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The Meaning of Self-Starvation: Qualitative Study of Patients' Perception of Anorexia Nervosa

Ragnfrid H. S. Nordbø, Cand Psychol[1]*
Ester M. S. Espeset, Cand Psychol[1]
Kjersti S. Gulliksen, Cand Psychol[1]
Finn Skårderud, MD[2]
Arne Holte, PhD[1,3]

ABSTRACT

Objective: Anorexia nervosa (AN) patients tend to place a positive value on their symptoms. Many clinicians believe that this plays a central role in maintaining the disorder. However, empirical research on how patients attribute meaning to their symptoms is lacking. This study aims at systematically exploring the meaning that the patients with AN attribute to their anorectic behavior.

Method: A qualitative, descriptive, phenomenological design was used. Eighteen women aged 20–34 with AN (DSM-IV) were interviewed with an informant-centered interview. The interviews were tape-recorded, verbatim transcribed, coded, and analyzed phenomenologically, using a QSR-N*Vivo software program.

Results: The psychological meanings that the informants attributed to their anorectic behavior could be summarized in eight constructs: "Security" (feeling of stability and security), "Avoidance" (avoiding negative emotions), "Mental strength" (inner sense of mastery), "Self-confidence" (feeling acknowledged and worthy of compliments); "Identity" (achieving new identity), "Care" (eliciting care from others), "Communication" (communicating difficulties), and "Death" (wishing to starve oneself to death).

Conclusion: The eight constructs may have central functions in the maintenance of AN and should be regarded when patients' motivation and goals for treatment are assessed. Further study of the possible functions of the constructs in maintaining AN is warranted. © 2006 by Wiley Periodicals, Inc.

Keywords: eating disorder; psychotherapy; treatment; function; illness perception

(Int J Eat Disord 2006; 39:556–564)

Introduction

Ambivalence about recovery is a central feature of anorexia nervosa (AN). Patients with AN rarely seek treatment on their own initiative,[1] the motivation to change is often low,[2] approximately one half of the patients drop out of treatment,[3,4] and treatment outcome is generally poor.[5] The strong hesitance to change has been attributed to the function of the anorectic symptoms.[2,6–8] Different from many other patient groups, AN patients tend to appreciate their symptoms.[7–10] This may explain their low motivation for change[11,12] and play an important role in maintenance of the disorder through self-reinforcement rather than social reinforcement.[9,10,12] In this way, anorectic behavior may be regarded not only as a set of physical and psychological symptoms, but also as a set of behaviors that have become meaningful to the individual.

For many years, clinicians and researchers have discussed how to understand the meaning of anorectic behavior.[8,9,12–17] AN is suggested to function as a way of regaining control of psychobiological maturing[18] or as a self-punishing defense when fearing lack of control.[19] Many of these meanings postulate motivational constructs (e.g., need for control, resistance to sexual maturation). These are based on theoretical inferences from clinical experience rather than systematic empirical studies. Systematic empirical studies on how AN patients themselves perceive their anorectic behavior as meaningful are scarce. Such insights may, however, be important in the study of the development, maintenance, and treatment of anorectic behavior. Furthermore, to help ambivalent patients achieve durable change in their condition, it is crucial to establish a sustainable therapeutic alliance. To

Accepted 13 December 2005
RHSN was supported by a grant awarded from the Health and Rehabilitation Foundation via the Norwegian Council for Mental Health; EMSE and KSG were supported by grants from the Norwegian Research Council.
Correspondence to: Ragnfrid H. S. Nordbø, Division of Mental Health, Norwegian Institute of Public Health, Oslo, Norway.
E-mail: ragnfrid.nordbo@fhi.no
[1] Division of Mental Health, Norwegian Institute of Public Health, Oslo, Norway
[2] Lillehammer University College, Lillehammer, Norway
[3] University of Oslo, Oslo, Norway
Published online 14 July 2006 in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/eat.20276
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attain this, the therapeutic alliance needs to be grounded on goals that are consistent with the patient's personal values rather than external motivation not shared by the patient.[8,20] In establishing such therapeutic alliances, systematic and differentiated knowledge about the psychological meanings that AN patients attribute to their anorectic behavior will be valuable.

Surprisingly, little effort has been focused on empirically establishing the meanings AN patients attribute to their anorectic behavior. Serpell et al.[7] addressed the issue by asking patients to write a letter to "AN as a friend" and "AN as their enemy." By examining the letters, they found that important benefits included feeling protected, gaining a sense of confidence, and feeling different, while reported drawbacks were, among others, constant thoughts of food, suffocation of emotions, and loss of social life. Although stimulating, this pioneering study suffers from methodological limitations. The patients were instructed to access their AN in positive and negative terms, and we do not know how the results would have been with a different or less directive instructions. In addition, the data were obtained through letters written by the patients, and the researchers were therefore not able to investigate the exact or extended meaning of the patients' written utterances through dialogue. A less directive and more interactive method of inquiry might both have given other results and strengthened the validity of the information obtained.

We have therefore conducted a comprehensive in-depth study using a semi-open, informant-centered, and interactive interview format. We were interested in which themes AN patients themselves describe as important from their experiences of living with AN. We assumed that by using a phenomenological approach, carefully explaining the intention of our study to the patients, conducting interviews within an interview-centered format, and analyzing the transcribed dialogues, we could detect a valid and reproducible set of constructs expressing how AN patients themselves experience their anorectic behavior. Hence, the main purpose of this study was to systematically explore possible meanings that AN patients attribute to their anorectic behavior.

Method

Participants

Informants included 18 women aged 20–34 years (mean, 25.5 years) recruited from three different clinical institutions in Norway, which included both specialized services for eating disorders and general psychiatric services. At the time of the interview, 14 of the informants were outpatients, and 4 were inpatients. Sample size was defined by criteria of data saturation according to Strauss and Corbin[21]: new informants were included until three subsequent interviews had been conducted without essential new information being added. When 18 informants were interviewed, the criteria of data saturation were fulfilled. All 18 informants had within the past two years been diagnosed with AN.[22] At the time of the interview, 12 informants fully satisfied the criteria for the diagnosis of AN. The mean of the reported lowest body mass index (BMI) while having AN was 12.9 (range, 8–16), mean duration of AN was 10 years (range 1–22 years), and mean years of treatment was 6 years (range, 1/2–14 years).

Setting and Procedure

The patients received a letter from their physician or psychologist that described the purpose of the study and the procedure and that asked them to participate. Twenty-one patients volunteered to participate as informants. Three were excluded because of high age or technical matters. After approving participation, the informants were contacted by the interviewer and were again informed about the purpose of the study. The interviews were conducted by the first two authors. Neither of these authors had any relationship to the treatment institutions. The informants were assured anonymity and the right to withdraw from the study at any time during or after the interview. Each interview lasted between 90 and 120 minutes and was audiotaped and transcribed verbatim.

All procedures were conducted in accordance with the Helsinki Declaration, and the study was approved by the Norwegian Regional Committee for Medical Research Ethics.

The aim of the interviews was to provide descriptions as precise and as close to the informants' subjective experience as possible. Accordingly, a phenomenological, descriptive, and qualitative study design[23] with elements of Grounded Theory[21] was applied. The data were collected by means of the "Experience interview,"[24] a semi-open, informant-centered and strategic conversation format developed from communication theory.[25] Some of the informants spontaneously began to describe their AN experiences, how this influenced their lives and how they perceived themselves after the purpose of the interview was explained. The other informants were instructed by an open question such as: "In your own words, describe how it is to have AN?" From there, the interviewer improvised on the basis of a semi-structured interview guide and structured the course of the conversation through responses to the issues brought up by the interviewee. To facilitate the interviewee's own development of their

themes, the interviewer responded mainly by means of open instructions ("Tell me more . . ."), references to her/his own impressions ("How sad!"), and frequent use of verbal ("Really!") and nonverbal (nodding) facilitators. Use of questions was either open (What happened?) or limited to elicit specific information (Did you?).

Data Analysis

The interviews were transcribed verbatim by the first two authors (RHSN and EMSE). Text analyses were conducted using the software program QSR-N*Vivo.[26] After repeated listening and readings of each interview, each text was explored by means of open thematic coding[21] according to the "bottom–up principle." In this process, each full text was divided into text excerpts according to their content of meaning. Based on semantic and contextual analysis, each meaning content was then condensed into its essence,[27] coded, and entered into the database in a consecutively revised tree of meanings. For example, a long text excerpt could be condensed into the essence, "I didn't know how to change, so I became slimmer to be a better person"; coded under the potential construct labeled, "Better person"; sorted under the higher-order potential construct, "New identity"; and categorized under the superordinate potential construct, "Meaning of AN," which was placed within the main area predefined in the interview guide as, "Life with AN." After semantic analysis, tests for coherence and contrasts, and exclusion of "outliers,"[28] each empirically generated potential construct, e.g., "Better person," at each level in the tree was defined with reference to the essences of all original text excerpts.

To arrive at the final constructs, the definitions of the potential constructs were tested against the text by confirming and selective coding[24] according to the "top–down principle." In this process, the potential constructs that had been generated through the open coding were applied to each full text excerpt under each relevant code. The purpose of this "backward translation" was to see whether the generated constructs fit with the text and to detect possible overlaps between constructs and needs for adjustments or supplements. For example, the applicability of the potential construct "Meaning of AN" that referred to informants' opinion that their anorectic behaviors had become psychologically meaningful, was checked by semantically reanalyzing and recoding all text excerpts that contained descriptions of AN as a psychologically meaningful behavior to see whether they were consistent or inconsistent with the construct definition.

To reduce chances of idiosyncratic coding, the "bottom–up" analyses were conducted equally by the first two authors. The correspondence between the coders was high in both processes and deviations were corrected through discussion.

In the presentation of results, all information that might lead to personal identification has been removed, although never in a way that interferes with the informant's style of phrasing.

Results

The informants described AN as being far more than a medical disorder. The informants explained how they perceived being anorectic as psychologically meaningful. The psychological meanings of the disorder were reported spontaneously when the informants described their anorectic behavior, everyday life with AN, and when they told about their difficulties in recovering from the illness. There was one exception; one informant did not report any psychological meaning of her behavior but described exclusively difficulties with "eating enough food." The other 17 informants attributed psychological meaning to their anorectic behavior.

The informants attributed different meanings to their anorectic behavior. One informant could report several meanings and changes in meanings during the course of illness. Some claimed that the meaning of the behavior had been there from the start of the illness. Others told that the anorectic behavior had adopted its meaning later on in the course of illness. In some cases, meanings that by origin seemed to be consequences of AN, such as getting an inner feeling of drive and mastery, later became prominent psychological meanings of AN.

By condensing the number of text excerpts coded as "Meaning of AN," we were able to detect eight constructs representing psychological meanings that AN patients attribute to their anorectic behavior. As in quantitative factor analysis before rotation, these constructs do not yet represent independent dimensions. Rather, they discern clinically meaningful constructs that one may want to explore when addressing a client's subjective meaning of her anorectic behavior. All eight constructs are illustrated with extracts from interviews. **Table 1** shows an overview of the distribution of the constructs.

1. Security ($n = 11$)

The security construct includes descriptions of AN as a way of obtaining a *sense of stability and security*. The anorectic behavior helped the informants structure their everyday life. They described several rules and how they planned each day. By organizing their days by means of strict rules and time schedules, they could achieve a sense of structure in life, which they had never experienced

TABLE 1. Overview of distribution of the constructs

	Security	Avoidance	Self-confidence	Mental Strength	Identity	Care	Communication	Death
Mary	X	X	X	X		X		X
Emma		X						
Sue	X	X	X			X		
Rita			X			X		
Eva	X	X	X	X				
Heidi		X						
Jane							X	
Ann	X	X	X	X	X	X		
Elisabeth	X		X	X				
Karen	X							X
Nina	X	X		X				
Frida	X	X	X	X	X		X	
Susan	X			X				
Irene	X	X					X	
Tina								
Sandra		X			X			
Johann	X		X	X		X	X	
Helen			X					
Total	11	10	9	8	3	5	4	2

before. Without this sense of structure, they felt confused and disorganized and became afraid of gaining weight. Often the informants described this construct in terms of what they would lose if they recovered from AN. The anorectic behavior represented a kind of security, particularly in the sense of predictability. They always knew what would happen next and thus had a sense of stability and certainty in life:

Frida: I could have written two full books about all the rules I had to follow. I couldn't just break them. . . .

Interviewer: If you broke them, then. . . .

Frida: I was so afraid of what would happen, maybe I would put on weight or something. . . .

Interviewer: So, if you'd done something That was against the rules, did it give you any feeling. . . .

Frida: Yeah, it was this uncertainty . . . something new I couldn't control . . . it was just very scary.

Nina: It's simply a way of handling everyday life. To manage to get up in the morning, manage to go to bed and manage a new day after that again. Simply to get a grip on yourself and what's inside you. If you lose your eating problem, you'll lose this too. That's pretty much what I'm afraid of. How on earth am I then going to manage my every day life?

2. Avoidance (n = 10)

The avoidance construct refers to AN as a way of avoiding *negative emotions and experiences*. The informants reported avoidance of hurtful feelings, relational problems, and high expectations for their own performance. Some informants linked this avoidance to the feeling of being safe, as described above. Others, however, exclusively described AN as a way of eluding problems. The type of problems varied. Some said that they felt a lot of pressure as to how to live their lives. The informants could feel that they had to take the "right" decisions in many areas, including education and appearance. To perform well in life felt like a huge pressure. These informants expected a lot from themselves, but they could also feel that pressure came from their friends and family. As a result, they felt sad, lonely, or angry. AN helped them avoid these negative emotions. When their everyday life was focused on body, weight, and food, they had little energy to concentrate on other difficulties or problems:

Irene: It's an easy way to avoid feelings. You escape relating to different things, you escape relating to different feelings, you escape relating to anything . . . avoiding to relate to myself because I feel so bad. So it's like drugs, you manage not to think.

Mary: Things were chaotic, the job, the school, all my relationships. . . . It's quite related to the eating disorder I guess, but I thought that as long as I had the eating disorder, I didn't need to focus on those things. Then I was thinking on food instead.

3. Mental strength (n = 9)

The mental strength construct includes descriptions of AN as a way of getting an *inner sense of mastery and strength*. As the informants managed to lose weight, they experienced an inner drive. This drive could feel as a rush or sense of power. They felt they had achieved a sense of mastery and self-control. Keeping a strict diet was described as a

struggle or a battle. However, when they managed, they felt an inner strength and invulnerability:

Nina: When I notice that "ok, I've lost two kilos," "now I've lost three" . . . the stronger and stronger I get to handle the things coming up. It's about the psychological. . .that you have the control there and then. . . . It's hard to explain, but it is as if the smaller I get, the stronger I get mentally.

Mary: I felt I was in better mood when I didn't eat. I had control, was on top of the situation. I compared myself to other people and then I felt privileged that I could control myself when tempted to eat.

4. Self-confidence (n = 8)

The self-confidence construct refers to AN as a way of *feeling worthy of compliments and acknowledged*. Losing weight made the informants feel better about themselves. They felt smart, pretty, and successful, and this was supported or confirmed by their surroundings. Receiving compliments about their looks from other people gave the informants an increased sense of self-confidence. Different from the mental strength construct, this construct includes descriptions of increased self-confidence based on a sense of external positive affirmation. Some of the informants reported this positive feedback to be of special importance when they first started to lose weight. Many of them meant that they had never before received compliments for their appearance and performance and that they always had had low self-confidence. AN made them feel better about themselves. The feeling of being pretty and successful helped them to improve their self-confidence. They received positive feedback about their appearance and their performance, and felt worthy of these compliments:

Rita: When it started, it was like this: "Wow, you're looking great Rita." And that really gave me a kick. "Ohao, you've lost weight haven't you?," "Gee, you're looking gorgeous," and "Fantastic body" (laughing). That really gave me an extra push, and I lost even more weight.

Sue: And it gave me confidence. I've always had low self-esteem, you see. . . . I felt quite good-looking first when I lost weight.

5. Identity (n = 3)

The identity construct includes descriptions of AN as a help to create a *different identity or personality.* Identity here refers to a person's inner, continuous, and subjective concept of oneself as an individual different from others. AN helped the informants change their perception of who they were. Before AN they could characterize themselves as being strict, harsh, or invulnerable. As they lost weight, informants felt that they became a different person. Now they were girlish, ascetic, vulnerable, or weak. They valued these changes positively. In contrast to both the mental strength and the self-confidence construct, the identity construct emphasizes the sense of change and of becoming different. The identity construct includes an experience of getting rid of one's old identity. These informants were no longer the harsh person they used to be. Instead, they had become a better and more likable person. AN had helped them change their identity:

Ann: When I was 14, I felt other people started to dislike me. They talked behind my back and so on. The day I decided to reduce my weight, it was about being a better person. Because then people wouldn't dislike me anymore. I lost a lot of weight, I got so tiny. . . . I wanted to change completely, but I didn't know how to do it. So then I got thinner because I thought it would make me a better person. Then it wasn't me anymore. I wasn't the old Ann anymore, I was new.

Sandra: At the same time I felt I took up to much space, I think. That it was too much of Sandra. So to make oneself smaller, one becomes smaller. . . . Doing that, one gets more rid of the ridiculous Sandra.

6. Care (n = 5)

The care construct refers to AN as a way of *eliciting care from other people*. As they lost a lot of weight, people around them expressed concern. Some of the informants had missed the expression of care from their friends or family. After AN, they perceived others as being concerned. The informants often used the word attention when they described this experience. However, different from the experience of feedback included in the self-confidence construct, this construct includes experiences of attention, which is interpreted as a sign of concern. When people around them were worried because they had lost weight; it became a sign that they cared. The informants interpreted this not only as attention but as attentiveness, thoughtfulness, consideration, and kindness. AN helped them feel loved, and they received a sense of care that they had not experienced before:

Johanna: You're so tiny and vulnerable, and you get extra care. People are more considerate. When

you're used to performing well and feeling the pressure from high expectations, then suddenly people are more like "Relax, it's not that important really," "Calm down and relax,"...this caring thing.

Mary: I missed him so much [her ex-boyfriend]. He was quite worried, and I felt good in a way....

7. Communication (n = 4)

The communication construct includes descriptions of AN as a means to *communicate difficulties* to other people. Some of the informants did not describe anything specific that they tried to receive from other people, such as the care included in the "care construct" or the compliments included in the "self-confidence construct." The communication construct is limited to include descriptions of AN as a method of communicating that there are difficulties. These informants said that they had problems they did not know how to express to their friends and family. Some had felt this for a long time. After AN they felt that other people had become aware that the informant actually had problems. They did not feel understood by the people around them. AN helped them to communicate, and other people realized that they had difficulties:

Johanna: It was the body's way to tell that I had a problem, a mental problem. That you don't feel good about yourself.

Frida: It felt good when my parents came here and received information about the disease. In a way I could calm down when I saw that my parents understood. It was primarily my parents I wanted to affect with my disease. First and foremost, I wanted to show.... It was my way to tell everybody that I felt bad and didn't like myself. Even if everybody around me thought I felt okay, and that I in many ways was okay...the fact is that I don't have anything.

8. Death (n = 2)

The death construct is based on only two of the informants. It defines AN as a way of *starving oneself to death*. Of all the informants, one third reported earlier suicide attempts. Some described earlier depressions and said that they had had a wish to die before they developed symptoms of AN. Others said they had had an increasing feeling of depression after they developed AN. However, two informants did not only report suicide attempts. They described being anorectic as a concrete expression of their wish to disappear. They did not want to live anymore. As one informant said, "Even if I've joined this treatment program, my biggest goal is to starve myself to death, that's what I'm longing for." The informants could feel that they did not have any right to live, and that their life was unbearable. Compared with other suicidal methods, one informant considered death by starvation as "a less brutal way of dying" because "the people around wouldn't notice":

Karen: I don't want other people to stop me in what's about to happen. In one way I want everything to be normal; that I could eat normal, do all the things I had the energy to do before. But I have to wake up in the morning and everything has to be normal, or else I won't be convinced. I hope I'll manage to disappear one day, but I know it will not happen because I always get stopped.

Mary: When I came home from the hospital, I thought, "Fuck! If I don't manage to commit suicide, then I'm going to starve myself to death!" That was my project.

Conclusion

This study shows that AN patients perceive AN not only as a medical disease, but also as psychologically meaningful behavior. This does not imply that the anorectic behavior is chosen or can be voluntarily controlled, or that the individual meanings that AN patients claim drive their anorectic behavior, have etiological significance. It does imply, however, that to these patients the anorectic behavior, either from the onset of illness or later on, attracts a meaning.

This study addressed the subjective meanings patients attribute to their anorectic behavior, and not the function of these meanings. The patients' positive valuations of their symptoms as described in this study may, however, be one of the mechanisms involved in maintaining anorectic behavior.[9,10,12] Our study suggests that these possible mechanisms of maintenance may have different origins. Some informants reported that the psychological meaning of their anorectic behavior had elicited their anorectic condition. Other informants talked about their anorectic behavior in terms of a specific motivation that had gone out of control when the anorectic behavior itself took over as if AN had its own force. Others regarded the meaning of AN as a quality that the anorectic behavior adopted after having been established and, despite the consequences, became meaningful later in the

course of illness. These findings may indicate that the constructs we have described are involved both in generating, eliciting, maintaining, and even eliminating anorectic behavior. Further research is needed before inferences may be drawn about such possible functions of the constructs.

The eight constructs found in this study were labeled security, avoidance, mental strength, self-confidence, identity, care, communication, and death. The constructs include descriptions of strong personal meanings and may be regarded as more or less inner oriented and potential internal reinforcers of the anorectic behavior.[9,10,12] The communication, the care construct, and to a lesser degree also the self-confidence construct, were the most clearly interactively oriented constructs and may be regarded as including potential social reinforcers.[9,10,12]

The security construct refers to AN as a way of structuring and organizing everyday life in order to get a sense of predictability and security, whereas the avoidance construct conceptualizes AN as a way of evading harmful feelings and thoughts. Although some informants linked their feeling of security to avoidance of harmful feelings, we chose to reserve the security construct to more cognitively oriented, proactive, and approach-driven attributions (e.g., predictability). The avoidance construct included more emotionally oriented, defensive, and evasive attributes. The security and the avoidance constructs are related and overlapping with what Serpell et al.[7] labeled as "guardian" and "avoid," respectively. This may indicate that obtaining predictability and avoiding harmful feelings and thoughts are central aspects of living with AN. The avoidance construct is also in line with the suggestion by Cockell et al.[6] that AN may be characterized as functional avoidance of aversive emotions. The remaining constructs found in this study indicate, however, that this view alone is too restrictive.

The mental strength construct refers to an inner power experienced as an inner drive, a feeling of "rush" and peaking of experience that enables one to meet the challenges of life. This construct emphasizes the inner sense of mastery rather than the affirmation through others that characterizes the self-confidence construct. The self-confidence construct addresses AN as a way of feeling smart, pretty, worthy of compliments, and acknowledged by others. The content of this construct seems to be less important than the degree of confidence achieved. The identity construct differs from the self-confidence construct by its emphasis on the content of personality traits and a strong wish to develop new personality traits. The constructs of the mental strength, self-confidence, and identity are conceptually related and similar to the perceived benefits of AN as described by Serpell et al.[7] These constructs are also consistent with earlier psychoanalytic[13] and more recent feministic hypotheses[29] describing AN in terms of an identity disorder. Our findings suggest, however, that rather than being associated with fear of maturity and antisexuality, it is the wish for a new personality that drives the identity construct.

Many informants used the word "control" when they described the meaning of their anorectic behavior. Most often the word "control" was used in relation to the mental strength construct. However, as in line with other authors on AN,[30,31] the interactive interviewing uncovered that informants used the "control" word in many different ways. In favor of several more restrictive and clinically applicable constructs, such as mental strength, avoidance, and death, we abandoned the concept of control as particularly valuable in depicting the meaning of anorectic behavior as seen from a patient's perspective.

The care construct refers to AN as a way of eliciting thoughtful considerations, kindness, reduced expectations from others, and care. Evoking attention was a feature of the care, communication, and self-confidence constructs. However, the emphasis on care and reduced requirements differentiates the care construct from the conceptually connected communication and self-confidence constructs. The self-confidence construct emphasizes the positive feedback from others that makes one feel better about oneself and worthy of the compliments from others. The communication construct, on the other hand, emphasizes a wish to change relationships so that difficulties may be conveyed, seen and understood by others.

The death construct refers to an intention to die. Previously, death has been regarded as a possible and unfortunate consequence of AN.[32] This study indicates that for some AN patients, to die may also be expressed as an intention of starving oneself. Even if the high mortality rate and elevated suicide rate associated with AN is well known,[32] systematic research has so far not described AN as an intended method of dying.

This study has several clinical implications. First, AN is also a psychologically purposeful behavior for many patients. Second, in working with patients who often deny both their own symptoms and the severity of their illness, an obvious challenge is to develop standard treatment goals. The results of this study include different intentions that AN

patients dysfunctionally link to their anorectic behavior. Therapists who do not take these intentions into consideration are likely to elicit resistance and sooner or later fail in their treatment attempts. In accordance with other investigators,[8,20,33] we therefore emphasize the importance of encouraging patients to express their personal values and to explain how their eating disorder both fulfills and compromises their values. In this process, the eight constructs of meaning uncovered in this study may be useful to clinicians and may serve as a guide to help the patient verbalize the conflicting motives associated with change.[2] Third, the identification of a death construct in this study reemphasizes the severity of this type of eating disorder. To prevent a fatal outcome, it is most important that the therapist gets the patient to disclose such a possible underlying intention. The intention to die may have deep implications in defining the therapeutic alliance with the patient. In this case, the therapist cannot base the therapeutic alliance on the underlying motive of the anorectic behavior (the wish to die).[8] The importance of having a potential death construct disclosed is therefore crucial from a strategic point of view as well.

There are some limitations to this study. The sample was restricted to young ethnically Norwegian women. It is likely that additional constructs of meaning would have been detected by using a different sample. Further investigations are warranted to explore constructs of meaning both in similar and different samples. Because the samples in this type of study may not be representative, the distribution of the eight constructs in the AN population remains unknown. We do not know whether a more homogeneous sample with regard to subdiagnoses (e.g., only bingeing or only a restrictive type of AN) would have yielded different conclusions. All the informants who participated in this study had been in treatment. They were consecutively recruited from different institutions and had experienced therapists of different theoretical traditions. This may have influenced their use of language and interpretation of AN and the informants' descriptions may reflect their therapist's understanding of AN rather then their own. A strength of this study was, however, the individually tailored, highly personal, experience oriented, and interactive interview format aimed at collecting as authentic reports as possible. A strong argument in favor of the personal interview in this type of study is the potential for tailoring the data collection method to each specific participant and interactively exploring the authenticity of and reflections about the uncovered meanings.

The authors thank Josie Geller, Asle Hoffart, and Henrik Daae Zachrisson for valuable comments on earlier drafts of this article.

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