



Why I recovered: A qualitative investigation of factors promoting motivation for eating disorder recovery

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Abstract

Objective: It is difficult for individuals with eating disorders (EDs) to build and maintain motivation to recover. This challenge contributes to high rates of treatment dropout and relapse. To date, motivational interventions have been largely ineffective, and there is little research on factors that affect recovery motivation. To better understand recovery motivation and identify potential intervention targets, this study examines factors that affect recovery motivation in individuals with EDs.

Method: *N* = 13 participants completed qualitative interviews. All had been recovered from their diagnosed and treated ED for at least 1 year. We applied thematic analysis to interview transcripts in order to identify factors that had influenced recovery motivation and to classify their effects as helpful, harmful, or mixed.

Results: Six main themes were identified, with subthemes detailed under each: (a) important people and groups (e.g., social circle, mentor), (b) actions and attitudes of others (e.g., judgmental responses, failure to intervene), (c) treatment-related factors (e.g., therapeutic skills, therapeutic alliance), (d) influential circumstances (e.g., removing triggers, pregnancy/children), (e) personal feelings and beliefs (e.g., obligation to others, hope for the future), and (f) the role of epiphanies (i.e., sudden insights or moments of change).

Discussion: In this study, we identified potentially malleable factors that may affect ED recovery motivation (e.g., removing triggers, focusing on obligation to others, getting involved in meaningful causes, securing non-judgmental support, building hope for the future). These factors may be investigated as potential targets or strategies in motivational interventions for EDs.

KEYWORDS

anorexia nervosa, bulimia nervosa, feeding and eating disorders, mental health, motivation, treatment adherence and compliance

1 | INTRODUCTION

Individuals with eating disorders (EDs) often feel ambivalent about recovery (Casasnovas et al., 2007), and roughly 25% drop out of treatment (Linardon, Hindle, & Brennan, 2018). Dropout rates are especially high for those with anorexia nervosa, from 51% in inpatient treatment

to 73% in outpatient treatment; dropout is similarly high for patients with BN, at up to 55.3% (Fassino, Pierò, Tomba, & Abbate-Daga, 2009). Additionally, 41% of patients across ED diagnoses relapse within a year of treatment (McFarlane, Olmsted, & Trottier, 2008). Given EDs' serious consequences (Franko et al., 2013; Rikani et al., 2013), it is imperative to understand what can motivate patients to recover.

Meta-analyses have shown that lack of motivation contributes critically to ED treatment dropout rates (Vall & Wade, 2015). To date, motivational interventions for ED patients (e.g., motivational interviewing) have been largely ineffective (Knowles, Anokhina, & Serpell, 2013; Waller, 2012). Compounding this problem, recovery and motivation to recover are difficult constructs to define and quantify (Vall & Wade, 2015; Wade & Lock, 2019). Additionally, motivation—often defined as readiness, willingness, and ability to change (Miller & Rollnick, 1991)—includes multiple facets (Waller, 2012). Efforts to boost recovery motivation will need to be informed by how that motivation may manifest, what factors may play a role, and which of those factors may be malleable and thus potentially addressable in ED intervention.

Few studies have analyzed factors that influence recovery in individuals with EDs, and, to the best of our knowledge, no studies have focused on factors influencing recovery motivation, but several valuable qualitative studies have examined facets of the recovery process more generally. In these studies, several themes emerged as helpful: hope, self-compassion (Bardone-Cone, Hunt, & Watson, 2018; Wetzler et al., 2020), supportive relationships (Bohrer, Foye, & Jewell, 2020; Wetzler et al., 2020), meaning/purpose (e.g., religion) (Matusek & Knudson, 2009; Wetzler et al., 2020), empowerment (Duncan, Sebar, & Lee, 2015), admitting to having a problem (D'Abundo & Chally, 2004; Matusek & Knudson, 2009; Pettersen & Rosenvinge, 2002), seeing the dangers of EDs (Lamoureux & Bottorff, 2005; Pettersen & Rosenvinge, 2002), negative life events (Arthur-Cameselle & Quatromoni, 2014a; D'Abundo & Chally, 2004), and motivation to change (Arthur-Cameselle & Quatromoni, 2014b; Pettersen, Wallin, & Björk, 2016).

The present study builds upon and complements these previous studies in four ways. First, unlike previous studies, we included only participants who had been recovered for at least a year in order to identify factors associated with full, long-term recovery. Second, while some previous studies have usefully focused on factors that assisted with recovery, we assessed factors that were helpful, mixed, and harmful for recovery. Third, unlike previous studies, we explicitly asked participants to identify factors related to recovery *motivation*, with the goal of informing and improving the effectiveness of motivational interventions for EDs. Fourth, in order to identify factors that might be influenced by intervention, we coded participants' responses for degree of malleability—i.e., the extent to which they could be influenced by patients, loved-ones, or clinicians.

2 | THE CURRENT STUDY

We conducted qualitative interviews with individuals who had recovered from any ED diagnosis to identify specific factors that influenced their motivation to seek treatment and recover. We chose a qualitative approach because this area of research is largely unexplored, and qualitative research may offer the greatest hypothesis-generating potential for further quantitative examination. In this article, we discuss several prominent themes and specific subthemes from these interviews, highlighting potentially malleable factors that played a role in participants' motivation to recover.

3 | METHODS

3.1 | Participants

Eligible participants met the following self-reported criteria: (a) at least 18 years old; (b) diagnosed with and treated for any ED; (c) recovered for at least one year (required because we aimed to identify factors associated with sustained recovery, and relapse rates are highest during the first year of recovery; Khalsa, Portnoff, McCurdy-McKinnon, & Feusner, 2017). Recovery was defined as: (a) scoring within one SD of the norm on the Eating Disorder Examination-Questionnaire (EDE-Q; Fairburn & Beglin, 1994; Mond, Hay, Rodgers, & Owen, 2006), and (b) self-reported abstinence from restriction, binge eating, or compensatory behaviors for at least one year.

We recruited 13 participants ($M(SD)_{age} = 32.23(6.92)$, $M(SD)_{recovery-length} = 3.81(2.59)$), most recent diagnosis: 46.15% AN, 15.38% BN, 38.46% Other Specific Feeding or Eating Disorder, first diagnosis: 76.92% AN, 0.00% BN, 23.08% OSFED) via email and social media of Project HEAL and Multi-Service Eating Disorders Association, two non-profit organizations that promote ED recovery (see Table 1 for demographic information and Figure S1 for CONSORT). Past research suggests that qualitative studies reach thematic saturation at a sample size of 12 (Crouch & McKenzie, 2006; Guest, Bunce, & Johnson, 2006); therefore, we aimed to recruit 12–15 participants. We included any ED diagnosis for several reasons: (a) high rates of diagnostic crossover in EDs (Eddy et al., 2008), (b) past research demonstrating that EDs exhibit a transdiagnostic “core psychopathology” involving cognitive over-evaluation and behavioral over-control of shape and weight (Fairburn, 2008), and (c) increasing emphasis on transdiagnostic ED treatments (Atwood & Friedman, 2020). Accordingly, 38.46% of our sample reported different first and latest ED diagnoses.

3.2 | Instruments

This study employed a demographic questionnaire and the EDE-Q (Fairburn & Beglin, 1994). The EDE-Q is a self-report questionnaire that assesses ED attitudes and behaviors. It has shown good internal consistency, validity, and test-retest reliability (Fairburn & Beglin, 1994; Luce & Crowther, 1999).

The study also included a semi-structured interview to identify factors that participants believed influenced their motivation to seek treatment and to recover. The script included eight central questions with optional follow-up questions. In the semi-structured interview guide, we included questions that might solicit malleable factors (e.g., “Did anyone do anything that influenced your decision to recover?”), and broader questions (e.g., “What factors motivated you to seek treatment for your ED?”).

3.3 | Procedure

All procedures were Institutional Review Board-approved. Participants completed the baseline screening survey, demographic and ED-history

TABLE 1 Participant demographics

Characteristic	Mean (SD)
Age at interview	32.23 (6.92)
Age at disorder onset	13.58 (2.81)
Age at first ED diagnosis	18.46 (3.50)
Age of recovery	28.50 (5.24)
Years between diagnosis and recovery	10.04 (6.17)
Mean EDE-Q total score	0.64 (0.97) ^a
Current BMI ^b	22.79 (2.99)
Median yearly household income	\$75,000–\$99,000 ^c
Ever received:	
Intensive outpatient care	7 (53.85%)
Outpatient care	13 (100.00%)
Residential care	6 (46.15%)
Day/partial care	7 (53.85%)
Inpatient care	6 (46.15%)
Characteristic	N (%)
Gender	
Female	13 (100%)
Race	
Whites	13 (100%)
Highest education	
Associate degree	1 (7.69%)
Bachelor's degree	3 (23.08%)
Master's degree	9 (69.23%)
Most recent diagnosis	
Anorexia nervosa	6 (46.15%)
Bulimia nervosa	2 (15.38%)
OSFED	5 (38.46%)
First diagnosis	
Anorexia nervosa	10 (76.92%)
Bulimia nervosa	0 (0.00%)
OSFED	3 (23.08%)
Most recent level of care	
Intensive outpatient	1 (7.69%)
Outpatient	6 (46.15%)
Residential	4 (30.77%)
Day/partial	2 (15.38%)
Inpatient	0 (0.00%)
Highest level of care at first treatment	
Intensive outpatient	0 (0.00%)
Outpatient	9 (69.23%)
Residential	2 (15.38%)
Day/partial	1 (7.69%)
Inpatient	1 (7.69%)

Abbreviations: ED, eating disorder; EDE-Q, Eating Disorder Examination-Questionnaire.

^aOne participant scored between 1 and 1.5 SDs from the mean because of an elevated score on the shape and weight subscale, which asks about cognitions pertaining to shape and weight. We decided to include this

survey, and the EDE-Q prior to the interviews. All participants were informed of the study aim (to identify factors that influenced their recovery motivation) and consented to audio-recording. We provided a list of local helplines and advocacy groups. Interviews lasted 53–100 min ($M = 75.00$, $SD = 15.33$).

The first two authors conducted the interviews, following training by the fifth author to ensure fidelity to the interview guide and standardization across interviews. The first two authors were trained to prioritize follow-up questions that might solicit malleable factors. Through the pre-prepared interview and follow-up questions, the interviewers prioritized discussion of factors that participants believed to precede or influence their motivation to recover, including those that initiated recovery motivation and/or built upon and continued motivation to change. The third author—a research coordinator in an ED laboratory and treatment center—transcribed and coded all transcripts (see Supplementary Codebook, Data S1). The fourth author, who also has experience in ED and qualitative research, coded seven transcripts for reliability—four using all themes and seven to obtain reliability on particularly challenging sub-themes. These four authors have research experience working in several clinical psychology laboratories, and the first three have clinical experience as lay-counselors. The fifth and sixth authors each have a doctorate in clinical psychology. The fifth author has extensive experience with treatment of and research on EDs, and the sixth author is an expert in youth psychotherapy research.

3.4 | Analysis

All transcripts were coded for themes and subthemes using thematic analysis (Braun & Clarke, 2006). Interviews were transcribed by the third author prior to coding. The first and second authors independently generated first drafts of the codebook using all transcripts, then created a combined codebook, which was iteratively refined by the first, second, third, and fifth authors. Throughout this process, the authors aimed to create a codebook with specific experiences, feelings, and beliefs, focusing on factors likely to be malleable. Notably, however, we did not limit the codebook to factors that were clearly malleable for two reasons: (a) we aimed to gain a rather complete understanding of factors motivating ED recovery and (b) it is difficult to know how malleable certain factors are before empirically testing their malleability.

The third and fourth author independently coded a selection of transcripts with the final codebook to ensure reliability. Cohen's Kappa ranged from $k = 0.72$ – 1.00 . The first, third, and fourth author resolved

participant in our sample because (a) they did not report any restriction, binge eating, or compensatory behaviors, (b) their scores on all behavioral subscales of the EDE-Q were within 1 SD of the mean, and (c) this participant was several months pregnant, and past research indicated elevated scores on the EDE-Q among healthy controls during pregnancy (Easter et al., 2015).

^bAll participants (except one who was pregnant) also affirmed that they had not missed a menstrual period in the last 4 months.

^cValues represent median, not mean.

disagreements through discussions. The third author coded the remaining transcripts and consulted the first author with questions.

4 | RESULTS

We identified six themes that participants described as important for recovery motivation; all with multiple subthemes (see Table S1 for themes, sub-themes, and their definitions). Tables S2–S7 list themes, sub-themes, example participant quotes, and the number of participants who described each subtheme as helpful for recovery motivation (i.e., if a participant described a theme as helpful in 75+% of instances and mixed in remaining instances), harmful (i.e., if a participant described a theme as harmful in 75+% of instances and mixed in remaining instances), or mixed (i.e., if a participant described a theme as both helpful and harmful within a transcript, or as mixed in 25+% of instances). Tables S2–S7 only include themes which four or more participants discussed. Two authors assessed each subtheme for malleability and indicated with the symbol “§” those that point to actions that patients or supportive others could take to promote recovery motivation. Importantly, all sub-themes could be discussed with patients with the aim of promoting recovery motivation.

We also offer group-level codes for each subtheme. Sub-themes are labeled “primarily helpful” if they were coded as helpful for 75%+ of participants who discussed them. The same system is applied for labeling subthemes as “primarily harmful.” Subthemes are labeled “mixed” if they did not meet either criterion.

4.1 | Theme 1: Important people and groups

This theme (mentioned by all $N = 13$) captures the types of people and groups whom participants found influential in their recovery process. Recovered role-models ($n = 8$), significant others ($n = 7$), advocacy groups ($n = 5$), and mentors/teachers ($n = 4$) were primarily helpful. Medical professionals ($n = 13$), family ($n = 13$), friends ($n = 11$), social circle ($n = 10$), figures with an ED ($n = 8$), and relationship with self ($n = 8$) were mixed.

All ($N = 13$) participants discussed the role of family in recovery motivation. Nine reported that family members were both helpful and harmful. Family members often helped pay for treatment and sometimes emotionally supported participants. Yet, participants described feeling that their family members ignored or even encouraged the disorder when they focused only on physical changes, passed harmful judgments, and lacked empathy for the participants' struggle. For example, one participant described how her recovery motivation improved when her treatment team recommended she stop seeking support from an unsupportive family member:

“He wasn't open to doing anything differently, and everything was my fault”... so it was helpful for [my treatment team] to say:

“He's not capable, at this time, to support you emotionally.”—Participant 6, Dx = BN, Harmful

Additionally, all $N = 13$ participants discussed the role of medical professionals in their recovery. Nine of these participants discussed helpful and harmful aspects of these relationships, and $n = 4$ discussed mainly helpful aspects. Participants often described medical professionals as the first people who made them feel heard and understood and said they provided hope and tools for recovery.

“It was revolutionary for me to be able to be completely honest with her about all I had done and be accepted and receive compassion. And she started me out slow... She just knew exactly when to start pushing for higher levels of care.”—Participant 4, Dx = AN, Helpful

Yet, participants also described situations when medical professionals harmed their recovery, such as when medical professionals brushed off eating concerns. One participant described going to a doctor, who did not notice the warning signs of her ED, even when her mother expressed concern:

“The doctor [said] ‘She's lost like ten pounds, but I just wouldn't let her lose any more.’”—Participant 12, Dx = OSFED, Harmful

4.2 | Theme 2: Actions and attitudes of others

The theme “actions and attitudes of others” (mentioned by all $N = 13$) refers to things that others did or said that affected participants' motivation to recover. We coded many passages as both “important people and groups” and “actions and attitudes of others”; the two themes, however, provided different information. The first described influential types of people and the second described specific influential actions/attitudes.

The themes non-judgmental ($n = 9$), non-directive ($n = 9$), and inquisitive ($n = 9$) were primarily helpful. Directive ($n = 11$), forced into treatment ($n = 7$), and strongly encouraged to go to treatment ($n = 6$) were mixed. Judgmental ($n = 9$), lack of intervening ($n = 5$), rewarding thinness ($n = 5$), reinforcement of the societal ideal ($n = 4$), and punishing weight gain ($n = 4$) were primarily harmful. The theme of directive advice (i.e., advice in which someone told a participant what to do), came up most frequently ($n = 11$), and was mixed for $n = 8$ participants. Often, the advice's content was accurate and well-intentioned, but the information was presented harshly, or in a way that ignored the emotional state of the participant. Directive advice was perceived more negatively when it seemed to ignore participants' wishes, removing their sense of autonomy. Sometimes, the tone or phrasing was so forceful and unempathetic that the participants saw directivity as harmful. One participant described feeling alienated when a sibling confronted her about her ED to encourage her to change.

“She called me out on my behaviors... said, ‘I see when ... the only thing you order is salad without dressing... you look so skinny. You really look like you're sick,’... It

sounds kind of punitive. It sounds not compassionate. It didn't feel warm...[It] felt like, 'You're doing this, and it's wrong.'—Participant 5, Dx = OSFED, Harmful

Participants ($n = 9$) mentioned receiving non-judgmental support (e.g., open-ended questions and validation of feelings). All those participants found it helpful. On the other hand, all $n = 9$ participants who described judgmental interactions, in which someone else offered judgments about the participant and their disorder or body, as harmful. One participant described overhearing her parents discussing how her body looked once she gained weight:

"I overheard them saying that I had, like, gained a lot of weight, and that I looked awful, and that was a really horrible experience."—Participant 9, OSFED, Harmful

Among the nine participants who discussed times when someone offered non-judgmental support, all nine also discussed how they wish they had received more non-judgmental support. These participants discussed the value of being asked how they were feeling, or of being offered empathy for their emotional state that accompanied their ED. They appreciated this approach much more than when others ignored their ED or simply pointed to changes in their bodies without acknowledging emotions.

"Sometimes it can be so hard to start that conversation about an eating disorder because you don't want to accuse someone. But I think it's even asking someone if they're okay. It was so helpful and laid out a supportive space for me to just be like, this is what's going on, and I really appreciate you asking and noticing."—Participant 9, Dx = OSFED, Helpful

Additionally, five participants felt people didn't intervene enough in their disorder, and instead people often ignored the disorder or passively perpetuated behaviors (e.g., by purchasing "safe" foods). $N = 4$ of these participants described a lack of intervention as exclusively harmful and one participant described it as mixed.

"I think that was really hard for me because there wasn't anyone that I felt like was saying, hey, you should probably get treatment, a lot of times throughout my life."—Participant 12, Dx = OSFED, Harmful

4.3 | Theme 3: Treatment-related factors

The theme of treatment-related factors (mentioned by all $N = 13$) encompasses themes related to treatment itself. Therapeutic skills ($n = 10$) and therapeutic alliance ($n = 9$) were primarily helpful. Treatment peers ($n = 6$) and attending treatment ($n = 5$) were mixed. Structural factors/insurance ($n = 7$) was primarily harmful. All $n = 10$ participants who mentioned "therapeutic skills" described it as helpful. These participants discussed specific ways of thinking and behaving

differently that they learned from therapy. For example, one described the value of Acceptance and Commitment Therapy in her recovery:

"In my undergraduate I was learning about [ACT]. But then, practicing it daily with my therapist, I liked the style of it. Since then, when I have had to seek [therapy] again, I have always asked people, well, do you do ACT?"—Participant 13, Dx = AN, Helpful

Additionally, $n = 9$ participants described the therapeutic alliance, or having a strong personal connection with their therapist, as helpful. For example, one participant said that because she trusted her therapist and knew her therapist wanted the best for her, she "did what [her therapist] said."—Participant 8, Dx = OSFED, Helpful

Slightly over half of participants ($n = 7$) discussed the role of insurance and other structural factors in their treatment, and they all described it as either harmful ($n = 5$) or mixed ($n = 2$) because insurance and structural factors often forced participants to seek shorter treatment or limited their choice of programs. For example, one participant struggled to find a program as her insurance plan changed:

"Financially, I had different health insurances, and that was a huge, huge barrier to treatment..."—Participant 13, Dx = AN, Harmful

4.4 | Theme 4: Influential circumstances

All $N = 13$ participants discussed influential circumstances; this theme captures life circumstances that did not relate necessarily to the ED, but nonetheless influenced motivation to recover from the ED. School performance/engagement ($n = 5$), pregnancy/children ($n = 5$), removing triggers ($n = 4$), and feminism ($n = 4$) were primarily helpful; life events ($n = 7$), career interference ($n = 7$), routine changes ($n = 5$), and medical problems ($n = 5$) were mixed. Additionally, although some factors were not particularly malleable (i.e., medical problems, life events), most of these subthemes point to potentially malleable motivating factors. For example, participants ($n = 4$) mentioned removing triggers, which they seemed to believe helped them avoid disordered thoughts and behaviors. One participant discussed removing tags from clothing, and another described how she decided "never to look at [her] weight on a scale."—Participant 9, Dx = OSFED, Helpful

Five participants were motivated by pregnancy/children because it seemed incompatible with EDs. For example, one participant did not want to raise a child while she struggled with an ED because she feared passing on harmful attitudes and behaviors. Another participant knew she could not safely have a child unless she recovered:

"I really wanted to have a baby. I knew that ... there was no way it [would] be possible. That was another big motivating factor for me, probably the biggest in terms of getting me there."—Participant 3, Dx = AN, Helpful

Participants described career ($n = 7$) and school performance ($n = 5$) as factors motivating recovery for similar reasons; often, the harmful effects of EDs on work and school (e.g., loss of interest, poor performance) motivated participants to recover. Finally, participants ($n = 7$) cited upsetting life events (e.g., the death of a sibling or loss of a major opportunity) as at least somewhat helpful in motivating recovery.

4.5 | Theme 5: Personal feelings and beliefs

This theme (discussed by all $N = 13$) captures personal thoughts and feelings that influenced recovery motivation. Obligation to others ($n = 9$), hope for future ($n = 8$), and “healthy-ish for treatment” ($n = 4$) were primarily helpful. Low point ($n = 10$) and sadness ($n = 7$) were mixed. Denying the problem ($n = 8$) and lack of hope for future ($n = 4$) were primarily harmful. Notably, $n = 10$ participants labeled an emotional low point as a mixed factor that somewhat motivated their desire to recover. One participant described it as “a hopeless, almost last resort kind of feeling.”—Participant 4, Dx = AN, Mixed. This feeling often led them to want to change something.

Additionally, $n = 9$ participants felt that their ED interfered with their ability to fulfill their obligations to others and they perceived this feeling as helpful for recovery ($n = 7$) or mixed ($n = 2$). For example, one participant feared that her ED would get in the way of her relationships, especially her relationship with her child:

“I do remember one mom, she talked about how she wasn't able to be a mom and still have her eating disorder ... You can't have true relationships with other people with your eating disorder. I think that stuck with me, because it's always gonna take over your life.”—Participant 1, Dx = OSFED, Helpful

Seven out of eight participants described hope for the future as exclusively helpful, and eight discussed their wish that they could have built more hope for the future. One participant said that teachers who frequently praised her bright future motivated her recovery:

“I have the most beautiful cards...that my teachers wrote me when I graduated....they were full of this idea that life was gonna be really beautiful...The idea that things were going to get better was really powerful.”—Participant 3, Dx = AN, Helpful

4.6 | Theme 6: Epiphanies in recovery motivation

This theme encompasses instances of sudden and gradual gains in recovery motivation. Five participants explicitly said they had a moment of epiphany or sudden, remarkable change; $n = 6$ described moments that coders identified as epiphanies; and only $n = 2$ explicitly denied having a moment of epiphany. Interestingly, participants were

unsure what exactly led to their moments of epiphany. For example, one participant suddenly decided to eat dessert after consistently failing to progress in treatment, and subsequently never skipped a meal:

“I decided to have a bowl of ice cream, like a normal person, for dessert, and ever since then, I haven't skipped a single meal.”—Participant 4, Dx = AN

Ten participants also experienced gradual changes in recovery motivation. Nine participants explicitly said they experienced gradual change and $n = 1$ experienced gradual change as interpreted by the coders. These participants discussed going to treatment several times, each time making small steps toward recovery:

“My motivation was always there, it just depended on how frustrated or miserable I was... I felt... more capable of recovery each time. I learned lessons...and I think it took a certain amount of...falling down so many times that I was like I need to step it up more...”—Participant 9, Dx = OSFED

Importantly, nine participants described *both* a sudden moment of change and gradual, overtime gains in motivation.

5 | DISCUSSION

The 13 participants in our study provided rich information about the specific and often malleable factors that influenced their recovery motivation. This information may be useful to researchers, clinicians, and lay-people who hope to understand and improve recovery motivation in individuals with EDs.

Many sub-themes point to malleable factors that may be acted upon to build recovery motivation, and all may be discussed to promote recovery motivation. For example, regarding theme two, others ignoring the ED was harmful for ED recovery. Instead, it may be helpful to openly express concern for the *emotional* wellbeing of those with EDs. Judgmental comments, especially those around weight and eating, are likely harmful and could often be replaced with comments and questions that acknowledge the wishes and feelings of those with EDs. Supportive others may struggle to balance encouraging treatment with being non-judgmental; discussing feelings instead of just weight and demonstrating the recovery is possible may help when encouraging treatment. Regarding themes one and four, and supportive others can help build recovery motivation by supporting pro-recovery beliefs and lifestyle changes (e.g., cutting out tags, buying foods other than “safe” foods, not talking negatively about weight and bodies), by building hope for the future (e.g., writing inspiring notes), and by discussing and working toward goals that conflict with the ED (e.g., volunteering, having children).

Regarding theme three, clinicians may also be able to help build recovery motivation by making clients feel that they will not be judged for their thoughts and feelings, by discussing values that conflict with the ED, by helping clients maintain a sense of autonomy

over their treatment, by teaching evidence-based therapeutic skills, and by helping clients build pro-recovery social circles. Many participants first sought treatment from clinicians other than ED specialists, who often did not recognize the disorder. These clinicians should be trained to identify and address eating concerns. Regarding theme six, motivation to recover may usually gradually build, often eventually culminating in an epiphany. Therefore, it may be important for clinicians and supportive others to continually implement motivational interventions and retain hope for recovery.

Some of the malleable factors identified in this study could be incorporated into motivational and treatment interventions. First, our data highlight the importance of blending supportiveness with directivity given that the majority of participants indicated therapeutic alliance ($n = 9$), non-judgmental attitude ($n = 9$), non-directiveness ($n = 9$), and specific skills ($n = 10$) were helpful in promoting recovery motivation. Therefore, integrating traditional MI strategies (e.g., meeting clients where they are, non-judgmental tone, open-ended questions; Miller & Rollnick, 2013) with more directive approaches (e.g., family-based treatment for anorexia, Lock & Le Grange, 2001, exposure-based interventions, Glasofer, Albano, Simpson, & Steinglass, 2015) may be particularly powerful. Practitioners might also encourage patients to reflect on their values, include stories from or interactions with recovered individuals, discuss hopes for the future, and allow participants to generate ways in which the ED conflicts with other goals (e.g., helping others or achieving professionally). Notably, certain factors may help some and harm others, and strategies should be tailored to meet individual personalities and preferences. Finally, directivity (e.g., forcing treatment) was viewed as mixed—it often helped lead to eventual recovery, but also made participants feel “called out” or less autonomous.

Several themes identified in this study corroborated past literature. For example, several studies conceptualized recovery as a long journey (Bardone-Cone et al., 2018; Kenny, Boyle, & Lewis, 2019), which corresponds with our finding that recovery motivation typically builds gradually. Additionally, two previously published articles provide detailed information on two subthemes (i.e., recovery disclosures and feminism/gender; Wasil, Venturo-Conerly, Shingleton, & Weisz, 2019; Venturo-Conerly, Wasil, Shingleton, & Weisz, 2020). Notably, however, this study identified many novel themes that may be acted upon and/or discussed to promote recovery motivation.

The findings of this study are exploratory, and the study has several limitations. First, we cannot establish causality based on this data. Second, all participants identified as white females, which is common in ED research, yet limits the generalizability of findings. Third, participant self-reports may have been inaccurate. Fourth, all the participants in this study recovered from their EDs at least one year prior to the interviews. Although the definition of ED recovery remains debated (Wade & Lock, 2019), some suggest using a conservative window of 18 months (De Young et al., 2020). Nonetheless, a cutoff of one year enabled us to identify factors associated with long-term, not only short-term, recovery; however, this may have led to over-representation of helpful factors and underrepresentation of harmful and mixed factors.

This study suggests several directions for future research. First, researchers could aim to understand precisely which malleable factors

are most motivating for whom by comparing factors that motivate ED recovery across demographic groups and diagnoses. Relatedly, future research could examine factors that affect recovery motivation in those who have not yet recovered from EDs, could examine perspectives of clinicians and loved-ones of recovered individuals, and could involve those with lived-experience as authors. Additionally, this study was not designed to detect differences in motivating factors across diagnoses, demographics, illness duration, or number of previous treatment courses; future research could investigate these differences. Importantly, the findings of this study may inform novel motivational interventions, which should then be tested for their effects on treatment initiation, motivation, engagement, and outcomes. The malleable factors identified in this study may assist clinicians, researchers, and loved-ones of those with EDs in their efforts to determine what to do (and not to do) to motivate those suffering from EDs to recover.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. Because of the qualitative nature of the data, they are not publicly available due to privacy concerns.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

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