results was compiled and served as guidelines for development and discussion in the presentation of results.

Thus, through the systematic EPP interpretation, I was able to extract the true “essence” of the phenomenon.

Validity

Marshall and Rossman (1999) discuss alternatives to the conventional positivist paradigms of research truth and value. Instead of referring to internal and external validity, reliability and objectivity, they refer to four alternative constructs that more accurately reflect the focus of qualitative inquiry.

The first is credibility which seeks to demonstrate that the research was conducted in such a manner to “ensure that the subject was accurately identified and described” (Marshall and Rossman, 1999, p. 192). As outlined above, in this study, I utilised a
systematic method (EPP) for data analysis and interpretation. I called on the expertise of my research supervisor to confirm that the data was accurately identified and described in the final description.

The second construct is dependability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for the study. This construct relates to the positivist concept of reliability. However, reliability relies on an unchanging world which can be perfectly replicated which contrasts the highly social world on which qualitative research is based. Thus, it is necessary to account for the changing, interpretive nature of qualitative research when considering such a concept. To account for this in my study, I was aware of any conditions which may have changed and how it may or may not have impacted the findings of this research. I used direct quotes to back up this research, therefore, this would also ensure dependability.

The final construct closely relates to the idea of objectivity. In qualitative research, this could be referred to as confirmability. It could also be considered "trustworthiness" and is similar to dependability. This would answer the question “do the data help confirm the general findings and lead to the implications?” thus removing the evaluative objectivity of the researcher and base the implications squarely on the data. In my study, the findings are based on the subjective experience of the participants. I have identified my stance and biases, and, through rich analysis and interpretation of the data I was able to objectively identify the phenomenon as lived by the participants and reflect this as accurately as possible. Through the use of direct quotes and field notes, the findings of this study can be confirmed as "trustworthy".
Anticipated outcomes

It is clear that young lives are deeply affected when an eating disorder tightens its deadly grip. Through exploration of meaningful experiences in one aspect of treatment, I was able to describe several themes and sub-themes which describe the girls' experiences in the group. These themes will help us further understand the girls' experiences in one aspect of treatment and, therefore, further our understanding of the process of recovering from an eating disorder.
Results

Nine themes (which are underlined) emerged through the course of data analysis. These themes also consist of "sub-themes" which are indicated in italics. These sub-themes reflect the underlying specific factors which may not be captured in reflection on the common main themes. The nine main themes which were identified in this study include: Feeling Validated, Identification with Other Group Members, Comparisons with Other Eating Disorder Clients, Appreciation of Parental Component, Opportunity for Opportunity for Interaction with Other Group Members, Satisfaction of Helping Others Through Sharing Individual Experiences, Becoming Familiar with Professionals in the Program, Apprehension About Participating in the Group and Awareness of the Stages of Change.

To demonstrate my findings, I will first provide an outline of each individual's account which reflects their "core" experience. These capture the essence of each girl's experience in the motivational enhancement group. I will then follow with the general structure where these core experiences are applied generally and the themes and sub-themes will be extrapolated and explained.

Situated Structure

Sophie. Sophie anticipated a boring experience in the group and was fairly resentful towards her parents for encouraging her to participate in the group. She did, however, describe the experience as worthwhile after returning home and experiencing increased understanding from her parents which resulted in decreased control issues. She was somewhat apprehensive about the group initially due to the fact that she felt somewhat judged. She realized that her "eating disorder mindset" had taken over.
Although others were not likely judging her, she was comparing herself to others and thus she realized her eating disorder is her own worst critic. Sophie found that it took time to feel comfortable in the group due to these factors, however, she did join with several other girls and has continued to keep in touch with them following the group. Sophie also experienced a great sense of validation in that she realized she is not alone in her family struggles as well as her struggles with food and body image.

Sophie was also able to see the program practitioners in a different light. Prior to attending the group, Sophie described her experience as intimidating. She was uncomfortable with some of the practitioners in the program due to the fact that she had only seen them for individual appointments. It was her initial impression that she was not well understood. Following the group, she was able to see them working together as a team and was much more convinced of their understanding and this increased her comfort level to access their support.

Overall, Sophie appreciated the opportunity to participate in the group in the end and found that it was of most benefit to her in terms of feeling better understood by her parents following the group.

Mary. Mary was very introspective about her eating disorder and described herself as being further along in the stages of change than others who participated in the group. It was evident that Mary had a great deal of knowledge surrounding eating disorders and was very passionate about her experience. She, too, was very pleased that the motivational enhancement group increased her parents understanding of eating disorders. She felt much better understood by them after they had received information from professionals, personal experiences from other girls and support from other parents.
She was also validated in that she saw other girls who struggle and realized that she was not alone in her experience.

Mary also described the comparisons with other group participants as overwhelming and triggering for her. She described one specific incident where the nutritionist asked the girls to compare their diets from the previous day which led her to begin questioning why her diet was not as restrictive as others. She described this as the component of an eating disorder which comes out very strong at times. Her account described the value and control which is perceived by the person struggling when the discipline of restriction is achieved.

Mary also had some apprehension about "walking into a room with other girls". She was anxious about being perceived as "not achieving perfection" as she had recovered and was at a healthy body weight. She also recognized two other girls from elsewhere and this was quite intimidating to her.

Perhaps Mary's most significant experience was her identification with other group participants. She connected with one other person in particular as they shared deep sensitivity. They were able to process this aspect of their personalities and how it relates to their eating disorder. With another participant she shared persistence which she describes as also feeding her eating disorder. She also described some of the conversations around common physical symptoms as being somewhat comforting as she realized that others were experiencing these challenges as well.

Mary displayed an increased awareness that helping others was very satisfying and described this as something she hopes to consider for future career goals. In terms of relationships with other participants, Mary felt that there was a norm of mutual respect
as everyone was struggling with similar issues. She described this as being evident amongst the parents as well. She also expressed the fact that the informal communication which occurred amongst the girls during the breaks was very beneficial. She felt that there was often more silence during the formal group sessions but many things were processed during the breaks when the girls were outside the room together.

Mary was also validated in that she had described her parents as being "overprotective" which resulted in her feeling a lack of personal control. This was something which several participants expressed so she felt validated in her frustration with this family dynamic. She described her parents as being much more accepting following the program as they seemed to realize that their daughter was not the only girl engaging in these destructive behaviors. Overall, Mary felt the group was a very positive experience and hopes to participate in other groups around disordered eating.

Chloe. Chloe expressed a much better relationship with her mother following the group. She attributes this to the fact that her mother's general questions about eating disorders were answered, the support her mother received from other parents and hearing the experience of other girls. She felt very validated following the group as her mother was able to practice new strategies for supporting her with her eating disorder as well as gain a heightened awareness that other parents are experiencing similar frustrations. Chloe also connected with several other girls, which was of great benefit and continues to be a source of support for her.

She described her mother's awareness of the stages of changes resulting in a significant shift in their relationship. Her mother was able to accept the fact that she could not force her daughter to recover, her daughter had to commit to recovery on her
own and this would be influenced by motivational change. Following the group, it was
Chloe's experience that her mother relinquished control which allowed her some space to
come to her own decisions and feel a greater sense of control in her life. She also found
that her mother's increased support following the group led to a much closer relationship.

Chloe experienced a great sense of empowerment in being able to help others,
particularly by sharing her ideas for support with the parents. She also benefited from
interaction with the parents in that it validated the feeling that her mother was overly
concerned about her welfare.

Chloe expressed anxiety over comparing herself to other girls when they initially
met; however, as the weekend progressed she was able to value people for their inner
strengths as opposed to their appearance. She made some friendships which continued
throughout her stay at the hospital and presently provide a support system for her in
recovery. She described her relationships and interactions with other participants as the
"push" she needed to move to the next step. Chloe also expressed identification with
other participants and that she felt comfortable discussing certain issues because she
knew they would understand.

She appreciated the opportunity to be introduced to the professionals working in
the program, this helped her to recognize them as credible practitioners as well as build
rapport and trust with them.

Chloe was very anxious and apprehensive prior to participating in the group.
There was a sense of dread over having to sit for long periods of time and the fact that
she was concerned about being able to concentrate on the material presented.
She recognized that the group helped her recognize where she was in terms of the stages of change and this helped her realize what was necessary for her to move forward. From this part, she was also able to have some compassion for herself due to her greater understanding of the recovery process. She was able to come to the conclusion that if she has a setback in the recovery process, it is not a complete failure and she is able to continue moving ahead. Overall, Chloe described her experience in the motivational enhancement group as being a solid foundation which was necessary for her to continue on her path towards recovery from an eating disorder.

Olivia. Olivia was very grateful for the opportunity to participate in the motivational enhancement group as well as this research study. She expressed great appreciation for people who care to do research on this issue she struggles with. She was also grateful to have an introduction to some of the professionals working in the hospital program as this resulted in increased trust and comfort with other aspects of her treatment.

Olivia's relationships with other participants allowed for her to gain perspective from someone else's view which, in turn, led to new personal insights. She was also able to identify with some of the girls, yet she had a new respect for some of the girls whom she did not relate with but could understand their point of view. She felt validated following the group as she realized she was not alone in her struggle and she received hope from others stories as well as from the information from the professionals.

Olivia's mother attended the group and she became much more informed about eating disorders and she was better able to understand and support Olivia following the
group, which resulted in a better relationship between the two. Olivia expressed great appreciation for the parental component of the group.

Olivia also felt a great sense of empowerment and liberation by being able to share her views with other girls and their parents. She expressed great satisfaction in her ability to indirectly help others by doing this.

Olivia, too, was uncomfortable with the comparisons which seemed to be made in the room. She also mentioned the nutrition exercise where the participants were asked to list their diet from the previous day. She described this uncomfortable situation which was brought up informally at the break by the girls and she felt all admitted they felt they were comparing themselves to others. Overall, Olivia describes the group as beneficial because it helped her mom to understand her, it gave her an increased sense of hope and it made her feel really good that enough professionals are interested in her struggles to run groups such as this and do research studies on eating disorder topics.

**General Structure**

The first main theme is *feeling validated*. This was the experience of group participants realizing they were not alone in their experience and that other adolescent girls were struggling with very similar issues. Within this theme were the sub-themes of *feeling better understood, realizing they were not alone in their experience, a renewed sense of hope, and recognizing a new reality* that moving forward is easier when you are supported by peers and professionals working towards the common goal of recovery.

The final sub-theme was that a great deal of *concern was expressed by all parents*, not just their own, which in turn led them to realize that their parents were not coming from a place of control rather a place of concern.
The second major theme which emerged was the identification with other group members. Several sub-themes were also significant within this theme which included the realization of common underlying factors such as personality characteristics, family issues, physical symptoms and realization that the road to recovery is not easy for anyone.

The third major theme which emerged was the appreciation for the parental component in the motivational enhancement group. As many of the girls had already received some sort of education or therapy around their eating disorder, they found that their parents needed additional education around disordered eating in order to better understand and support them. Many described this as particularly helpful when hospital professionals delivered it. The sub-themes which emerged from the appreciation for parental component include support and validation from other parents, the value of the psychoeducational component, closer relationship with parents, understanding of the stages of change, relinquishing control and the value of parents hearing the experiences of girls other than their own daughters.

The fourth theme which emerged was comparisons are made with other eating disorder clients. This is a concern in eating disorder treatment, particularly in groups such as this when clients are brought together for the first time. Within this theme existed physical comparisons and behavioral comparisons.

Another theme which emerged amongst the group participants was the opportunity for interaction with other group participants. The sub-themes which were expressed include mutual respect, being awakened to another view, future relationships,
increased comfort with program clients and increased awareness of the stages of change by relating to others at different stages.

The sixth significant theme was the satisfaction of helping others through sharing individual experiences. This theme related to providing support to others and the satisfaction the girls received from doing this. The sub-themes which emerged from this theme included two aspects of the group, the fact that those "further along" in the stages of change were able to help those not so far long and they were able to reflect back on being at that stage. Additionally, the girls were given an opportunity to meet with other parents. This gives them a sense of empowerment as they were able to help other group members indirectly.

The seventh theme is becoming familiar with professionals in the program. They were able to build rapport with program professionals in the group. This facilitated their recovery process by creating an environment of trust and safety.

Another theme which emerged reflected the apprehension about participating in the group. There were reflections on this which emerged but would not constitute sub-themes. These included the fact that participants were not looking forward to spending their entire weekend in groups at the hospital and were anticipating a boring experience. Additionally, the apprehension that they may encounter a girl they know from elsewhere and the fact that many were struggling with their eating disorder quite severely and knew that they may experience difficulty concentrating.

A final theme which was quite significant is one of the major goals of the motivational enhancement group. This was awareness of the stages of change. The girls definitely related to the process of change which is inherent in recovery from an eating
disorder. The sub-themes for this category include recognition of recovery as a process, realization of where they are and the need for readiness to change which could also be viewed as a commitment to recovery.

All of these themes were extracted through the data analysis process as outlined previously in the methodology section. Meaning units were deciphered from each transcript and themes which were common amongst most participants were extracted. From this, sub-themes were identified based on commonalties amongst participants.

Elaboration of themes

The nine main themes have been demonstrated by most of the participants, however, not all four girls reported each sub-theme in their accounts. I will identify the sub-themes as they emerge within individual accounts through the use of italics.

**Feeling validated.** As described above, feeling validated was an important theme for each of the girls. The girls identified a sense of feeling validated by not feeling alone, increased understanding from parents and consequently less parental control issues, increased feelings of hope, new reality that others struggle thus identifying the fact that this is a fairly widespread problem which manifests itself with similar symptoms. A final sub-theme which falls under the feeling validated theme is the realization that concern was expressed by all parents.

Some of the girls described the feeling of not being alone in various manners. For instance, Sophie states, "I think it was a good to break away for our own parents and hear other parents and how frustrated they really were with their daughters as well - it made me realize I wasn't alone." Thus, Sophie is feeling validated that other parents display signs of frustration and consequently, she is able to shed some of the personalization of
this experience with her family. Additionally, she states, "Now my mom does meal
support with me and she knows what to say and do." In her words, Sophie is feeling
better understood and supported by her mother. She continues, "Yeah, and my dad has
been better too." She explains that control has always been an issue with herself and her
father and he is more frequently able to relinquish control. Mary, too, felt validated as a
result of her parents hearing information about eating disorders and hearing other girls' stories. She states:

As much as they tried to gain an understanding, I think it was helpful for them to
gain a different perspective on things. And to meet with other parents and see
other girls with eating disorders. I was better understood. It was much better;
there was less tension. I can't exactly remember what happened but I do
remember that for a few weeks to come it was much better - they treated me
better.

Researcher questions, "Was there less frustration and more understanding?" She
responds, "Yes, and they also learned to appreciate me a little bit more - they recognized
how far along I had come along the way of recovery when they were able to see me
compared to other girls." Thus, Mary is also identifying several of the sub-themes which
fall under the umbrella of feeling validated. She identifies feeling better understood and
less parental control. She continues to touch on this, "We had questions to answer - the
parents got to hear the girls' perspective but it wasn't their own daughter so there wasn't
that - they could more objectively see." She expresses her feelings of validation later in
her account when she asserts:
I don't know what they did in the parent workshops, I know the overall group was helpful for them, perhaps someone should do a study on that - the parents' part of the program. I know they were a lot more accepting of me after.... Like, I don't know if it was the overall atmosphere of seeing other girls or if they did direct certain exercises that made them realize certain things they hadn't realized before.

So again, Mary describes the increased understanding her parents obtained from the group and how this made her feel much more accepted by them.

Chloe also expressed a sense of being validated following participation in the group. She states, "Like, I'm glad that my mom went to it because then she kind of backed off a lot and she could understand things a lot better." Thus, Chloe expresses her mother's increased understanding which, in turn, led to her "backing off" which indicates less parental control issues. She continues to speak of parental control:

Yeah, because before she wanted to be in every aspect of my life, like, not just eating but everything because she thought I couldn't cope with anything...then, after that with all the different steps and everything, she realized that you have to recognize it for yourself and do all the different steps, I don't really remember what they are called....because before that she was pushing for me to go in and I was pushing not to go in the program because I didn't want to go in and it was sort of a control thing again...So, after that she, like, on the drive home in the hour back to Coquitlam, we were talking about it and she was like, 'Now I know I can't do anything, you have to decide.' So after that point I decided to go into the program and I decided when I would leave, like even now she's like 'I know it was your decision and I can give you advice and support you.'
This clearly illustrates the control struggle this mother and daughter experienced prior to the group. This was somewhat resolved when the mother recognized the need for her daughter to reach her own decisions concerning treatment. As Chloe describes above, her mother relinquished control following her increased understanding of the stages of change and the recovery process which is inherent in an eating disorder. She also describes a shift where her mother realizes that the greatest benefit to her daughter would be to give advice and support her daughter. Chloe also had a strong sense of validation in terms of how her mother reacted to her eating disorder. She states, "I could see how concerned the other parents were about their daughters and I could see, so it just helped me understand I'm not the only one whose mom was really concerned." What Chloe is alluding to here is the fact that she was validated by the reactions of other parents and realized that other parents were reacting with a high level of concern. She continues, "Yeah, by seeing how worried they were and seeing how eager they were to help and not that they were doing it for control." In other words, she was able to see that the other girls had also encountered a high level of parental concern which could have been deciphered as control in some cases. She also describes the sub-theme of *not feeling alone* when she speaks of the relationships she formed in the group: "And like one girl who was there, she's in here right now still, like I think I'm pretty good friends with her. I can just go to them and talk about whatever because I know that they understand." Chloe is not only expressing *not feeling alone* in this statement but also *feeling understood*. Olivia expresses similar sentiment: "It awakened me to a new reality...It also helped me to realize I wasn't alone." She speaks of feeling a *greater sense of hope* when she states, "...By being connected with the girls and professionals it really gave me hope. I also
like that things are being researched and someone is taking an interest in this. I realize I am not unique. I also learned about the condition a lot." Later in her account she reiterates, "It gives me a lot of hope." She describes the experience of feeling better understood by her mother: "I felt more united with my mother after this. She understood so much more." She continues, "I also though it was really interesting when we split off into groups. Before some were more enclosed in our ideas, we were biased and by opening up to other parents, the parents were liberated by it." Thus, she had a new reality and realized that others struggle too.

Identification with other group members. The next theme which was strongly represented in the girls' accounts was the ability to identify with other group members on a number of levels. The sub-themes include underlying personality characteristics, common family issues, realization that the road to recovery is not easy for anyone and common physical symptoms. Although this does not fall under a sub-theme, Sophie expressed a discussion she had with other group participants at the break. She was feeling very uncomfortable about an exercise where their diet from the previous day was shared and she felt her "eating disorder mindset" was making comparisons. She states, "...I don't think it was such a good idea for the nutritionist to do it...like we were talking about it later...at the break." She had identified a source of discomfort for others and they were able to discuss this at the break. Similarly, Mary discusses her experience in the mixed girl/parent groups. She states, "That was really good, I found, and most of the girls discussing it later on, I found, felt is was more objective, there were less emotions." Thus they were able to identify with each other on certain portions of the program and
how their emotions or reactions were common. She also describes identification with certain personality characteristics:

It was more like persistence...there was one girl who I really understood, we had a lot of the same responses to a lot of things...it was like a consciousness of the world and increased awareness of how things affect us. We don't want to hurt other people and this carries over into other aspects of our lives as well....it was really great that I was able to meet someone like that. In [foreign country named] I had attended a group session and again, I found that there was a lady in there I could really identify with who had really similar concerns like I had. On the other hand it was good to see that I'm not the only one in the world that feels that way but on the other hand it was almost frustrating because it was like is this my predicament? I am this way - will I be this way for the rest of my life and will it keep resurfacing? ...Like it's good to see someone who sees the world in the same way but it's frustrating that this person also has an eating disorder....real sensitivity to things in the world and it's almost like - it's great to relate to someone but it's frustrating that they all have eating disorders. Do those two things go together?

Thus, Mary is referring to her identification with another group member which also brought up the issue that these personality characteristics may contribute to an eating disorder and she was reflecting on this. At this point, the researcher attempted to reassure Mary that there are many factors which contribute to an eating disorder and just because she is identifying with others struggling with disordered eating in terms of personality characteristics, it does not necessarily mean that it will continue to resurface in this way.
I also assured her that her awareness of this personality trait will help her to channel it in a non-destructive manner. Mary's compassion for others and sensitivity was obvious when she states, "but really, I thought I could really identify with a lot of the girls - even the ones that were still on the pre-contemplation stage. I really felt for them and wanted them to get better." What Mary is relaying here is her identification with others in the group in terms of the stages of change they may be working through. She is expressing her ability to identify with those who were at a stage through which she had previously passed. Further to this she states, "Well, there were girls at a lot of different stages - like we all got along, and there were some I could relate with less but there was definitely a feeling of respect."

Mary also identifies with other group members in terms of physical symptoms. She describes a discussion about the medical consequences of eating disorders: "Yeah, like we were talking about hair falling out - like something that I could really relate to is that you know this and you really don't start taking it seriously and you don't start intellectually think about it until you see things start to happen." She further explained the experience of identifying with other girls that had reached a point when they were able to see the physical consequences which resulted in a new reality, and perhaps, a shift in motivation to change. Chloe, too, expresses identification with other group members. She addresses the sub-theme of family issues when she states, "It just helped me to understand that I'm not the only one whose mom was really concerned."

She also expresses identification with other group participants when they are able to overcome comparisons, "Like, even though there was that competition in the beginning, everybody felt that way, later we all just figured we were in the same situation
and we weren't really competing like that, even though it may have still been there a bit."

Thus, Chloe is expressing her identification with other group participants being in the same situation and the fact that they were able to overcome the urge to make comparisons by this identification with each other.

Olivia also touches on her ability to identify with other participants: "I was able to see similarities and differences between me and some of the other girls. It also helped me to realize I wasn't alone." This observation was quite significant as I was able to detect the common theme of identification quite readily in all of the accounts. They acknowledged that they identified with each other on the same issues and this resulted in a positive experience in the group.

Appreciation for Parental Component. As the motivational enhancement group is based on the structure which includes a psychoeducational component for parents or guardians, this theme also arose throughout the interviews with the girls. They all felt strongly that this resulted in closer relationships with parents, value in psychoeducational component, an increased understanding of the stages of change, relinquishment of control and value in hearing the experiences from girls other than their own daughter. Sophie's apprehension about going to the group was minimized when she realized it might benefit family relations. She demonstrates this in her statement, "Well, it was really more for the parents. So I went for them....it did make them understand better. There had been a lot of fighting around meals with my parents and then they learned not to push so much." She later reiterates this: "Well, mainly it was for my parents. I didn't get much out of it because I already knew all the stuff. It made them understand better." Similarly, Mary speaks of her perception of her home situation following the group:
...I want to find out about it and I do a lot of research on it and I didn't think I would learn anything new but in the end I think got a lot out of it not because of what I learned which I may know for other sources but I think it was important for my parents that they went. As much as they tried to gain an understanding, I think it was helpful for them to gain a different perspective on things...and to meet with other parents and see other girls with eating disorders.

The researcher then asks, "How did that affect your experience, perhaps at home, for instance?" Mary responds, "I was better understood." Thus, through her parents having a better understanding of eating disorders and hearing the experiences of other girls, Mary felt better understood. She continues:

It was much better, it was less tension. I can't exactly remember what happened but I do remember that for a few weeks to come it was much better - they treated me better....and they learned to appreciate me a little bit more - they recognized how far along I had come along the way of recovery when they were able to see me compared to other girls.

So Mary not only feels a greater sense of appreciation from her parents but she also touches on the fact that they recognized the stages of change required for recovery from an eating disorder and they are able to recognize their daughter's commitment to recovery. Chloe also describes this in her account:

I think it was beneficial for the parents to be there because all of us had learned so much about eating disorders already but the parents had a lot of questions and it was good for them to talk to each other and other daughters...you get so
emotionally involved with your own daughter so it was good to hear other girls' perspectives and experiences....plus she made friends with other parents.

Chloe touches on several sub-themes here in terms of the value of the psychoeducational component resulting in increased knowledge for her mother, support from other parents when relationships with other parents were formed and value of hearing the experiences of girls other than their own daughters. Chloe later describes her mother's relinquishment of control which allowed her the necessary space to make decisions, feel in control of her life and move further towards recovery:

Yeah, because before she wanted to be in every aspect of my life, like, not just eating but everything because she thought I couldn't cope with anything..then after that with all the different steps and everything, she realized that you have to recognize it for yourself and do all the different steps, I don't really remember what they are called.....yeah, she realized that she couldn't really force me to do anything...she could just be there for me so she started to do that and I entered the program because I wanted to not because she wanted me to.

The researcher then asks, "Great it sounds like that was significant for you then because often times a big part of the eating disorder is all in the control so do you feel that helped you in terms of your sense of personal control - in that your mom was no longer forcing things - it was your decision and she was opening space for that?" Chloe responds, "Yeah, because before that she was pushing for me to go in and I was pushing not to go in the program because I didn't want to go in and it was sort of a control thing again..." She describes a turning point when her mother told her, "I know it was your decision and I can give you advice and support you." Chloe felt this was a turning point in their
relationship, "so I think it helped our relationship a lot because we never really had a
good relationship." This statement demonstrates the sub-theme of a closer relationship
developing between mother and daughter. Chloe also felt it was helpful in her
relationship with her father, although he did not attend the group, as her mother was able
to pass important information on to him. Olivia also describes the support her mother
received from other parents:

Well, my mom was also able to connect with other parents. She learned a lot
about the condition too. I felt more united with my mother after this...she
understood so much more...well, it really took the pressure off. We were
liberated. It really helped us.

So Olivia, experienced, a closer relationship with her mother following the group, and
less pressure (presumably resulting from less control issues) resulting from her mother's
increased knowledge of her eating disorder following the group.

Comparisons with other eating disorder clients. The "comparison factor"
described by the girls' accounts of their experience was relayed with somewhat negative
connotation. Although it was quite strong amongst the girls, it was acknowledged by all
and they seemed to move past it once rapport, safety and trust were established in the
group. For instance, Sophie speaks of making behavioral comparisons when they were
asked about their diet of the previous day. When she was asked about a particular group
or session which stood out for her she responds:

Well I do remember one session where we had to write everything down we had
eaten the previous day...well, my eating disorder mindset was to make
comparisons, like, it is a constant battle...I just looked up at the screen and all I
could think is that someone else had managed to eat less. Like it was an accomplishment or something.

Mary speaks of the same session with a similar experience:

Oh, there was one that was sort of bad for me which was led by a dietitian where we were comparing food and we had to list out what we had eaten the previous day...there were girls in the program then who were already on a weight gain meal plan and there were others who ate like a pickle that day...there was a real big difference between the two and I just got a real...like if I was in the pre-contemplation stage and if I saw what I would have to be eating and I hadn't been recovering I would have probably chosen not to recover because it's scary - having to go from three pickles a day to eating six meals a day and each of them being like 500 calories each...like for somebody who isn't...I'd probably just be petrified and it would be step backwards rather than kind of motivating me to do it...like for somebody who isn't started on recovery they would be like, oh, I'm better than all these girls because I can only eat three pickles a day, like you said, the comparison factor, I wasn't quite sure that was too helpful.

Olivia also spoke of this group recalling the discomfort she felt:

There is always that competition factor but we were comfortable most of the time, except one group...well, it was a comparison of our diets. It was very uncomfortable to have to put what you ate up for the others and that was pretty common amongst us.

So, Olivia also alludes to the *behavioral comparisons* which were her experience and felt it was a common experience amongst the group. She continues that this sense of
discomfort was brought up informally amongst the girls at the break. Chloe touches on the physical comparisons which seemed evident at the onset of the group but diminished as the group evolved:

Well, like when we first met everyone was judging everyone else and rating ourselves... like, even though there was that competition in the beginning, like, everybody felt that way, later we just figured we were in the same situation and we weren't really competing like that - even though it may have still been there a bit.

The researcher then asks if this was acknowledged or discussed in the group and she describes the informal "unspoken knowledge" that seemed to exist in the group:

No, they didn't really go into anything, but we, I don't know it's just there... Like I was really afraid to go into the group because I'd never really met any of the other girls before, so I didn't know what to expect, like if I would be the biggest one there.

She speaks of this competition in terms of behavioral and physical comparisons taking place for her in general:

But whenever a new girl is coming into the program, we're all really anxious because we think what if she's sicker, what if she's whatever... then in the groups too, it can be kind of triggering, because maybe they are talking about their struggles with clothing shopping and it would kind of relate to you and it would really upset you because you would kind of relive it.

Additionally, Sophie speaks of the competition and how it may influence one's behavior:
I just really think that was not a good thing to do for all of us. You could just feel it in the room...I was really worried about that at first. I remember when my mom was taking me into the clinic for the first time - she told me, 'Don't let any of the other girls influence you into things like smoking.' Well everyone knows that there's a lot of competition and stuff so she was worried that I would be picking things up from the other girls.

So, she speaks of her awareness and her mother's concern of the competition being a negative influence prior to starting the group.

Opportunity for interaction with other group participants. The interaction of group participants was a theme which emerged primarily in response to the third interview question: "When you think of the group in terms of your relationships with other participants, what was it like?" Although this theme was interwoven throughout girls' accounts, this question elicited the greatest number of common meaning units. The sub-themes include mutual respect, being awakened to another view (group participants and parents' views), future relationships were established for support, increased comfort with program clients and increased awareness of stages of change by relating to others at different stages. One of the most significant observations was that all the girls found benefit in interacting with the other group participants. For instance, Sophie states, "Well there are a few girls I really liked and I still keep in touch with them." Thus, she connected with others who could relate to her experience and future relationships have developed for support. Chloe relates to a similar experience:

Plus, I made friends with the other girls and it was really good because like before that I never really did any sort of group thing, I just did outpatient, and you don't
really meet people because people aren't that friendly in the waiting room.....after that it was much better because there were like 10 families there and now I see people and it's a lot more helpful being here.

She expresses increased comfort with the program clients which made for a more positive experience in general while visiting the clinic in addition to developing future relationships. She continues:

Then everyone was like - the group with just the girls really helped us get to know each other then, during the breaks, we would hang out and we would talk and the parents would talk.....I talked to one girl today and I talked to another girl on the weekend and another one last week. Like I think four of them are still pretty good friends and we've become better friends by seeing each other here [at the clinic] and some went into program with me....I can just go to them and talk to them about whatever because I know that they understand....we are closer together than anyone who we didn't go through the group with.

So for Chloe, the group was certainly an opportunity to connect and form future relationships and friendships which have been very supportive in her treatment process. She describes these relationships forming in the group and evolving as they continue to see each other at the clinic. Chloe also speaks about the fact that those further along in the stages of change were able to assist her in decision-making and give her some reassurance around furthering treatment for her eating disorder:

Yeah it was perfect. Like I was so anxious before going into the day program. It just gave me the little push I needed because the girls I talked to said it wasn't
very different from the program itself - and I'm really glad I went into the day program.

Mary identifies herself as further along in the stages of change, at the maintenance stage. She enjoyed being able to help others based on her personal experience, "But really, I thought I could really identify with a lot of the girls—even the ones that were still on the pre-contemplation stage. I really felt for them and wanted them to get better." She also identified the mutual respect which existed in the group, "...there were girls at a lot of different stages—like well got along, and there were some I could relate with less but there was definitely a feeling of respect." She continues to express how she experienced the informal norm of mutual respect:

Otherwise in terms of relationships there was respect at least it seemed, between the girls and the parents and the girls....I know this might sound awful, but I think that even amongst the parents there was really nobody who was truly ignorant there, like this is not for me...it was all people who came to learn more and came in with that attitude. So it was helpful that they came that way because you can't teach that...you can't teach someone to respect an anorexic girl.

Olivia was greatly impacted by hearing that she was not alone in her struggle and being awakened to another view. Her primary answer to the broader question, "What was it like to participate in the motivational enhancement group?" was, "Well, for me it gave me a perspective of someone else's view." She described this as a process of awakening for her as she was able to put aside her personal biases and allow for greater insight into the roots of her eating disorder. She also describes the relationships which were formed and evolved throughout the course of the group, "Well at first we were all sort of quiet
and then we got very talkative and it got people to open up." She describes some conversations taking place at the breaks amongst the girls which gave them a chance to further connect and socialize outside of the formal group structure.

**Satisfaction of helping others.** This theme was not strong with all of the participants, however, for those who it did experience it, it was quite evident. Mary feels quite passionate about helping others and finding value in her experience with an eating disorder through helping others. She gained greater clarity of this through the motivational enhancement group. As previously discussed, Mary considered herself in the "maintenance" stage of recovery. She had already been through therapy and treatment for her eating disorder, however, she still required support to maintain her recovery status. This is demonstrated when she states:

I thought I could really identify with a lot of the girls - even the ones that were still on the pre-contemplation stage. I really felt for them and I wanted them to get better...from the group I learned that I enjoyed helping others and I would like to study psychology and do something in that field...I think I was more on the giving end than on the other side, but I had no problem with that at all...like, I was talking and one girl was saying how she never has breakfast and I was telling her that even if she could just have an apple, that's progress, it might not seem like a big deal-like I never got to that stage but I could understand how that is progress to someone else.

Mary is essentially saying that she was able to use her experience of progressing through the recovery process to understand and help another group participant. Chloe identified
strongly with helping others by sharing her experience with some of the other group participants' parents:

   We got to talk to other parents and our parents got to talk to other girls. They broke us up into groups so that we weren't together and we talked about how to talk to people while they were in the contemplation stage and the stage after that...I don't remember what it was...[action stage]...Yeah, and things you can say and things you can do so I could see how concerned the other parents were about their daughters and I could see, so it just helped me understand I'm not the only one whose mom was really concerned and it was kind of helpful because we could tell them things they could do...that was a lot of fun actually, that really stood out for me.

So, Chloe was able to gain a sense of empowerment through this portion of the group. Olivia also expressed this in her statement, "I also thought it was really interesting when we split off into groups. Before some were more enclosed in our ideas, we were biased and by opening up to other parents, the parents were liberated by it." She felt that by sharing her experiences with other parents, it gave her a sense of empowerment. Mary also expresses this when she describes:

   We had questions to answer - the parents got to hear the girls' perspective but it wasn't their own daughter so there wasn't that - they could more objectively see. There were more of the girls and more of the parents...that was really good, I found, and most of the girls discussing it later on, I found, felt it was more objective, there was less emotions.
Thus, they were able to recognize the value of indirectly helping the other group participants by enlightening the parents of their experience.

**Becoming familiar with professionals in the program.** This theme was not represented as widely as some of the other themes. However, there was certainly great benefit to the girls becoming acquainted with the professionals working with the eating disorder clinic. Chloe expresses this when she states:

Well, I liked that so many different people were involved, like it was the whole program...everybody who works here pretty much was there, and we heard a lot of different perspectives from psychologists and doctors and nutritionists...it was really good.

She continues with a specific example:

I didn't know all of them, I only knew Dr. P. and the nurses...I got to meet our family therapist...like one day me and my mom fought in the car the whole way down and then when we got there it was such a relief because there were all these people there who could be there for support that day.

Thus, Chloe felt she trusted the professionals in the program and knew them following the group so she was able to turn to them for support when she needed it.

Olivia also appreciated the fact that the clinic professionals were all involved with the group at some level as this gave her a sense of hope and showed her that people care. She states, "I also liked that things are being researched and someone is taking an interest in this...It also makes me feel really good to see that there is enough interest in this to do research on it. It gives me a lot of hope." In her account, she was referring to not only the fact that research is being conducted on this group, but that she was able to recognize
the competence of professionals working in this field as well as the fact that there has been a great deal of previous research on the treatment of eating disorders.

**Apprehension about attending the group.** Several of the girls reported some sort of anxiety leading up to the group and in the early stages of the group process. Sophie reports not only apprehension but also a feeling of dread, "Well, it was so incredibly boring. Before I was just dreading going for the whole weekend....Well, it was really more for the parents. So I went for them." Chloe also states, "We found it kind of boring from our perspective but the parents found it really good." She also relates that she was somewhat anxious about sitting for such a long time and not moving around. She expresses some apprehension about being able to concentrate throughout an intensive series of group sessions, "So I think you lose concentration, like, people with eating disorders don't have a lot of concentration to start with." She also expresses anxiety over not knowing what to expect: "Like, I was afraid to go into the group because I'd never really met any of the other girls before, so I didn't know what to expect, like if I would be the biggest one there." Mary expresses similar apprehension prior to the group:

Well, as much as I really didn't want to share with other girls, it was sort of scary just walking in to the room and there were two other girls from my school in there. One of them I guessed she had an eating disorder - it was sort of obvious but the other one I had no idea. So, like out of six girls [initially] first, three were from my school.

Thus, not only was she apprehensive before the group but her anxiety increased when she walked into the room and saw two other girls she knew from elsewhere.
Awareness of the stages of change. As mentioned in previous sections, one of the group goals was to bring awareness to the stages of change based on Prochaska & DiClemente's Transtheoretical Model of Change. The sub-themes are recognition of the recovery process, realization of where they are and the need for readiness to change. Again, not all of the girls' accounts strongly reflect this theme, however, it was evident for most of the girls. Sophie describes her frustration with wanting to participate in meal support following the group and not feeling supported by her father. This frustration was fueled by the fact that she was aware she was ready and motivated to change:

But, he just wants it over - one day he was driving me home from clinic and I wanted to stay for meal support and he just told me I didn't need to be there for that - what would it really do...well, I just had such rage over wanting to go back and him not letting me.

Thus, she addresses the fact that she was ready to accept the support the program had to offer, yet, her father was not supportive of her in this. Prior to the group she had been somewhat resistant to meal support opportunities at the clinic, and it was very frustrating for her when she had realized that she had progressed to a different level of motivation and she was not supported in this. Chloe was referring to the stages of change in her statement:

Well, I thought it was really good that it was all broken down so you could see where you are. I know it's not just applied to eating disorders, it could be applied to anything so it was good to relate it to other things, maybe...so it was really interesting to understand that.
What Chloe describes here is the realization of where she is at in addition to her interest in the fact that the transtheoretical model of change is applied to other issues thus reflecting change as a process which one must pass through. She also addresses the recovery process aspect of this change when she discusses the awareness that although one may have setbacks, it does not necessarily mean that they do not "start over" in the recovery process:

I think it would be good - I don't know if they did say this or they didn't that people do slip and it doesn't mean everything is just lost....my mom just freaks out if one day I don't eat very much - she thinks everything is gone and I'm going to slide back.

She continues with her story in terms of recognition of the need for readiness to change: "...I entered the program because I wanted to, not because she [her mother] wanted me to." Mary's recognition of the stages of change was closely related to the theme of helping others. She often referred to the stages of change in her account, for instance:

I think it was easier for someone to take advice from someone who's been there and I could identify with that - I think it was more helpful for them to hear words coming from my mouth because I wasn't just the dietitian talking, it was me who had been there, done that, I know what it feels like and it does get better so I think I gave them some hope.

Olivia also touches on her experience in the group as creating "new hope" which, in turn, resulted in increased motivation to move through the recovery process. It reduced her ambivalence towards recovery and allowed her to reach out for further help.
Discussion

"They say time always changes things, but you actually have to change them yourself"
-Andy Warhol

"Things do not change, we change"
-Henry David Thoreau, Walden, 1970

The research question posed in this study was: "What are adolescent girls' common experiences in a motivation enhancement support group for disordered eating?"

This chapter will summarize the findings of this study, address the significance of the research findings and compare and contrast these findings to the literature presented in the literature review. I will also discuss the limitations of this research, my personal reflections on this study, the implications for future research and the implications for counselling practice.

Summary of Findings

My findings in this study bring to mind the fable of the sun and the wind. The sun and the wind were having a competition to see who was the most powerful. They challenged each other to see who could force a man walking along the road underneath them to take his coat off. The wind first blew a strong gale. The man only buttoned his coat up higher around his neck and tightened his belt. The sun shone mildly and slowly, gradually intensifying it's rays - the man then took his coat off. This analogy demonstrates the need to proceed gently or be met with increased resistance. The girls in this study were like the man in the coat, when "pushed" too much, their resistance increased. The identification with the stages of change and the realization of what stage
they were at and that recovery was a process empowered them to feel in control of their recovery and that it was a process. Through this, they were able to relinquish self-defeating presuppositions that recovery was an easy task which would readily occur without some level of hardship and work.

They described their experience in the group as allowing them the opportunity for validation and identification which allowed them to feel that they were not alone in their struggle and others were there for support. Additionally, the fact that parents gained greater insight and become more informed about disordered eating took the pressure off in their interactions with parents. All of the participants described this as a very liberating experience as it reduced their feelings of being controlled. Although there was some apprehension about attending the group, they were all able to see the group as a positive experience in the end.

In the eating disorder field, it is a well-known fact that comparisons can be made between eating disordered clients. Thus, many groups are structured so that the focus is on feelings, not on weight, eating behaviors or body/shape concerns. This was clearly a source of discomfort for the participants when they perceived judgement from others or they were aware that their eating disorder mindset was a negative, critical influence in this regard.

This study reveals the value of peer relationships, both through identification and validation, in addition to the fact that the girls felt very empowered when they perceived their sharing as helpful to others. Additionally, they formed friendships and relationships which have provided them with support and understanding. The stages of change were also evident in terms of relationships and those further along the road to recovery were
able to act as "mentors" to those who were not quite as far along through instilling hope, providing an empathic stance and offering practical advice.

This group could be described as a "bridge" to further treatment. It serves this purpose in various ways. Firstly, the group participants were able to become familiar and establish trust with the clinic professionals. As the professionals were all involved in administration of the group sessions, the participants were able to meet them and establish somewhat of an alliance. Additionally, they were awakened to the fact that so many professionals possess a great deal of competence in the eating disorder field and they established an environment of support which was very comforting to the participants. As the parents are an integral part of the treatment plan for adolescent girls, it was of great benefit for the parents to participate in the psychoeducational component of the group. They learned how to better understand and support their daughters as well as gaining support from other parents struggling with similar issues.

It became clear to me from the girls' accounts that the motivational enhancement group was not the only treatment required for their eating disorder. The motivational enhancement group provided education and some tools required for success at recovery. Thus, it achieves its goals to be part of a larger continuum of care. Two of the girls entered a more intensive hospital treatment program following this group and reported that the group prepared them for further treatment. It did this by providing tools and it also enlightened them to the fact that there were many issues underlying their eating disorder and they would have to work through these issues as a process.

The girls' demonstrated a clear understanding of the fact that the change process is not linear and you can "have setbacks". Prochaska and DiClemente (1992) describe this
process of cycling back through stages which does not represent failure, rather the non-linear nature of their model of change. This, in turn, gave them knowledge as well as empowerment and a feeling of being in control of the process.

Lastly, an umbrella concept which seemed to result from the findings was that they felt more in control of their recovery process because they were informed and empowered. They were able to set realistic goals and became aware of their limitations. This helped to clarify the task at hand by fragmenting it into a series of steps or stages. This eased the pressure of the overwhelming task of recovery from an eating disorder.

Comparison of Findings with Literature

The results of this study reflect much of the current literature that was cited in the literature review. It further illuminates the voice of adolescent girls in their experience in a motivational enhancement group which has not previously been explored. For instance, the participants in this study realized that the first step towards recovery was admitting the desire to change which Pettersen and Rosenvinge (2002) also described in their study which combined qualitative interviews and standard questionnaires. Schmelefske, Fraleigh, Henderson and Pinhas (1999) identify this phenomenon as a key factor in their recovery process:

The teens typically have difficulty making a commitment for change. They believe the solution exists outside of themselves. The change model helps demonstrate that to succeed, personal commitment, planning and risk taking are necessary. (p. 12)

Thus, the identification of a commitment to recovery and the necessary planning and goal setting around this process empowers teens to take action. The girls in this study
demonstrated this in their awareness of the stages of change which included the need for readiness to change and making a commitment to this.

Just as this study found that the opportunity for interaction with other group members was beneficial, as well as becoming familiar with professionals in the program, Pettersen and Rosenvinge (2002) report that treatment effects were related to a feeling of "being ready" or "motivated to change" (p. 66). They stressed the need for a positive therapeutic alliance which conveyed understanding, empathy, respect and seeing the individual "beyond the symptoms" (p. 66). Again, these findings parallel the findings in this study in that the girls felt validated in their experience when they were heard and understood in a compassionate, respectful environment. Additionally, Pettersen and Rosenvinge (2002) noted that the participants in their study reported effects related to the opportunity to meet with other sufferers. This parallels the theme of interaction with other group participants described here and also touches on the fact that they felt validated when they were able to meet others struggling with eating disorders. Overall, Pettersen and Rosenvinge's (2002) findings parallel these presented here in the importance of patient perspective and their feelings of control and decision around their treatment. This was also a significant factor in the study with the adolescent girls. They felt very validated when they were given the opportunity to share their story within their group. This relates to the feeling validated theme as well as identification with other group members. The theme of control and having a voice was woven throughout the themes as it related to feeling validated and the appreciation for the parental component in terms of being able to relinquish some control and see their daughter's struggles in a new light.
This study also shows some similarities to Feld, Woodside, Kaplan, Olmsted and Carter (2001). However, as this is a qualitative study, it is difficult to compare it to such as study as Feld et al. utilized various measures such as URICA to measure motivational change. Based on the their Likert scales, however, which addressed the questions, "How motivated are you to change?", "If you decided to change how confident are you that you would succeed?" and "How ready are you to change?", an increase was noted from the first to the final session on these measures. The feedback from the girls in the motivational enhancement group did not necessarily address these questions specifically, however, it did certainly indicate that it provided favorable conditions for change.

The girls certainly expressed their need to feel control over their situation and the recognition that they needed to be ready to change, this was a process which could not be forced by parents or treatment professionals. This finding illuminates Vitousek et al. (1998) and Kaplan and Garfinkel's (1999) recognition that eating disorder clients can be very resistant to change. Prochaska, DiClemente and Norcross (1992) suggest that their trans-theoretical model of change addresses the fact that if patients' readiness for change does not match the treatment approach and it therefore may not be beneficial. I certainly feel that the girls recognized this and described it most clearly in the theme of awareness of stages of change. As a result of the group, they were able to realize, perhaps, where they were in the change process and the fact that a commitment to change was essential prior to embarking on a more intensive treatment protocol. Prochaska, DiClemente and Norcross (1992) primarily reference the transtheoretical model of change as it applied to substance abuse, however, I feel that this study validates its use with eating disorders. This further supports the findings of other studies which have suggested that the
transtheoretical model of change, specifically, motivational enhancement therapy is a useful framework and intervention for use with eating disorders (Ward, Troop, Todd & Treasure, 1996; Blake, Turnbull & Treasure, 1997; Treasure et al., 1999). In addition to the girls' awareness of the stages of change, it was also found that they recognized recovery as a process which may include setbacks. This confirms the findings of several other studies which suggest that the transtheoretical model of change is spiral as opposed to linear. Additionally, clients may cycle back and forth between the stages (Prochaska & DiClemente, 1994; Feld et al., 2001). Fraleigh and Pinhas (2000) refer to recovery from an eating disorder in adolescence specifically. They, too, write about recovery as a process of change. The emphasize that an eating disorder develops over time and is multi-factored in origin, thus, it follows that changes do not occur overnight. Fraleigh and Pinhas (2000) also describe the transtheoretical model of change using the metaphor of the Trapezoid of Change. This illustrates that change does not continue in one direction. They liken it to a game of "Snakes and Ladders" (p. 3). Their explanation of this process mimics the experience many of the girls were able to recognize and describe following their experience in the motivational enhancement group:

Generally speaking, when we work towards change, we make process, hit a rough spot, fall down a stage or two and then climb back. Each time we start the climb again we have learned something and approach the task with more experience and knowledge. This is the normal process of change. The challenge is to keep going even when it feels like you have fallen back to the beginning. Remember, once you have some experience and knowledge, the beginning is never quite the same.
It is still trial and error, but since you know your path you will always know where you are. (p. 2)

As many of the participants in the group described, they were able to identify their stage of change and realize that change is an ongoing process which may include some setbacks. This was also identified in the theme which related to the appreciation for parental component as the parents, too, were able to recognize that setbacks did not necessarily constitute failures.

Tantillo, Bitter and Adams (2001) describe the support group experience as empowering, just as a result of attending the group in itself. I feel that my study also highlights this sense of empowerment the girls' gained from helping others, enlightening others and feeling a sense of mutual respect and support. Additionally, Hsu, Crisp and Callender (1992) examined women's subjective experience 20 years following eating disorder treatment. They interviewed 6 clients and were able to define common themes reported by the women based on their self-reports of factors contributing to recovery. Among these themes were "being understood" which was also a sub-theme in this study.

Overall, support groups have been found as effective for adolescent girls working through other issues such as sexual abuse and depression (Butler & Fontenelle, 1995; Lindon & Nourse, 1994). Mishna (1996) found that the phenomenon of "mutual respect" amongst a support group for adolescents was beneficial and led to enhanced self-esteem. This was certainly the finding with the adolescent girls in this study. They often used the term "respect" as somewhat of an informal norm of the group. This environment of "mutual respect" let to greater feelings of validation and also helped with the family
dynamics around power and control which can become a focus in families where a member struggles with an eating disorder.

Miller et al. (1993) described the motivational enhancement therapy used with addictions. They emphasized that resistance often follows confrontation and that motivational enhancement reduced client negativity around treatment. This study confirms this finding. Most of the girls in this study described a "softening" in their attitude towards change and decreased resistance. The process through which they went through was often different, some required less confrontation from parents and others required less confrontation from themselves (i.e. less resistance to overcoming their eating disorder) or from treatment professionals. Nonetheless, the accounts from the girls all describe their reactions to some sort of confrontation. Although the confrontation may have come from a place of anxiety about the client's physical status, it usually had a negative affect on the client's recovery.

Additionally, the group participants seemed to describe this aspect of the group as non-confrontational reflecting an environment of respect, empathy and compassion. They also felt valued in that they could express themselves in a safe, non-judgmental group with support. Geller, Brown and Srikameswaran (2002) describe the importance of fostering an atmosphere of acceptance and understanding when working with ambivalent eating disorder clients:

When clients express ambivalence about making changes or engaging in treatment, it is common for care providers to feel responsible for initiating this change. Unfortunately, overly directive approaches have been shown to be detrimental to the therapeutic alliance, and to decrease the likelihood that the
client will follow through on treatment recommendations. In motivational approaches, responsibility for change is the client's. (p. 29).

They confirm what the girls reported in terms of their awareness of the stages of change and the fact that decreased control from parents (and practitioners) resulted in a greater willingness to recognize their problem and seek help. Schmelefske et al. (1999) confirm that one of the goals of the motivational enhancement group as follows:

It is helpful to encourage them [the parents] to externalize the eating disorder so that they are able to blame the problem rather than their child. The role of the helper is a big issue in this session. Some parents may be very actively involved in trying to monitor or control their child's eating and/or eating disorder symptoms. Many believe that if they stop monitoring and nagging their child that he/she will spin out of control. This is a good topic for group discussion. Some parents may have reached the point where they have realized that they cannot make the changes for their children. (p. 21)

This relates to the theme which opened space for the relinquishment of control on behalf of the parents. This fell under the theme of appreciation for parental component which was expressed by all of the study participants.

Treasure and Schmidt (2001) describe the spirit of motivational enhancement with the metaphor of a dance, as opposed to a wrestling match. All of the participants of this group identified the value in this gentle, validating approach as opposed to the forceful techniques which have been detrimental in the past.

This leads to the finding that all of the group participants described the benefit of the motivational enhancement group in terms of increased understanding from the
parents. The parents were educated, therefore, they understood the issues underlying the eating disorder better. This led to less parental control issues. The girls also felt validated as their parents were able to see that other girls were struggling with similar issues and it wasn't just "their daughter". The girls described this dynamic as tremendously liberating as it took the pressure off somewhat. This relates to the findings of Haworth-Hoeppner (2000) in that the familial factors which can contribute to the development of an eating disorder or perpetuate eating disorder symptoms include a critical family environment and an atmosphere of coercive parental control. Thus, this dynamic of control was expressed as a cause for increased resistance in the girls. When the girls perceived the easing of this control, they seemed to express less resistance. This was expressed in various themes such as feeling validated and appreciation for parental component.

Fraleigh and Pinhas (2000) identify the following phenomenon which can occur as a result of motivational enhancement therapy for adolescents struggling with eating disorders:

Adolescence is about change and learning how to change. The skills you learn on the road to recovery from your eating disorder will also help you in your passage through adolescence. During recovery, you will have the opportunity to learn to identify how friends, family or therapists can be helpers, and how to ask for and obtain support. You will also have an opportunity to learn how to value things about yourself besides appearance. Attending group or other therapy may also provide you with opportunities to learn coping and communication skills that can be used and built upon throughout your life. (p.2)
In the study described here, the girls related this phenomenon in that they were able to interact with other group members and professionals from the program in order to form a support network for recovery. Additionally, they were able to recognize the support their parents could offer as a result of increased education or understanding of their eating disorder. Although the learning to value yourself for qualities other than appearance was not identified as a theme, this phenomenon as described by Fraleigh and Pinhas (2000) was also described by some of the participants.

Overall, the authors of the "Why Weight" Program, which inspired this motivational enhancement group, reinforced the experiences of the girls in this study. Schmelefske et al. (1999), recognize that this model is intended as a part of a large continuum of care. The girls all identified that this group was an impetus or complement for other aspects of their treatment. It was not effective as a sole treatment strategy, however, it worked to promote readiness to change or otherwise augment their recovery experience.

The girls' identification with each other was also a significant theme. They showed greatest interest in each other and the group experience provided validation as well as a sense of empowerment. Their accounts also reflected the many ways they were able to identify with each other. Schmelefske et al. (1999) identify this as an expected outcome of the motivational enhancement group process:

....[an activity] provides the participants with a non-confrontational, non-threatening way to find out about who in the group is suffering or has suffered with similar symptoms. The number of ways the eating disorder has impacted on their health surprises many of the participants. The teens are more receptive to
talking in their peer group. They are curious about each other. Some may ask
others about their symptoms, how long they have been symptomatic, and whether
or not they binge and purge or restrict. (p. 12)

This describes the experience of girls reporting "not feeling alone" but also reflects the
curious stance which constituted comparisons amongst other participants. The girls were
very interested in each other and had a desire to find out about other girls' experiences
with their eating disorder.

Schmelefske et al. (1999) also identify the apprehension the group participants
expressed prior to attending the group. They or their parents were concerned that they
would learn new ways of expressing their eating disorder from others in the group:

In general, parents are pleased that the teens are being provided with information
about characteristics and possible consequences of an eating disorder. They also
worry that their child will learn new ways of expressing their eating disorder from
the others in the group. Some parents express fear about the seriousness of
potential side effects and worry that their child will develop them all. They often
express a need for immediate solutions and this is where the varied experience of
the entire group becomes important. Group members whose daughters have been
symptomatic longer, or who have a long history of treatment may provide some
perspective. It is important to promote realistic expectations for change while
maintaining a sense of hope. (p. 13).

Although this was a concern and source of apprehension for some of the participants
and their parents prior to the group, they were able to see that the atmosphere of mutual
respect was established throughout the group process and it diffused the phenomenon above.

The one area which was suggested strongly by the literature but not supported by this research was that of future direction. Schmelefske et al. (1999) suggest that the final stage of the motivational enhancement group will focus on the goal of problem solving. Although this is described as the ultimate aim of this group, the participants in this study not at all mentioned it. It seems that the benefits of the group were not a pragmatic process which resulted in decision-making or problem solving. It was clear that it provided a foundation for future work.

Other literature also suggests that motivational enhancement therapy or groups are beneficial for planning treatment and determining what is the best direction for clients (Treasure & Schmidt, 2001; Treasure et al., 1999). This consequence or phenomenon was not supported by this research as it did not identify a certain, clear direction for treatment. None of the participants identified goal setting or planning for future treatment direction as a consequence of their participation in the motivational enhancement group. It seems that they more strongly identified with the internal phenomenon which occurred as their experience in this group.

Limitations of the Study

This study was a qualitative study it represents an in-depth, rich account of the girls' experiences in the group. As these findings represented a minimal number of participants, they cannot be inferred to the general population of girls experiencing a motivational enhancement group for disordered eating. However, the rich experiences certainly set the stage for future research. It was difficult to recruit participants for this
study due to the time commitment required of the participants as well as their parents. This is a fairly new group and there were not very many participants in close proximity to draw upon. Many of the participants had accessed this tertiary, provincial eating disorders program although they lived out of town. Additionally, the last two interviews conducted did not reveal anything new, thus, it appeared that saturation had been achieved despite. Additionally, there were many commonalities amongst the girls' accounts therefore I feel this shows that these results are fairly reliable.

The participants in this study may have represented clients further along in the recovery process. It also represented the girls who were most keen to continue dialoguing about the group. Thus, these are the participants who may have felt the most enlightened by the experience. Additionally, all of these girls were obviously capable of meeting the requirements for participation. Had they been medically unstable or cognitively impaired, they likely would not have been capable of meeting the requirements for participation. This study does not take into account that some of the participants who are struggling may not have been able to participate in the study due to physical, emotional or cognitive difficulties.

The phenomenological approach does not aim to be explanatory, thus, this does not shed light on the factors which facilitate change or enable recovery. Although it may have shed light on the factors which may influence recovery, it was not specific. It was aimed at the girls' experiences in the group as opposed to cause and effect factors. This may be viewed as a limitation as it did not provide concrete support for or against motivational enhancement therapy with this population. It may have given insight into directions to take for further work utilizing the same approach.
This study also did not take into account other forms of treatment which may have been taking place concurrently with the group. Some of the clients may have been seeing a private therapist while attending the group which may have influenced their experience in the group. In order to decipher the other factors which were taking place at the time of the motivational enhancement group would have been nearly impossible, however, I did maintain a focus specific to the motivational enhancement group, as much as possible, while interviewing the study participants.

**Personal Reflections**

Throughout the course of this research project, I was not only working towards completion of this degree but also working in the field with eating disordered clients. I found this particularly enlightening as it gave me great insight to the commitment which is required for recovery from an eating disorder. There were many times when I felt this research seemed so insignificant in the sea of research, literature and theory which applies to the treatment of eating disorders. However, when I began the interview process with the girls, I gained a new sense of appreciation for their experience and the value of recognizing their voice.

Doing this research also gave me greater perspective on the task at hand. For me, completing this thesis was a very labor-intensive task which required a tremendous amount of focus. This was not always a possibility due to a very busy life outside of my academic endeavors, however, it gave me an opportunity to recognize the need for balance in my life. It helped me realize that I, too, needed to make a commitment to completing this thesis and until I made that personal commitment, no amount of support, assistance or extra time would bring me to that end. As I write this last chapter of this
work, I realize that this is only the completion of one chapter of life. I will always be
driven to strive for more and work towards my lifelong dream of helping others in a
therapeutic manner and making a difference in the lives of others.

I wish to express my sincere gratitude to the girls who participated in this study. They contributed to this work of research and moved us towards a better understanding of one aspect of eating disorder treatment, but they also provided me with some very valuable lessons. I am better able to understand and appreciate adolescents and my work in the field with them. Through doing this work, I realize that this is a population I enjoy working with and hope to have the opportunity to continue to work with adolescents in the eating disorder field in the future. I was also affirmed that the work that I am doing is very important and valued and it increased my passion for continuing to build my clinical strengths in this area.

I was also able to learn lessons which I will apply to my personal life. Through realizing the importance of validating a young person's experience, whether it be a struggle or an achievement, I will be conscious of this in my personal life and carry it with me always.

Although this process was not easy, I feel that my own perceived barriers were exaggerated and I viewed the task as onerous when it actually turned out to be a very rewarding and stimulating project.

Implications for Counselling Practice

The value of this research is that it provides insight into adolescent girls experiences in a particular mode of treatment for eating disorders. This is a relatively new approach as it is applied to eating disorders. By exploring the experience of this
through the voice of the participants, we are better able to understand the aspects of motivational enhancement therapy which may be useful in the future.

These findings normalize and validate the participants’ experiences as it highlights the common themes which were reiterated in this work. The mere fact that the girls felt “heard” by telling their stories was indicative of the empowerment which counseling practitioners should strive for in the future.

The content of the participants’ accounts will assist in directing practitioners in designing programs in the future. The content and format of the groups was analyzed and there were certainly some factors to consider for future practice. For example, the girls expressed their dissatisfaction with lengthy sessions. They identified difficulty concentrating on the material after remaining seated for long periods of time, thus, the structure and format of future motivational enhancement groups could be altered taking this into consideration. Additionally, the girls identified one particular activity as particularly triggering for them. This was the activity which involved reporting their previous day’s meal plan to the group. They expressed that this set them up for comparisons with other group participants in a detrimental manner. This highlights the fact that practitioners should consider the activities which may perpetuate eating disorder behaviors, or, these issues should be addressed openly as an opportunity for exploration of these situations.

Perhaps the most significant implication for future counseling work is the recognition that the girls recognized the stages of change and were able to liaise with practitioners for future treatment planning. There was an indication that those girls who participated in the group prior to embarking on other treatment options, such as the day
program, felt the group provided them with a sense of readiness. The girls who participated in the group as an adjunct following treatment indicated that the group was somewhat repetitive and the purpose of recognition of the stages of change was insignificant at this point. Thus, practitioners can use this knowledge to guide them in future decisions around the appropriateness of group participants based on their comprehensive treatment program.

Implications for Future Research

Further research endeavors which are more widespread may involve inclusion of more participants from other programs. Additionally, a quantitative study assessing stages of change, readiness and commitment to recovery with this population would be very useful.

All of the participants expressed value in the parent participation component of the motivational enhancement group. Thus, it would seem logical that future research would focus on the parents' experiences in this group. One of the participants even suggested this as she felt it was a significant experience for her in terms of her relationship with her mother and it would shed light on the dynamics which occurred in the group.

Although some longitudinal studies have been conducted with general eating disorder populations, it would be interesting to conduct a follow-up study on girls in this group and how they perceived their experience of change, in general, over a period of time.

It is evident that there is limited exploratory research with this population. The insights gained from this study indicate that there is great value in allowing participants
to have a voice in their treatment options. It would, therefore, suggest that continued qualitative research with other treatment methods would seem logical.

Conclusion

This study has cast light on girls’ experiences in the motivational enhancement group. By having the opportunity to share their experiences, the girls felt heard and it is my hope that their voices will resonate with practitioners and enable us to work more effectively with this population. Eating disorders can be devastating illnesses for those struggling as well as the people who are close to them. For this reason, it is a problem which must be addressed. By exploring the girls’ experiences in the motivational enhancement group, we have illuminated the issues which girls find important in their treatment for eating disorders while involving the girls as active participants in their treatment.
References


DSM - IV diagnostic criteria for anorexia nervosa:

A. Refusal to maintain body weight over a minimally normal weight for age and height (i.e. weight loss leading to maintenance of body weight 15% below that expected), or failure to make expected weight gain during periods of growth, leading to body weight below 25% of that expected.

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or denial of the seriousness of current low body weight.

D. In postmenarchal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles.

The diagnostic criteria as indicated in DSM-IV for bulimia nervosa follows (American Psychiatric Association, 1994):

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances;

2. A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.
If I have any concerns about treatment or rights of a research subject, I may contact the Research Subject Information Line at (604) 822-8598.

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw for the study at any time without jeopardy to access further services through the program. I understand that I will receive a $20.00 gift certificate for my participation in this study, regardless of whether or not I choose to withdraw.

I have received a copy of this consent form for my own records.

'I consent/I do not consent (circle one) to my participation in this study.'

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Appendix E

Orienting Statement:

The goal of this research is to explore the experiences of adolescent girls in a motivational enhancement group for disordered eating. The reason this research is important is due to the fact that counsellors and other practitioners need further understanding as to how these programs are experienced by the participants. We want the participant's perspective on such programs. Specifically, I am interested in common experiences in the therapeutic motivational enhancement group based on the participants lived experiences.

Can you tell me what it was like to participate in the motivational enhancement group?

Was there anything from the group or any session in particular which really stood out for you? What was it like?

When you think of this group in terms of your relationships with other participants, what was it like?