DIMENSIONS OF SELF-OBJECT NEEDS AND EATING DISORDERS RECOVERY

A Dissertation Submitted to the
Faculty of The Institute For Clinical Social Work
For the Degree of Doctor of Philosophy

By
KATHLEEN CHECK

Chicago, Illinois
May 4, 2012
Copyright © 2012 Kathleen Check
ABSTRACT

Using the conceptual framework of Kohut’s self psychology, this study made preliminary distinctions in the relationship between dimensions of selfobject needs, the therapeutic alliance, and eating disorders recovery. A sample of women (N=151), who self reported (a history of or current) eating disorders behaviors, thoughts, and attitudes, completed an internet based survey. The website survey consisted of three instruments, open ended text box questions and demographic questions; totaling 91 questions on the survey. The survey was designed to assess participants’ selfobject needs orientation, eating disorders recovery self-efficacy, the therapeutic alliance, and ideas and attitudes regarding eating disorders recovery. The Eating Disorder Recovery Self-Efficacy Questionnaire (EDRSQ) (Pinto & DiClemente et al., 2006); the Revised Helping Alliance Questionnaire (HAq-II) (Luborsky, Barber, Siqueland, & Johnson, 1996); and the Selfobject Needs Inventory (SONI) (Banai, Mikulincer, & Shaver, 2005) psychometric instruments were used. Multiple regression analysis was completed to determine if there is a predictive relationship between selfobject needs, the therapeutic alliance, and eating disorders recovery. Although several of the regression models were found to be significant, the hypothesis was unsupported. Statistical analysis did find that women who have had or are currently in psychotherapy had significantly higher scores on eating disorders recovery as measured on EDRSQ compared to women who have not had psychotherapy. Further, substantial subjective information was collected from participants supporting self psychological assertions regarding eating disorders. Both sets of findings, quantitative and qualitative, and therapeutic implications are discussed.
To all the women who generously shared their time, experience, and intimate details of
their individual paths of recovery from eating disorders, and to all of
my patients who have inspired me and shared their ongoing experiences of
eating disorders recovery.
ACKNOWLEDGEMENTS

I would like to acknowledge the guidance and influence of my dissertation committee, Mary Connors, PhD, Constance Goldberg, MS, BCD, Denise Duval, PhD, and Theresa Vidalon, MSW. Special thanks goes to my dissertation committee chair, R. Dennis Shelby, PhD, whose humor and focus motivated me to complete this endeavor.

I greatly appreciate the technical and computer support from Solo Group, Inc., without whose unstinting technical and engineering know-how this project would not have been realized. My friends and colleagues who supported and responded to my own twinship, mirroring and idealization needs include Rebecca Meyer, PsyD, James Lampe, PhD, and Boris Thomas, PhD.

And, to the four M’s: Mary, Mom, Michael and Marilyn...each of you individually and collectively supported and believed in me in ways that I can only aspire to pass on.

KC
"My Body Is a Cage"

My body is a cage that keeps me
From dancing with the one I love
But my mind holds the key
I'm standing on a stage
Of fear and self-doubt
It's a hollow play
But they'll clap anyway
My body is a cage that keeps me
From dancing with the one I love
But my mind holds the key
You're standing next to me
My mind holds the key
I'm living in an age
That calls darkness light
Though my language is dead
Still the shapes fill my head
I'm living in an age
Whose name I don't know
Though the fear keeps me moving
Still my heart beats so slow
My body is a cage
We take what we're given
Just because you've forgotten
That don't mean you're forgiven
I'm living in an age
That screams my name at night

vi
But when I get to the doorway
    There's no one in sight
You're standing next to me
    My mind holds the key
    Set my spirit free
    Set my body free
    Set my spirit free
    Set my body free

~Arcade Fire
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xi</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Overview of the Problem</td>
<td></td>
</tr>
<tr>
<td>Formulation of the Problem</td>
<td></td>
</tr>
<tr>
<td>II. LITERATURE REVIEW</td>
<td>8</td>
</tr>
<tr>
<td>Introduction</td>
<td></td>
</tr>
<tr>
<td>A Brief Description and History of Eating Disorders</td>
<td></td>
</tr>
<tr>
<td>Eating Disorders Recovery and Predictive Factors Research</td>
<td></td>
</tr>
<tr>
<td>Selected Therapeutic Alliance (Relationship) Research</td>
<td></td>
</tr>
<tr>
<td>Theoretical and Conceptual Framework</td>
<td></td>
</tr>
<tr>
<td>Theoretical and Operational Definitions</td>
<td></td>
</tr>
<tr>
<td>Statement of Assumptions</td>
<td></td>
</tr>
<tr>
<td>Research Questions Explored</td>
<td></td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>III. METHODOLOGY</td>
<td>42</td>
</tr>
<tr>
<td>Introduction</td>
<td></td>
</tr>
<tr>
<td>Study Design</td>
<td></td>
</tr>
<tr>
<td>The Study Sample Selection</td>
<td></td>
</tr>
<tr>
<td>Data Collection and Instrumentation</td>
<td></td>
</tr>
<tr>
<td>Data Analysis</td>
<td></td>
</tr>
<tr>
<td>Quantitative Data</td>
<td></td>
</tr>
<tr>
<td>Qualitative Data</td>
<td></td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>59</td>
</tr>
<tr>
<td>Participant Demographic Statistics</td>
<td></td>
</tr>
<tr>
<td>Quantitative Results</td>
<td></td>
</tr>
<tr>
<td>Ancillary Quantitative Analyses</td>
<td></td>
</tr>
<tr>
<td>Qualitative Results</td>
<td></td>
</tr>
<tr>
<td>Conclusion</td>
<td></td>
</tr>
<tr>
<td>V. DISCUSSION AND CONCLUSION</td>
<td>114</td>
</tr>
<tr>
<td>Introduction</td>
<td></td>
</tr>
<tr>
<td>Discussion of Results</td>
<td></td>
</tr>
<tr>
<td>Dimensions of Selfobject Needs and Eating Disorders</td>
<td></td>
</tr>
<tr>
<td>Hopelessness, Helplessness and Ego Syntonic Symptoms</td>
<td></td>
</tr>
<tr>
<td>Reigniting Dimensions of Selfobject Needs in the Therapeutic Alliance</td>
<td></td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td></td>
</tr>
<tr>
<td>Implications for Social Work Practice and Policy</td>
<td></td>
</tr>
<tr>
<td>Conclusions and Implications for Future Research</td>
<td></td>
</tr>
<tr>
<td>Appendixes</td>
<td>Page</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
</tr>
<tr>
<td>A. INFORMED CONSENT</td>
<td>136</td>
</tr>
<tr>
<td>B. INSTRUMENTS</td>
<td>139</td>
</tr>
<tr>
<td>C. WEBSITE PAGES</td>
<td>143</td>
</tr>
<tr>
<td>D. MARKETING FLYER</td>
<td>155</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>157</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Frequencies and Percentages for Group Demographics</td>
<td>59</td>
</tr>
<tr>
<td>2. Means and Standard Deviations for Subscales</td>
<td>61</td>
</tr>
<tr>
<td>3. Pearson Correlations between Variables</td>
<td>64</td>
</tr>
<tr>
<td>4. Regression with the SONI Subscales and Alliance Predicting EDRSQ</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
</tr>
<tr>
<td>5. Regression with the SONI Subscales and HAQ Predicting EDRSQ</td>
<td></td>
</tr>
<tr>
<td>Normal Eating</td>
<td>67</td>
</tr>
<tr>
<td>6. Regression with the SONI Subscales and Alliance Predicting EDRSQ</td>
<td></td>
</tr>
<tr>
<td>Body Image</td>
<td>68</td>
</tr>
<tr>
<td>7. Regression with the SONI ‘super’ scales and Alliance Predicting EDRSQ</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
</tr>
<tr>
<td>8. Regression with HAQ Predicting SONI Hunger for Twinship Subscale</td>
<td>69</td>
</tr>
<tr>
<td>9. Regression with the HAQ Predicting SONI Avoidance of Idealization</td>
<td></td>
</tr>
<tr>
<td>and Twinship</td>
<td>70</td>
</tr>
<tr>
<td>10. Regression with the HAQ Predicting SONI Hunger for Idealization</td>
<td></td>
</tr>
<tr>
<td>Subscale</td>
<td>70</td>
</tr>
<tr>
<td>11. Regression with HAQ Predicting SONI Hunger for Mirroring Subscale</td>
<td>71</td>
</tr>
<tr>
<td>12. Regression with HAQ Predicting SONI Avoidance of Mirroring Subscale</td>
<td>71</td>
</tr>
<tr>
<td>13. Regression with the HAQ Predicting EDRSQ Total</td>
<td>72</td>
</tr>
<tr>
<td>14. Regression with the HAQ Alliance Predicting EDRSQ Normal Eating</td>
<td></td>
</tr>
<tr>
<td>Scores</td>
<td>73</td>
</tr>
<tr>
<td>15. Regression with the HAQ Predicting EDRSQ Body Image Scores</td>
<td>73</td>
</tr>
</tbody>
</table>
## LIST OF TABLES -- Continued

16. Results for *t* Tests for 5 SONI Subscales and 3 EDRSQ Recovery Scales by Group ........................................................................................................74

17. Descriptions of Therapeutic Relationship ..................................................................................75

18. Most & Least Valued in Therapeutic Relationship .....................................................................81

19. Reasons for Not Seeking Psychotherapy or Counseling ..........................................................91

20. Differences in How Participants Describe Eating Disorders Recovery .................................99
CHAPTER I

INTRODUCTION

Overview of the Problem

Today in the United States, as many as 10 million women and 1 million men are struggling with eating disorders such as anorexia or bulimia (NEDA, 2006). The population that is diagnosed each year with eating disorders is increasing. In spite of the growing eating disorder population, there is not a professional consensus about how and if this afflicted group is able to recover. There continue to be differences among clinicians and researchers regarding the likelihood that one can fully recover from eating disorders (Von Holle, et al., 2008). Estimates of eating disorder recovery ranges from 21%-75% (Bruch, 1973; Garfinkel & Garner, 1982; Von Holle, et al., 2008). Further, the National Institute of Mental Health reports that the mortality rate among people with anorexia nervosa has been estimated at 0.56 percent per year, or approximately 5.6 percent per decade; this is about 12 times higher than the annual death rate due to all causes of death among females ages 15-24 in the general population (NIMH, 2010).

It is understandable that clearly defining the process by which one recovers from eating disorders has been elusive for researchers and clinicians alike. Likewise, the extreme range of outcomes in eating disorders recovery is confounded by the lack of clearly defined criteria with which to define recovery. The increase of occurrence, diagnosis, and presentation for treatment in eating disorders highlights the need for
understanding of any clear predictive factors leading to the recovery of eating disorders. Specifically, it is important for these factors to be clearly defined to assist clinicians in creating a clinical environment that will best facilitate recovery. This study aims to illuminate just such factors and to further examine the relationship between eating disorders recovery, the therapeutic alliance, and selfobject needs using quantitative instruments on a website survey. Also included on the online survey were open ended questions to provide enriching qualitative information.

This study represents both a professional and a personal endeavor for this researcher. As a teenager, this researcher struggled with eating disorders and went on to fully recover with the help of a skilled psychotherapist and a supportive family. This author was fortunate to have had a useful combination of external and internal resources. As indicated in the statistics presented above, recovery is not the norm, and there is little consensus about the process by which one recovers from eating disorders. The hope for this research project is to present an empirical representation of how the therapeutic alliance effects an individual’s ability to recover from eating disorders.

Hilda Bruch began her groundbreaking work with eating disorders in the late 1960s (Bruch, 1973; Bromberg, 2000). Her detailed writings describing her experience of treating eating disorders inspired not just this researcher’s current study, but an entire profession’s understanding of the intricate psychological workings of the minds of people with eating disorders. Professionally, this author’s fascination with the clinical understanding of eating disorders deepened through completing a Master’s internship in a facility treating anorexia nervosa and bulimia nervosa.
Currently, a large portion of this researcher’s private practice caseload is made up of individuals dealing with eating disorders. As a result, this researcher is constantly seeking to gain a better understanding of this constellation of disorders. The desire to learn and understand more deeply the patient’s experience and to assist in his/her pursuit of recovery from eating disorders also led this researcher to choose a dissertation topic which involves defining specific psychodynamic factors leading to eating disorder recovery. There is a deficit of empirical data on this subject and it is an important aspect in the treatment of eating disorders that needs to be clarified and more fully articulated.

This research was designed to identify specific factors that can predict or lead to eating disorder recovery. The researcher sought to better understand and conceptualize what clients are experiencing internally and psychologically, as they move through their difficulties with food, weight and body issues. Ultimately, the aim of this study was to articulate the ways in which the therapeutic alliance assists individuals with eating disorders by building internal psychological structures that promote recovery from eating disorders. Further, by intricately delineating the psychodynamics present when recovering from eating disorders, this researcher hopes to contribute to clinical practices in the treatment of eating disorders.

Formulation of the Problem

As noted earlier, eating disorders are on the rise (Vanderlinden, Buis, Pieters & Probst, 2007). Without adequate understanding of predictive factors within the therapeutic relationship that lead to full recovery, the numbers of individuals suffering will only continue to grow. Having a better understanding of specific factors that
influence or predict recovery from eating disorders will assist social workers in treating this growing population with greater mastery. Also, with the increase in number of individuals presenting for treatment, it is imperative that social workers understand and can assist in creating a therapeutic environment that will be best suited to respond to the internal psychological deficits existing for those with eating disorders. Giving social workers a fundamental understanding of what was missing in the internal structures of individuals with eating disorders will serve in distinguishing features necessary for the treatment of this unique population. Without adequate understanding of the factors within the therapeutic environment that predict recovery, it is difficult for social workers to plan effective treatment protocols.

Further, this study aims to expand the base of knowledge in social work by illuminating factors leading to eating disorder recovery within the therapeutic relationship; this can widen the range of clinical interventions and broaden the scope and depth of understanding for both social workers and patients alike. Moreover, Prestwood and Waller (2004) observed that a majority of the research in the eating disorders field is carried out by a small group of clinical researchers and academics. Prestwood and Waller note “most research in the field is conducted by psychiatrists and psychologists, while little research is conducted or published by nurses, psychotherapists, occupational therapists and other professions” (p. 205). The result is that best practice and evidence based results come from a limited set of clinical researchers, neglecting a much broader knowledge pool. This research aims to bring forth empirical evidence on behalf of clinical social workers.
With the rise in individuals presenting for the treatment of eating disorders, capturing reliable data is more necessary, and more possible, than ever before. This research provides an opportunity to gather valuable information about how to effectively treat eating disorders and to describe specific psychological factors to predict recovery. The purpose of this study was to examine and understand the relationship between selfobject needs, the therapeutic alliance and recovery from eating disorders. The intent is to test the hypothesis that eating disorder recovery is significantly related to the extent to which selfobject needs are met in the therapeutic alliance that is established between an eating disorder patient and a therapist. Or, stated another way, the operational hypothesis of the current study is that there is a positive relationship and a strong correlation between willingness to engage and have one’s selfobject needs met, the therapeutic alliance, and recovery from eating disorders. An internet survey was used to gather data. The survey was composed of three statistically valid and reliable instruments and open ended questions to provide quantitative data for further hypothesis testing.

Recently, there has been an increasing focus on providing empirical evidence documenting psychodynamic and psychoanalytically informed literature (Crits-Christoph, Gibbons, Losardo, Narducci, Schamberger & Gallop, 2004; Shedler, 2010). Similarly, within the psychoanalytic study of eating disorders, there is relatively little empirical data prioritizing one type of treatment over another. There is, however, a growing body of literature suggesting an integrative treatment approach when treating eating disorders (Connors, 1994, 2011; Strober & Johnson, 2012). Few authors have studied the therapeutic alliance with regard to the treatment of eating disorders (Bloomgarden & Rabinor, 2000; Constantino & Smith-Hansen, 2008; Toman, 2002;
Vocks, Legenbauer, & Peters, 2007). Defining the problem to be studied centers around the dearth of empirical evidence to guide the field of social work in the psychoanalytically informed treatment of eating disorders.

There is a significant amount of psychoanalytic literature addressing eating disorders from a self psychological perspective (Barth, 1994; Brenner, 1983; Connors, 1994; Geist, 1989; Goodsitt, 1985; Sands, 2003). The scope of this literature clearly articulates ideas about eating disorders as being directly related to deficits in the formation of the psychological structures of the self. Further, the psychoanalytic literature conceptually defines how selfobject needs can be temporarily met or subjugated (Geist, 1989; Sands, 1989, 2003) by eating disorder symptoms. Similarly, eating disorder symptoms represent a person’s inability to develop the capacity to regulate difficult emotional states, modulate self esteem and provide a sense of vitalization (Brenner, 1983; Goodsitt, 1985).

This study used the theoretical perspective of self psychology with which to understand the data collected. To date, there are no empirical studies that have measured selfobject needs in the recovery from eating disorders. Authors have conceptualized eating disorders through a self psychological lens, but there do not appear to be empirical data collected regarding the process by which people with eating disorders have their selfobject needs responded to or the role of selfobject needs in relation to the therapeutic alliance and recovery from eating disorders. The increase in eating disorder research in the past decade has produced studies seeking to illuminate eating disorder recovery, but the role of the therapeutic alliance has been under examined. Further, there is no
literature looking directly at the relationship between selfobject needs, the therapeutic alliance, and eating disorder recovery.

Finally, many authors point to the need for significantly more comprehensive research to be done to operationalize the definition of recovery for eating disorders and to have specific course of illness specifiers identified (Herzog, 1989, 1991, 1999; Keel et al., 2002, Kordy et al. 2002). Operationalized course-of-illness specifiers are lacking in empirical or diagnostic literature (Von Holle et al., 2008). Although many of the authors measured length of remission, there was great variation among the literature reviewed in how long symptomatology must be absent for patients to be considered “in remission.” Herzog et al. (1999) noted that relapse rates for both anorexia and bulimia are extremely high and that developing greater understanding of predictive values may assist in more progressive treatment strategies and decrease the number of relapses. (Kordy et al., 2002) called for the development and operationalization of appropriate longitudinal ideas for treatment and prediction of recovery for anorexia and bulimia, again to assist in lowering the longevity and course of these disorders.

In conclusion, with the absence of studies explicating the relationship between the dimensions of selfobject needs, the therapeutic alliance and eating disorder recovery, this study sought to test the hypothesis that dimensions of selfobject needs and a positive therapeutic alliance are significantly related to eating disorder recovery. Further, using open ended text questions, this study concurrently gathered additional information regarding participants subjective experience of the therapeutic relationship and eating disorders recovery.
CHAPTER II

LITERATURE REVIEW

Introduction

The following literature review is divided into four parts:

1. A brief history of research focusing on eating disorders
2. Selected research studies exploring predictive factors and eating disorders recovery
3. A collection of research focusing on eating disorders recovery and the therapeutic relationship
4. Theoretical and conceptual framework encompassing this research project

A Brief Description and History of Eating Disorders

Eating disorders are a complicated combination of behavioral, biological, physical and psychological symptoms. The *Diagnostic and Statistical Manual IV-Text Revision* (APA, 2000) currently has three diagnostic categories for eating disorders: anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified. Anorexia nervosa (AN) is defined by the DSM-IV-TR (APA, 2000) by: failure and refusal to maintain body weight that is at or above minimally normal rate for the individual’s height and age;
intense fear of fat and gaining weight regardless of underweight status; undue influence of weight and shape on individual’s sense of self and self esteem or denial of current low weight status and potential associated dangers with low body weight; and amenorrhea or absence of menstrual period for three consecutive months. Bulimia nervosa (BN) is defined by DSM-IV-TR (APA, 2000) as: self esteem and self evaluation are significantly defined by one’s weight and body; one has recurrent episodes of eating large amounts of food in a short period of time and feeling a loss of control over this eating or inability to stop eating; and one has recurrent purging behaviors in order to negate the amount of food eaten during the binge episodes described above. These compensating behaviors may be excessive dieting, exercise or fasting. One may also abuse laxatives, diuretics or purge through vomiting. The diagnosis of eating disorders not otherwise specified (EDNOS) are defined as disorders of eating that do not meet the criteria for the above two eating disorder diagnoses. Examples include: for female patients, criteria for AN are met except that the patient has regular menses; all criteria for above are met except that, despite significant weight loss, the patient's current weight is in the normal range; criteria for BN are met except that the binge eating and inappropriate compensatory mechanisms occur less than twice a week or for less than 3 months; the patient has normal body weight and regularly uses inappropriate compensatory behavior after eating small amounts of food; or the patient engages in repeatedly chewing and spitting out, but not swallowing, large amounts of food; or the patient has recurrent episodes of binge eating. Further, patients who suffer from eating disorders are a heterogenous population with a wide range of disturbances in attitudes, behaviors, and body mass indices, as well as a range in regard to co-morbid Axis I and Axis II conditions (APA, 2000).
Historically, where psychodynamic and psychoanalytic literature are concerned, the attack on one’s body that surrounds eating disorders is less than novel. Ideas regarding starvation, bingeing, and purging have existed for decades. Unfortunately, however, there is not a unified understanding of the etiology, treatment and recovery process from eating disorders. Although examining the etiology of eating disorders will be touched upon as it pertains to therapeutic alliance as a predictive factor in the process of recovery from eating disorders, it will not be examined in detail. For the purposes of the current study, discussions of causal factors will be reviewed as they are pertinent to generating greater understanding of how the field of social work can better facilitate recovery when working with individuals with eating disorders.

In the following section, relevant historical knowledge regarding eating disorders is presented, as well as literature describing the process of recovery from eating disorders. And lastly, the role of therapeutic alliance with regards to eating disorders is examined.

Eating disorders and their manifestations have a lengthy history in psychoanalytically informed literature and clinical work. A physician named Sir William Gull in 1873 began reporting occurrences of this serious and fascinating disease. He began working with cases of extreme starvation and deprivation in a set of financially privileged twin girls (Brumberg, 1988). Still earlier observations were made by Richard Morton in 1689 describing a “nervous consumption” and more vividly, “a skeleton only clad with skin” (Brumberg, 1988, p. 18). And only a few years later, in 1889, Sigmund Freud wrote his friend and one time confidant Wilhelm Fleiss regarding the “anorexia nervosa of girls” (Gay, 1988, p. 61-64). Further, as Freud (1923) articulated his
topographical theory of the structure of the mind, he described ego and its relationship to individual perception as representing a mental projection of one’s physical body. In other words, he posited that one’s body is the most basic organizer of subjective or ego experience.

Melanie Klein (1921), with a specific focus on the internal psychological use of good and bad objects, discussed ideas of ingestion and expulsion of the maternal and paternal objects, clearly using the organismic metaphor to describe a process that echoes a bulimic or anorexic fight against metabolization. Later, Strober (1991) uses similar language describing eating disorders (primarily anorexia nervosa) from an organismic developmental paradigm, when he states, “[the paradigm] takes account of a growing consensus that genetics, biology, and psychology are closely interrelated aspects of the total phenomenology of self experience (p. 138).” Further, Sours (1980) describes defects of ego and dynamic, symbolic distortions of the self manifesting in individuals with eating disorders. For Sours, eating disorders (particularly bulimia nervosa) result from poor differentiation between the self and objects, and inability to maintain self or other object constancy.

Sugarman (1991) proposes that individuals with bulimia nervosa fail to develop the ability to communicate affect states, as well as needs and desires, through verbalization. Instead, the body becomes the means of communicating unconscious conflicts. The individual’s body self is not integrated into the psychological self, thus sequestering affect experiences to more defensive operations. Likewise, in an earlier pivotal examination of eating disorders, Sugarman and Kurash (1982) posit that the body can be viewed as a transitional object in eating disorder patients. Kohut (1971)
articulates the centrality of selfobjects in the language of self psychology (to be more fully addressed in the following section) when he states, “some of the most intense narcissistic experiences relate to objects; objects, that is, which are either used in service of the self and the maintenance of its instinctual investment, or objects which are themselves experienced as part of the self.” (p. xiv). Kohut describes the latter as the definition of a selfobject. Instead of the separateness Sugarman and Kurash (1982) imply by the body being used as a transitional object separate from the self and functioning outside, in service of the self, Kohut (1971) empathically articulates the selfobject experience as being part of the self, inside the subjective experience of the self, not outside.

The idea of selfobjects, according to Kohut’s articulation, is a primary focus of the current study. As will be discussed in later section of this paper, there is not a plethora of psychoanalytically informed empirical research or statistically valid and reliable instruments to quantify the complex constructs of the psychology of the self, namely selfobjects. However, researchers Banai, Mikulincer, and Shaver (2005) developed the Selfobject Needs Inventory (SONI). The SONI is a 38 item, psychometric self report instrument developed to assess an individual’s approach or avoidance of the selfobject needs of mirroring, idealization and twinship as originally articulated by Kohut in his formulations of the psychology of the self. The SONI is one of the three psychometric instruments used for the specific purposes of the current study. Each of the psychometric instruments are described and discussed at greater length in subsequent sections of this paper.
Eating Disorders Recovery and Predictive Factors Research

Several authors have sought to name factors that are predictive in recovery of eating disorders. Cogley and Keel (2003) identified and measured influence of weight and shape in individuals who were in various stages of recovery from eating disorders. They also measured social adjustment and levels of depression and anxiety in individuals recovering from eating disorders. Likewise, Kordy et al. (2002) measured recovery, remission and relapse processes and factors in individuals with bulimia and anorexia. Kordy et al. (2002) found that there were several factors that correlated with recovery from both anorexia and bulimia, namely, duration of sustained remission and psychotherapy as treatment intervention. Herzog et al. (1999) also looked to identify relapse and recovery factors and sought to measure specific predictive factors that were present in recovery of bulimia and anorexia separately; they found that duration of eating disorders before intake diagnosis and treatment was a strong negative predictive factor.

Herzog et al. (1999) also discovered that low body weight at the time of intake diagnosis also had a high negative prediction value for recovery or full remission. Olmstead and Kaplan (1994) found that age of onset was a specific factor and stated it was the only demographic variable that was found to be a significant predictor. Likewise, Herzog et al. (1999) found that age of onset could also be a significant predictor in partial recovery. Herzog et al. (1999) also found that there were slight differences in recovery and relapse rates between samples with BN versus those who were diagnosed with AN. Body weight was assessed by authors and was found to be a significant predictor as well (Herzog et al., 1991, 1993; Olmstead & Kaplan, 1994; Kordy
et al., 2002). Each of these authors has found that lower body weights at time of intake adversely affect a participant’s likelihood of recovery. Further, in a groundbreaking study, Garner, Olmsted and Polivy (1983) discovered that subjects with a greater degree of body dissatisfaction, which is defined as concerns, thoughts, or beliefs surrounding body shape, weight and size that disproportionately affect the individual, are less likely to recover from eating disorders.

A review of the literature illustrates that because there does not appear to be a clearly defined and operationalized definition of recovery, the terms recovery and relapse are measured differently across the literature. As stated earlier, Herzog et al. (1999, 1993) applied the Frank et al. (1991) use of full remission, etc. However, it is important to note that other authors used significantly varying definitions and durations to define and measure relapse and recovery. Olmstead and Kaplan (1994) employed criteria from DSM III-R (APA, 1987) to define recovery from bulimia and anorexia, but used the duration of eight weeks to define full recovery. This is a significantly different duration than the one used by Herzog et al. (1993, 1999) who used a longer period of a symptomatology to define full recovery. Full remission was defined by Herzog et al. (1999) as any individual who is asymptomatic for a period longer than one year, according to the DSM IV-TR (APA, 2000) for anorexia nervosa or bulimia nervosa. Likewise, Kordy et al. (2002) followed parameters for measuring full remission as outlined by Frank et al. (1991).

Few authors in the field of eating disorder research have been able to articulate in specific terms the nature and definition of recovery from eating disorders. However, Frank et al. (1991) have called for a coherent and consistently used definition of recovery
that allows for comparable research studies, and is consistently used across studies and across areas of expertise. Frank et al. (1991) sought to solidify the nature of recovery so that it would be operationalized to assist researchers across fields of expertise in defining and better understanding the process of recovery of mental disorders. The researchers described a general framework, applied to depressive disorders, using episode, partial remission, full remission, relapse, recovery, and recurrence to describe the various frames of symptomatology change and how long the changes last. Further, Herzog et al. (1993, 1999), in both his groundbreaking eating disorder studies, used the framework set forth by Frank et al. (1991). Both of these authors and their colleagues sought to define ideas; to aid the field in understanding and development of treatment and outcome scenarios; and to compose a specific framework for developing predictive factors that lead to the recovery from psychological disorders.

Although Frank et al. (1991) set out to describe a more coherent and contained nomenclature to define symptomatology change and duration of change within the broader field of mental health, it is Herzog and colleagues (1993, 1999) whose research is most germane to the current study because of its specific application to eating disorder symptomatology. Similarly, Von Holle et al. (2008) used the conceptual framework of remission and recovery set forth by Frank et al. (1983). However, Von Holle et al. (2008) studied groups of patients with bulimia nervosa and anorexia nervosa separately and used a more conservative time frame to measure recovery. Recovery was defined by three years without eating disorder symptoms in order to distinguish between more temporary remission and observable recovery.
Most significantly, Clausen (2004) carried out a longitudinal study (currently ongoing) in which results offered a template of a time course of behavioral, psychological and physical symptoms in the recovery of eating disorders. Clausen studied patients in an eating disorders unit in Denmark from the time of initial assessment and inpatient hospitalization through discharge to outpatient treatment and through a two and one-half year follow-up. Patients were all diagnosed with eating disorders from moderate to severe according to DSM IV-TR (APA, 2000) criteria. With a sample of 123 at the beginning of the study using pattern of time to reflect process of change, Clausen’s analysis found varying times to remission for different behavioral, psychological and physical symptoms for the total sample. Analysis also showed that different diagnostic groups of eating disorders (AN and BN) varied in symptom remittance over time; fear of gaining weight was the only symptom that showed specificity as this psychological symptom remitted before other psychological symptoms in BN sample and after other psychological symptoms in AN sample; the remission time of disturbed body perception in BN and AN indicated that the obsession with weight and shape is a global symptom and this symptom perseveres over time between diagnostic groups. Further, Clausen found that physical symptoms remitted before psychological symptoms. Overall, there was a high variability of time to remission of eating disorders. Results showed that time to remission is often long and stepwise for different individuals as well as different diagnostic groups. Clausen concluded that treatment and research should focus on small steps changes in the process of recovery for eating disorders (Clausen, 2004).

Similarly, Ficter, Quadfleig, and Hedlund (2006) studied outcome predictors in eating disorders over a twelve-year course. With a homogeneous sample in the size of
103 women diagnosed with AN, subjects were followed for twelve years and measured at two years and six years follow up points using self-reports and expert-rating interviews. Overall, the authors found 27.5% of the sample had a good outcome, 25.3% intermediate outcome, 39.6% had poor outcome, and 7.7% were deceased. More specifically, authors discovered that 52.4% showed no major DSM-IV eating disorders diagnosis, but that using an empirical model 45% of sample showed negative predictors including sexual problems, impulsivity, long duration of inpatient treatment and long duration of an eating disorder. Ficter et al. (2006) concluded that mortality in AN eating disorders is high and systematic recovery is protracted.

Current research suggests there is a need for additional investigation of predictive factors leading to the recovery from eating disorders. Herzog et al. (1993, 1999) discussed the need to collect increased amounts of valid and reliable data regarding what factors will aid in the recovery from eating disorders. All of the authors reviewed call for additional research and a need to have this facet of eating disorders more defined. The authors all stipulate that there is difficulty in comparing similar empirical findings when there may be different parameters used to define duration of symptomatology or lack of symptomatology. However, predictive factors in recovery from eating disorders comprise an important area that is only beginning to be researched.

The above studies represent a body of literature has been reviewed to look at what factors are currently under study to assist in more comprehensive treatment and understanding of eating disorders. Certain variables stand out in the literature reviewed. Authors have found that age of onset for eating disorders, concurrent mood or anxiety disorders, and body image at time of presentation for treatment all play a significant role
in predicting outcome for individuals with eating disorders. It is also clear that more research needs to be done in order to have a more substantial understanding of the factors that lead to the recovery from eating disorders.

Of the psychometric instruments developed to assess, evaluate, describe, and measure eating disorders, there are few instruments designed to predict recovery from eating disorders. One such measure, the Eating Disorder Recovery Self Efficacy Questionnaire (EDRSQ) (Pinto & DiClemente et al., 2006) is an empirically derived 23 item self report instrument designed to assess confidence to eat without using eating disordered behaviors or experiencing undue emotional distress, and confidence to maintain a realistic body image that is not excessively concerned with thinness. This instrument will be described at length in later sections of this paper. It is important, however, to introduce this instrument, as it is unique in its ability to measure and predict self efficacy and confidence to engage in normative eating behaviors and maintain a realistic body image and the EDRSQ will be used for the specific purposes of the current study. Further in this research project, recovery and remission were used synonymously and defined as an individual who is asymptomatic for at least one year according to the DSM IV-TR (APA, 2000) for anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified.

Similarly, in a recent study, Ranson and Robinson (2006) sought to determine the type of psychotherapy clinicians are using when working with the eating disorder population. The authors posited that learning of what approach is used most often by clinicians treating eating disorders would assist in furthering the field’s understanding of how to effect change. The authors surveyed clinicians working with eating disorders and
found that 50% of the clinicians surveyed used an ‘eclectic’ approach and 33% used a ‘cognitive behavioral’ approach. Although this study adds to our knowledge of the types of approaches used with eating disorder patients, more information about the therapeutic alliance in the treatment of eating disorder patients is still needed. Further, having a better understanding of factors within the therapeutic relationship that lead to recovery from eating disorders is warranted.

Selected Therapeutic Alliance (Relationship) Research

Few authors have investigated the therapeutic relationship as a predicting factor in recovery from eating disorders. Beresin, Gordon, and Herzog (1989) found that 90% of the sample of recovered anorexics interviewed named the therapeutic relationship as a major experience related to recovery. Outcome studies outside of the eating disorder field have long since associated the therapeutic alliance with positive outcomes in the therapeutic process. Wetterson, Lichtenberg, and Mallincrodt (2005) posit that it is the factors within the therapy, not the forms or approaches of the therapy, that are responsible for facilitating change. Likewise, Luborsky and Auerbach (1985) acknowledge the therapeutic alliance as a significant factor in the effectiveness of psychotherapy. Similarly, Luborsky et al. (1996) designed the Revised Helping Alliance Questionnaire (HAq-II) to describe and measure the collaboration and bond between patient and therapist. This psychometric instrument is composed of 19 self report items. This instrument reliably assesses the relationship between therapeutic alliance and outcome (Luborsky et al., 1996; Crits-Christoph & Gibbons, 2003; Macneil, Hasty, Evans, Redlich, & Berk, 2009). There are numerous instruments that have been developed to measure the
quality and properties of the therapeutic alliance (Crits-Christoph & Gibbons, 2003; Macneil et al., 2009). However, the HAq-II was used in the current research project to measure the therapeutic relationship quantitatively. A detailed explanation of this instrument and its psychometric properties will be discussed in a later section of this paper.

Zetzel (1956) first began elaborating on the concept of therapeutic alliance in psychoanalytic literature. Greenson (1965) elevated the concept to a respectable position within the psychoanalytic vernacular by further delineating and expounding on its utility within the psychoanalytic endeavor. Later, Meissner (1992, 2006) articulated aspects of the therapeutic alliance and articulated distinguishable differences of the therapeutic relationship from the therapeutic transference. Much earlier, Freud offered this approximation of the therapeutic alliance as an, “unobjectionable aspect of the positive transference” (1905, p. 261). In the current research project, Meissner’s description of the therapeutic alliance (relationship) will be used. According to Meissner, the therapeutic alliance is a rich and central component which consists of “the components of empathy, the therapeutic framework, responsibility, authority, freedom, trust, autonomy, initiative, and ethical considerations within which the patient and therapist engage in the work of the therapy” (p. 1067).

Within the field of eating disorders, however, there is a limited amount of empirical evidence studying the significance of the therapeutic alliance in recovery from eating disorders. A predominant portion of the literature identifying the therapeutic relationship as a factor leading to eating disorder recovery has been qualitative in nature. For example, Gallup, Kennedy, and Stern (1993) studied the therapeutic alliance on an
inpatient eating disorder unit. The authors measured staff and patient perceptions of the therapeutic alliance as measured by a standardized instrument reflecting aspects of the therapeutic working relationship. Although there was no correlation between staff and patient perceptions and the study had a small sample size, the authors did reveal that patient perception of the therapeutic alliance is a defining factor in the maintenance of the therapy; that is, the patients with higher therapeutic alliance scores were found to stay in the treatment program longer and with better outcomes than those with lower scores.

Similarly, Vanderlinden, Buis, Pieters, and Probst (2007) outlined elements in the treatment of eating disorders that patients considered useful in their recovery process. This study solely focused on treatment using cognitive behavioral oriented therapy in the treatment of eating disorders. The authors compared elements named by patients to be integral components in their treatment. Such elements as improving self esteem; improving body experience; learning problem solving skills; support from therapist; and learning to express feelings were listed as key components within the treatment.

Additional studies addressing how the therapeutic alliance is affected by physical features of the patients and by the clinician have been studied. Body mass index of patients has been found to have had significant effects on the therapeutic alliance (Toman, 2002). Authors have also studied the shape and size of the therapist and its effect on the therapeutic alliance in eating disorder treatment (Vocks, Legenbauer, & Peters, 2006). In both research scenarios, qualitative data presented suggests that body size and shape of patients and therapists may affect the therapeutic alliance.

Constantino and Smith-Hansen (2008) studied interpersonal factors and therapeutic alliance in two different treatment modalities for bulimia nervosa. The
researchers compared cognitive behavioral treatment and interpersonal treatment in two randomized groups of individuals with bulimia nervosa. Patient interpersonal factors and therapeutic alliance were measured and evaluated for both groups. Overall, Constantino and Smith-Hansen discovered that interpersonal treatment had a higher therapeutic alliance growth than that of the group receiving cognitive behavioral treatment. Interpersonal variables (distress, rigidity, control, and affiliation) and alliance variables (early stage, middle stage, late stage) were measured in both treatment modality groups and found to be significant factors in the development of therapeutic alliance. Likewise, therapeutic alliance was studied as part of a longitudinal study of bulimia nervosa in adolescents at the University of Chicago. Zaitsoff, Doyle, Hoste, and Le Grange (2008) sought to observe and measure therapeutic alliance and treatment acceptability of adolescents with bulimia nervosa. Randomized groups of adolescents with bulimia nervosa received either family based treatment (FBT) or supportive psychotherapy (SPT). Therapeutic alliance, treatment expectancy, and treatment suitability ratings were measured in both groups. Here, the researchers found that ratings did not differ, as had been hypothesized, between participants in both treatment groups.

It is abundantly clear that there is a dearth of empirical research on the role that the therapeutic alliance plays in the recovery process of eating disorders. This research project sought to illuminate the relationship between the therapeutic alliance, self object needs and eating disorder recovery.
Theoretical and Conceptual Framework

Introduction

For the purposes of the current study, self psychology was used as the theoretical framework with which to analyze, view and understand the data gathered. In the following section, literature is presented to outline ways in which the theory of self psychology is a unifying and cogent framework through which the current study will be viewed. In order to situate the current study in the tenets of self psychology, fundamental components of self psychology will be discussed. In conjunction with these tenets, current eating disorder literature will be presented to further describe the self psychological lens with which the current study will be viewed.

The formulation and articulation of how one recovers from eating disorders is sparse in psychoanalytically informed literature. However, self psychological constructs have been used by several authors to articulate the constellation of eating disorders. Further, several authors do take on the conundrum of etiology of eating disorders and the later manifestations of patients presenting with this complex symptomatology.

Kohut (1971) originally conceptualized two selfobject functions mirroring and idealizing. Later the third selfobject function of twinship was added. Rector (2000) describes an optimal selfobject experience when she states, “when these needs are met self-esteem is enhanced and narcissistic vulnerability is reduced. A sense of cohesion is strengthened and the self is less likely to be derailed in the face of disappointment” (p. 259-260). In other words, in the most ideal situation an individual will be able to have a consistent flow of selfobject functions being met, either through mirroring, idealizing or
twinship throughout one’s life. The self is never devoid of the need of selfobject functions.

The term mirroring, according to Rector (2000) in her paper describing selfobject functions, “is used to define the experience of the other as important only in the enthusiastic confirmation of the self” (p. 261). Using the baby as an example, the self of the baby subjectively experiences being validated and ‘echoed’ by the parents. The idealizing selfobject function was most poignantly described by Kohut and Wolf (1978) as “those to whom the child can look up and with whom [the child] can merge as an image of calmness, infallibility and omnipotence” (p. 418). Kohut (1971) defined the twinship selfobject function as the last of three selfobject developmental processes. Twinship was seen according to Kohut as a less archaic need with a greater amount of differentiation and separateness from the other. Stated another way, an individual has more ability to discern differences in others; however, seeking similarity and sameness in the person’s surround is the primary focus. Self psychology’s theory of development incorporates a healthy growth facilitating matrix combining attuned parental responsiveness, or as Kohut and Wolf (1978) state, “The essence of the healthy matrix for the growing self of the child is a mature, cohesive parental self that is in tune with the changing needs of the child. It can begin with a glow of shared joy, mirroring the child’s grandiose display [and moments later] should the child become anxious by its exhibitionism, it will curb the display by adopting a realistic attitude...such optimal frustrations of the child’s needs be mirrored and merge into idealized selfobject, with optimal gratifications generating appropriate growth-facilitating matrix for the self” (p. 419).
Developmental failures occur when the parent or caregiver is not adequately able to provide mirroring, twinship and idealizing selfobject needs of the infant/child. These failures result in deficits in the child’s ability and capacity to maintain self cohesion, self esteem and other self regulating functions. This self-selfobject milieu is fertile ground for the development of eating disorders. Goodsitt (1977), Sands (1991) and Geist (1985) all describe these deficits as leading to an increased vulnerability to the development of eating disorders.

Geist (1989) presents articulate reflections regarding the process of 20 individuals in long term psychotherapy. Geist espouses a basic tenet of self psychological principles applied to eating disorders when he states, “eating disorders [can be understood] as one major form of self pathology in which there has been both a traumatic and chronic disturbance in the empathic connectedness between parent and child” (p. 9). Goodsitt (1983) views eating disorders as a basic and prolonged deficit in self regulating functions. Casper (1998), however, views symptomatology of bulimia as an effort to abort pressure to consolidate a defective self.

Further, because there is a massive failure in the empathic attunement between self and selfobject environment, the eating disordered self is left depleted and starving for sustenance. This is the polar opposite of Tolpin’s articulation of the self and its selfobjects. “The human self, experienced as a sense of wholeness, aliveness, and vigor, an independent center of initiative over time and through space, is the essence of one’s psychological being... Only a responsive selfobject milieu can provide those experiences of living that facilitate the transformation of the [person’s] potential into a creative aliveness and realness -- a self structure with joyful interests and self affirming initiative.
This human caretaking environment, because it provides those confirming, calming, and sustaining functions -- mirroring, idealizing, and partnering is experienced as part of the self. In the language of self psychology, we refer to empathic responsiveness from such an environment--to those perceived aspects of another that shore up the self--as selfobject functions” (Tolpin, 1980).

The absence of empathic attunement to a person’s needs for soothing, partnering, and sustaining functions cause the self of the eating disordered person to continue its subjugation and enslavement. Or, stated differently, lack of responsiveness to one’s selfobject needs can result in disturbed psychological functioning, severe disturbances in the way one sees oneself, misinterpretation of internal and external stimuli, and a paralyzing sense of helplessness (Bruch, 1978, p. 18). Likewise, Kohut (1980) describes empathy as a “sustenance that keeps us psychologically alive” (p. 481). Several authors speak to the effect of empathic misattunement. Kohut speaks specifically to the misattunement of a caregiver’s responsiveness when a fragment of the child’s self is responded to, instead of the total self of the child (Kohut, 1977). Sands (1989) describes an exaggerated version of mirroring that results in a preoccupation with bodily experiences, weight, and appearance. The self of eating disordered individuals becomes fragmented with a loss of self cohesion and an inability to integrate body self into the total self structure (Goodsitt, 1985; Geist, 1985). The result, then, is that the body of eating disordered individuals becomes increasingly a source of shame. Or as Sands (1989) posits, “Body exhibitionism becomes an increasingly difficult attempt at restitution with eating disorder individuals, especially in adolescence where there will be additional difficulty accepting the bodily changes and imperfections” (p. 80). Sands
(1989) further articulates that the body and its appearance may be the only avenue to receive mirroring. Similarly, deGroot (1994) postulates that bodily preoccupations in eating disorders represent both an arrest in development of the psychological sense of self and an attempt to bolster the sense of self.

Kohut (1971) states, “failures in empathic mirroring and idealizing and appropriate transitional experiences during childhood create deficiencies that interrupt development of the self” (p. 166). Several authors posit eating disorder symptoms serve to fill in these deficiencies. deGroot & Rodin (1994) speak to the deficiencies within the self of eating disordered patients. They outline the specific deficiencies of affectivity (the ability to experience inner qualities of feelings) and lack of a sense of agency as being missing within eating disordered patients.

Still other psychoanalytic authors conceptualize eating disorders using self restitutive concepts. Krueger (1997) describes a pathological striving when he states, “Individuals with eating disorders use food to soothe, to reward, to distract, or to substitute . . . . It is an attempted selfobject experience” (p. 620). Or, said another way, food is a more tangible, predictable and a safer alternative to disappointing or unavailable humans. Food then becomes a pathological selfobject experience which is addictively repeated, as the object ingested provides comfort and relief with an intense regulatory effect (Krueger, 1997). Similarly, Connors (1994) describes an individual’s growing reliance on an activity or concrete object for self regulation. She states, “Addictive behaviors may be seen as efforts to stave off fragmentation in a vulnerable self by establishing a selfobject relationship with a substance or activity, which then becomes
habitual and destructive” (p. 515). Further illuminating the addictive processes in the self, Kohut (1978) says,

It is the tragedy of all these attempts at self cure that the solutions they provide are impermanent, that in essence they cannot succeed... They are repeated again and again without producing the cure of the basic psychological malady... No psychic structure is built; the defect in the self remains. It is as if a person with a wide open gastric fistula were trying to still his hunger through eating. He may obtain pleasurable taste sensations by his frantic ingestion of food, but, since the food does not enter the part of the digestive system that absorbs it into the organism, he continues to starve (p. 425).

Heinz Kohut (1971) began formulating the Psychology of the Self, later termed self psychology, as he studied and trained in techniques of traditional psychoanalytic treatment. Through his clinical work, he discovered that an individual’s subjective experience of him/her self can be dramatically affected in the analytic process. He observed that in the clinical situation some individuals would suffer disruptions of self cohesion when he as the analyst would fail to understand, communicate or empathically respond to the individual. This seemingly small observation would revolutionize the field of psychoanalytic practice. Kohut (1971) would later come to understand his clinical experience with individuals as fundamentally connected to the individual’s early experience as a child and the connectedness, or failures in connectedness, felt with parents or caregivers. The individual’s experience of this connectedness becomes the foundation on which psychological structures are built.

The development of the self is built upon the attunement and responsiveness of the individual's selfobject environment. A parent or caregiver’s ability to respond to the developmental needs of a child ultimately assists in building the internal psychological workings of the child’s sense of self. Thus, early selfobject attunement leads, ideally, to one’s ability to express and understand affect states, regulate tension, self soothe, and
maintain a sense of self esteem and the capacity for self cohesion. Individuals who develop eating disorder symptoms present a complicated combination of deficits of these selfobject experiences expressed through eating disorder symptomatology. This research project sought to explore and illuminate the relationship between selfobject needs, the therapeutic relationship, and eating disorder recovery. Further, this study was carried out with the hope to determine if selfobject needs responded to within the therapeutic relationship can serve as predictive factors in eating disorder recovery.

Discussion

Kohut (1977) viewed the self as a subjectively experienced psychological structure. He further defined the self as, “purely and simply the center of initiative . . . the ‘I’ of experience” (p.22). In the later more formulated stages of self psychology, Kohut and Wolf (1978) refer to the self as “the core of our personality” (p. 418). Developmentally, a baby is joined with its parent or primary caregiver. The primary self of the baby is dependent upon the parent or primary caregiver. Initially, the mind and body of the primary caregiver or parent is the primary self of the baby. If the mind and body of parent or primary caregiver is compromised, so too will the child’s ability to receive adequate and affirming selfobject needs. Selfobjects can include parents, caregivers, and others in the environment of an individual with whom selfobject functions can be subjectively experienced. Developmentally, though, there is a duration wherein the child’s primary self develops from and through the selfobject functions of the parent or caregiver (Kohut, 1971; Kohut & Wolf, 1978).

Kohut (1971) describes a process in which, with appropriate amounts of selfobject nourishment, a child continues to develop, grow and transform. However, when parents
or caregivers are themselves needy, self involved, overwhelmed, anxious, or depressed, the psychological consequences for the child are profound. Empathic attunement and connectedness are missing for the developing child. The chronic disruption and/or lack of authentic responsiveness between parent and child prevents the child from internalizing soothing and anxiety regulating mechanisms, thus leaving the child to develop alternative strategies for coping. Geist (1989) states,

The interweaving of these cumulative and acute empathic failures becomes the anlage of eating disorders; and later an attempt to fill in structural deficits by symbolically recreating with symptoms of anorexia and bulimia both the danger to the self and the efforts at self restoration (p. 7).

Or, in other words, eating disorder symptoms are viewed as an attempt to restore or fill in what is structurally missing. Individuals with eating disorders are attempting to compensate for the internal psychological deficits and an inability to maintain a sense of vitality and internal affective regulation. Likewise, Goodsitt (1997) states of the resulting manifestation of eating disorders,

If caregiving is not responsive to the developmental needs, the capacities to provide vitalization, cohesion and tension regulation are deficient and a disorder of the self results (p. 102).

Similarly, Connors (1994) states regarding symptom formation, “chronic failure to respond to a child in an attuned fashion can result in derailments of self development and relational development that may take many forms” (p. 511). Further, Geist (1989) postulates that in the population of bulimic and anorexic individuals, “a defensive structure has been mobilized to cope with specific, sudden, and prolonged disruption in the early child-parent relationship” (p. 12). Eating disordered patients can be best understood as having deficiencies in self-organization and self-regulation and can be
subject to profound states of overstimulation and tension. They then attempt to drown out those anguished feelings by frantic self-stimulating activities (Goodsitt, 1989).

And finally, a pioneer in the field of eating disorders, Hilda Bruch (1957, 1978, 1985) likened her own findings regarding the lack of parental responsiveness in working with eating disorders to Kohut’s articulations of the development of the self. She states, “child initiated clues appeared to be related to the patients’ deficits on self concept and in hunger awareness” (p. 49). The development of eating disorders is situated firmly within the development of the self as it forms in relation to its use of selfobjects in the surround. The resulting culmination of selfobject failures which are massive in nature, extended in duration, and disruptive to self structural growth, create a gap in the child’s ability to internalize self regulating functions. Eating disorders develop as a way to fill in these gaps, which are in essence the result of major developmental selfobject failures.

Further depicting Kohut’s idea of inability to satiate the self, Goodsitt (1983) describes eating disordered patients’ relationship to their bodies and sensations of hunger as often being suppressed or ignored, until ultimately patients give in to the extreme need to eat. The eating disordered patient eats without recognition or response to bodily sensations of fullness, thus illuminating the hallmark of eating disorders: a profound inability to self regulate (Goodsitt, 1983).

How is it, then, that there is a population that is able to recover from eating disorders (Herzog, 1999; Clausen, 2004; Von Holle et al., 2008)? Following the idea that individuals with eating disorders have suffered empathic failures in selfobject responsiveness, this study sought to explore ways in which the therapeutic relationship has an impact on an individual’s ability to recover from eating disorders vis a vis an
individual’s ability to have her selfobject needs responded to in the therapeutic alliance. This research was originally formulated with the hope of bridging the gap between the theoretical and conceptual understanding of eating disorders and the lack of empirical data to document the connection between selfobject needs, the therapeutic alliance and the process of recovering from eating disorders.

Kohut (1971) describes the theory of cure as a process of nutrient re-feeding to the self of the patient. Transmuting internalization is the process by which this takes place. This is a slow and arduous process wherein the self of the patient is responded to by the selfobject of the therapist. The structure building that takes place for the patient must in essence act much the same way as that of the newborn’s self developmental process. There are several necessary components for transmuting internalization to take place. Kohut and Wolf (1978) outline the components:

It cannot occur without a previous stage in which the child’s mirroring and idealizing needs had been sufficiently responded to; that it takes place in consequence of the minor, non-traumatic failures in mirroring and idealized selfobjects; and these failures lead to the gradual replacement of selfobject functions by a self and its functions (p. 424).

As Kohut (1984) continued to expand his formulations he later articulated, “while a nuclear self cannot be created by the therapy, the patient can still use the therapist as a selfobject to build up new defensive structures, and especially, to firm already existing defensive structures” (p. 9). The organismic metaphor of protein feeding the patient is again applicable. The protein is taken in by the patient from the self of the therapist as a result of failures in the therapeutic milieu. The patient may need to reorganize the protein as it is foreign (experienced as empathic failures) to the patient. Ultimately, the protein is ingested and results in the patient’s ability to develop its own protein.
Several authors have described the complexities of treating eating disordered patients. Krueger (1989) describes ways in which transmuting internalization in the treatment of eating disorders builds up capacities to self regulate, self feed, self amuse, and self soothe. Empathic inquiry and the stance of empathic introspection are primary modes with which to work with eating disordered patients (Bruch, 1978; Goodsitt, 1985; Sands, 1989). Kohut (1980) speaks to the centrality of empathy when he describes empathy as, “sustenance that keeps us psychologically alive” (p. 489). Empathy becomes even more central as most eating disordered individuals are unaware of their own feelings, wishes, and needs. Conversely, eating disordered individuals are often acutely sensitive to the needs and expectations of others (Bruch, 1973; deGroot, 1994; Sands, 1989). Sands (1989) describes this stance when she states,

The first goal of treatment must be to convince the patient through our understanding of her hopes and fears that she should give human beings another chance; to rekindle the hope that at least one human being, the therapist, can provide the attuned responsiveness that will allow her development to begin again where it was derailed in early life (p. 93).

However, with the complicated nature of eating disorders being an attempt at restoration, many difficulties may arise in forming a therapeutic alliance. Goldberg (1983) further elaborates Kohut’s formulation of selfobjects when he says,

The term selfobject, which usually connotes another person who is experienced as performing a necessary psychic function for the self, would include the range of functions that have to do with impulse control, limit setting, and others dealing with the containment of action and behavior (p. 161).

**Conclusion**

Goldberg’s expansion of the concept of a selfobject is particularly poignant as it can be extrapolated to the selfobject transference in the treatment of eating disorders.
The idea of selfobject functions within the treatment of eating disorders has been addressed as both an integral component and as a complicated one in the treatment of eating disorders (Goodsitt, 1983, 1977; Sands, 1989; Barth, 1988). It is within the establishment of the therapeutic alliance that the remobilization of selfobject needs can be responded to (Kohut & Wolf, 1978). The current study seeks to illuminate the relationship between selfobject needs and responses to them within the therapeutic relationship and eating disorder recovery.
Theoretical and Operational Definitions

**Eating Disorders** - According to the DSM-IV-TR (APA, 2000) criteria for diagnosis for anorexia nervosa (AN) are failure and refusal to maintain body weight that is at or above minimally normal rate for the individual’s height and age, intense fear of fat and gaining weight regardless of underweight status, undue influence of weight and shape on individual’s sense of self and self esteem or denial of current low weight status and potential associated dangers with low body weight, and amenorrhea or absence of menstrual period for three consecutive months. Bulimia nervosa (BN) is defined by DSM-IV-TR (APA, 2000) as self esteem and self evaluation are significantly defined by one’s weight and body, one has recurrent episodes of eating large amounts of food in a short period of time and feeling a loss of control over this eating or inability to stop eating, one has recurrent purging behaviors in order to negate the amount of food eaten during the binge episodes described above. These compensating behaviors may be excessive dieting, exercise or fasting. One may also abuse laxatives, diuretics or purge through vomiting. Eating disorders not otherwise specified (EDNOS) are defined as disorders of eating that do not meet the criteria for the above two eating disorder diagnoses. Examples include for female patients, criteria for AN are met except that the patient has regular menses; all criteria for above are met except that, despite significant weight loss, the patient's current weight is in the normal range; criteria for BN are met except that the binge eating and inappropriate compensatory mechanisms occur less than twice a week or for less than 3 months; the patient has normal body weight and regularly uses inappropriate compensatory behavior after eating small amounts of food; the patient
engages in repeatedly chewing and spitting out, but not swallowing, large amounts of food; or if the patient has recurrent episodes of binge eating.

**Eating disorders recovery** - In this study eating disorders recovery is classified any individual who is asymptomatic for a period longer than one year, according to the *DSM IV-TR* (APA, 2000) for anorexia nervosa, bulimia nervosa or eating disorders not otherwise specified.

**Eating Disorders Recovery Self-efficacy Questionnaire (EDRSQ)** - (Pinto & DiClemente et al., 2006) The Eating Disorders Recovery Self-Efficacy Questionnaire (EDRSQ) will be used to identify and illuminate psychological and behavioral traits found in recovery from eating disorders. This is a self-report scale developed by Angela Pinto, Angela Guarda, Leslie Heinberg, and Carlo DiClemente applicable for females, ages 16 and over. The EDRSQ is a 23-item, 5-point choice inventory, consisting of two subscale scores: Normative Eating Self-Efficacy and Body Image Self-Efficacy. The authors define normative eating as “the confidence to eat and perform eating related activities without engaging in eating disordered behavior (e.g., restricting, binge eating, purging, or excessive exercise) or experiencing undue emotional distress (e.g., guilt, anxiety)” (p.377). Body image self-efficacy is defined by the authors as “the confidence to maintain a realistic body image that is not dominated by the pursuit of thinness and does not place undue influence of body shape and weight on self-esteem” (p. 377).

External validity information was based on a diverse sample of eating disorder patients who completed information on both subscales. Internal consistency of the subscales was evaluated using a standardized Cronbach alpha coefficient. Factor analyses further demonstrated that the EDRSQ has good internal consistency reliability. Convergent and
discriminant validity were measured by identifying positive or negative correlations with various other related yet distinct, instrument scores. Content validity was strengthened by incorporating qualitative and quantitative feedback from experts in the eating disorders field.

**Therapeutic alliance** - The relationship, bond and collaboration between patient and therapist (Meissner, 1998). The therapeutic alliance is a rich and central component which consists of, “the components of empathy, the therapeutic framework, responsibility, authority, freedom, trust, autonomy, initiative, and ethical considerations within which the patient and therapist engage in the work of the therapy” (Meissner, 2006, p. 1067).

**Helping Alliance Questionnaire (HAq-II)** - (Luborsky, Barber, Siqueland, & Johnson, 1996) designed the Revised Helping Alliance Questionnaire (HAq-II) to describe and measure the collaboration and bond between patient and therapist. Further, this psychometric instrument, composed of 19 self report items, has been shown to be a successful predictor of outcome, as well as showing a reliable correlation between therapeutic alliance and outcome.

**Self Psychology** - Self psychology is a school of psychoanalytic theory and therapy created by Heinz Kohut and developed in the United States at the Chicago Institute for Psychoanalysis. Self psychology explains psychopathology as being the result of disrupted or unmet developmental needs. Integral components of self psychology include, but are not limited to: empathy, selfobject needs, mirroring, twinship, and idealization.
**Self** - Self refers to a psychological structure, the core of personality, established in a matrix of selfobject relationships (Kohut, 1971, 2001, 1977).

**Selfobject Needs** - “Essential psychological experiences originating in childhood that continue in varying form throughout life. These include the need to idealize, the need to be affirmed, valued and validated, and the need for a sense of commonality and kinship with another human being” (Siegel, 1996, p. 207).

**Selfobject Needs Inventory (SONI)** - The selfobject needs inventory (SONI) (Banai, Mikulincer, & Shaver, 2005) is a psychometric instrument composed of 38 self statements to assess an individual’s approach and avoidance orientations regarding the selfobject needs of mirroring, idealization and twinship. Banai et al. (2005) developed the SONI as a self-report measurement corresponding with Kohut’s self psychology selfobject constructs. The SONI measures respondents according to their approach or avoidance of each of the selfobject needs.
Statement of Assumptions

1. The researcher assumes that the way in which participants self select to participate in this study (the manner in which the website is set up) will produce a reasonably generalizable sample of women who have experienced eating disorders.

2. The researcher assumes that individuals who participate in therapeutic treatment will improve structural self deficits.

3. The researcher assumes that treatment alliance scale (HAq-II) will reflect quality of treatment process.

4. The researcher assumes that the selfobject needs scale (SONI) will accurately reflect deficits in selfobject needs consistent with clinical and theoretical literature.

5. The researcher assumes that recovery from eating disorders is positively correlated with the belief and confidence to engage in activities without using eating disordered behaviors and without undue emotional distress.

6. The researcher assumes that treatment is a positive factor in the prognosis of recovery from eating disorders.

7. The researcher assumes that participants will answer questions honestly and to the best of their ability.

8. The researcher expects each respondent to answer the questionnaire only once.

9. The researcher expects for there to be a measurable relationship between the independent and dependent variables in this study; that is, that eating disorder recovery, as measured by the EDRSQ, will be positively correlated to selfobject
needs, as measured by the SONI, and the therapeutic alliance, as measured by the HAq-II.

10. Participants, in each group, either the group that has received treatment or the group with no prior history of treatment, will be able to answer open ended survey questions regarding ideas, attitudes, and thoughts about eating disorders recovery and the therapeutic relationship which will convey psychological ideas related to theoretical concepts.

Research Questions Explored

The following are questions that this research project explored through quantitative methods (Couper, 2008; Creswell, 2009; Rubin & Babbie, 2001) and qualitative methods (Creswell, 2009; Thayer, 2007; Weber, 1990). The hypothesis for this research project is that high scores on selfobject needs inventory (SONI) and helping alliance scale (HAq-II) will be significantly related to high scores in eating disorder recovery self-efficacy questionnaire (EDRSQ).

Quantitative and Qualitative Questions related to the general research question (hypothesis) include the following:

**Quantitative Questions**

1. What is the relationship between an individual’s ability to have her selfobject needs met (as measured on SONI), therapeutic alliance (as measured on HAq-II), and eating disorder recovery (as measured on EDRSQ)?

2. Does the relationship with the therapist (therapeutic alliance) predict an individual’s ability to have her selfobject needs met (as measured on SONI)?
3. Does the relationship with the therapist (as measured by HAq-II) predict recovery from eating disorders (as measured by EDRSQ)?

Qualitative Questions

1. How do participants view the therapeutic relationship and its impact on her recovery?
2. What did women who received treatment most value in the treatment process?
3. What did women who received treatment find least helpful in the treatment process?
4. What are the reasons participants did not seek psychotherapy or counseling?
5. Is there a difference in how women who did not receive treatment define recovery from eating disorders than those who did receive treatment?
CHAPTER III

METHODOLOGY

Introduction

This study followed primarily a quantitative exploratory and descriptive research design and employed regression statistics for analysis purposes (Creswell, 2009; Field, 2009). Quantitative data was gathered using three instruments that participants answered on an internet based survey. Further, qualitative data was also collected from the website survey using open ended questions and analyzed using content analysis (Neuendorf, 2002; Thayer, Evans, McBride, Queen, & Spyridakis, 2007) to enrich descriptive statistics gathered from instruments and more deeply describe the subjective experiences of participants (Creswell, 2009). The following chapter is divided into four parts:

1. The research study design
2. The study sample selection
3. The data collection and instrumentation
4. The data analysis for quantitative and qualitative data
Study Design

The above represents a summary for the methodology design for the current study. These methods were structured using a ‘concurrent embedded strategy’ mixed methods design (Creswell, 2009). In this strategy there is one data collection phase, in which both qualitative and quantitative data are collected simultaneously. This study was primarily a quantitative design combining qualitative data to further enrich quantitative data (Creswell, 2009). Both quantitative and qualitative data were collected concurrently using Creswell’s (2009) concurrent embedded strategy design. In this design strategy, the quantitative data addresses the outcomes expected while the qualitative data explores the process experienced by individuals within each of the two groups. Both types of data were collected simultaneously using an internet based survey in which participants completed three valid and reliable instruments, answered demographic questions, and responded to open ended text box questions within the website survey. The website survey was formulated according to the guidelines and best practices outlined by Couper (2009) and Sue and Ritter (2007). The quantitative data collected from instruments was intended to be the predominant method of inquiry, while the qualitative opened ended text responses served to enrich the description of the sample subjects and enhance the quantitative data (Creswell, 2009). This study focused on understanding the relationship between eating disorder recovery, the therapeutic alliance, and selfobject needs. According to Creswell (2009), using a concurrent embedded strategy also involves an explicit theoretical perspective to inform the overall method. In this study, self psychological constructs informed the process, and were used as the lens by which to understand both quantitative and qualitative data. Further, to strengthen the statistical
validity of data collected, a between-group design (Field, 2009; Rubin & Babbie, 2001) was used in which participants were placed into Group 1 (history of or current therapy) or Group 0 (no current or history of therapy).

As stated above, this study used a primarily quantitative design combining qualitative data to further enrich quantitative data. This study was both exploratory and descriptive in nature. There does not appear to be any research exploring the selfobject needs, the therapeutic alliance and eating disorders recovery; therefore this study is exploratory. It is also descriptive in its purpose as data was gathered to further understand the relationship between eating disorders recovery, the therapeutic alliance, and selfobject need approaches and avoidances within two groups of participants who have experienced eating disorders. The instruments used to obtain the quantitative data are the Selfobject Needs Inventory (SONI) (Banai, et al., 2005); the Helping Alliance Questionnaire (HAq-II) (Luborsky, et al., 1996); and the Eating Disorder Recovery Self-Efficacy Questionnaire (EDRSQ) (Pinto & DiClemente et al., 2006). Further, using the theoretical constructs of self psychology allowed theoretical integration with potential empirically significant results. This combination does not appear to have been done previously.

The Study Sample Selection

This study used purposive non-probability sampling and snowball sampling methods (Rubin & Babbie, 2001, p. 247-248). In this study, only females, with current or history of eating disorders were sought. Therefore, a purposeful sampling method was employed using a qualifier website page to screen potential participants. Participants
sought for this study were 120 women over the age of 18 dealing with current, history of, or recovery from eating disorders. Participants in this research self identify as having experienced eating disorders. Sixty (60) participants were sought who have had psychotherapy or counseling (either past or present) and sixty participants were sought who have not had, present or history of, counseling or psychotherapy. Sample size justification, or compromise power analysis, was completed using software program G*Power 3 (Faul, Erdfelder, Buchner, & Lang, 2009) to determine necessary sample size for this study (Faul, Erdfelder, Buchner, & Lang, 2009). Additionally, sample size justification was based on a multiple regression model for data analysis with one dependent variable (DV) and three independent variables (IV). Overall, one hundred and twenty (120) participants were needed to attain statistical significance; sixty (60) participants who have had or are currently in therapy (Group 1); and sixty (60) participants who have no therapy treatment (Group 0). However, as many as one hundred (100) participants in each group (Group 1 and Group 0), or a total of two hundred (200) participants may have been sampled (Faul, Erdfelder, Buchner, & Lang, 2009). The rationale for extending the number of participants sought was to provide a safety margin in the event any cases needed to be excluded (Faul et al., & 2009; Field, 2009).

Snowball sampling was also used because this study sought specific members of the population of individuals dealing with eating disorders (e.g., females over 18 years old) (Rubin & Babbie, 2001). Criteria for inclusion in this study were: 1) self reporting current or history of eating disorder symptoms; 2) minimum age of eighteen (18) years old; 3) English speaking. Criterion for exclusion was: age of less than eighteen (18)
years old; self reporting no symptoms of eating disorders; or being male. The population that meets, or has met in the past, criteria for bulimia or anorexia nervosa is largely female, with a small percentage (11%) being male (Von Holle et al., 2008). For generalization purposes of the results of the current study and to prevent gender bias (Rubin & Babbie, 2001) only females were included in this study. Further, the EDRSQ has undergone psychometric evaluation and been tested for reliability and validity in only female populations. The authors of the EDRSQ suggest that although further studies using male participants and the EDRSQ are warranted, modifications would need to be made to EDRSQ that address gender specific concerns and behaviors (Pinto et al., 2008).

The ethnicity of individuals most commonly meeting criteria for eating disorders is Caucasian. There is an increasing number of individuals being diagnosed from African American and Latino ethnic groups and it would be important to have a representation from these minority groups as part of the population being researched as well. Among the literature reviewed for the current study, only a small percentage of the population being studied has been from outside the Caucasian ethnic group. The average age of onset for eating disorders is between 14-16 years of age (Herzog, 1989). Therefore, participants were at least 18 years old. As stated earlier, participants were recruited through a snowball” and “purposive sampling” (Rubin & Babbie, 2000, p. 247-248). Specifically, participants were recruited through one of the following methods: advertisement in a non-for-profit eating disorder association; fliers posted in university counseling centers; advertisements on internet based referral sources for eating disorders; and from a website promoting the study with specific information about the study.
Potential participants who heard about the study were directed to the website:

The website included a brief description of the study (see Appendix D) to assist potential participants in deciding if they want to participate in the study. Potential participants were asked the following qualifying questions to determine inclusion or exclusion from the current study: Do you now or have you ever had an eating disorder or experienced any of the following: constantly think about food, weight, and body image; have guilt, worry, and or shame about what they eat or do not eat; count calories whenever they eat or drink; feel ‘out of control’ about food; binge eat twice a week or more; exercise compulsively; vomit after eating; use laxatives or diuretics to control their weight; or severely limit their food intake?; and lastly, are you 18 years old or older? If potential participants answer ‘yes’ to both questions, they were then asked to create a user name and provide an email address. Further, potential participants were asked if they have had counseling or psychotherapy. Their answer determined which group, should they qualify to participate, they were part of. Two groups, participants who have had treatment and participants who have had no treatment, were created.

After qualifying to participate, participants were informed that the email address will not be used in any way other than providing them with an invitation, sent via email, to participate in the study. The invitation email contained a unique password all participants entered when prompted to gain access to the survey. These passwords were logged separately and not linked to responses of individual participants, thus ensuring privacy of responses and ensuring participants answered the survey only once (Couper, 2008; Sue and Ritter, 2007).
The invitation email to participate in the study included a welcome message and a link to the Informed Consent webpage (see Appendix A). The following information was included for participants to read and check a box (Couper, 2000; 2008) on the website giving consent: estimated time to complete the survey questionnaire; contact information regarding eating disorders education and treatment for eating disorders; that if at any time during answering the questionnaire they feel uncomfortable and not able to continue, they should discontinue answering the questionnaire and would be given website links and telephone numbers for crisis lines; that the information they are providing will be kept private and confidential; and that the email address they provided is on a secure server to provide as much privacy as possible and used solely to preserve the research data collected and protect against multiple submissions (Couper, 2008).

Further, if a potential participant answered ‘no’ to any of the qualifying questions she was thanked for her interest in furthering the study of eating disorder treatment and recovery, but informed that she does not meet the necessary requirements of the current study. Thus, any ‘no’ responses to qualifying questions were excluded from the study.

Participants completed the online survey wherever they had access to a computer and to the internet. Participants had the option of saving their data and logging in at a different time to complete the questionnaire. They were able to log out and log back in using the invitation email initially sent to them with the unique password they were given. Lastly, in addition to participants answering ‘yes’ to all qualifying questions, participants must have access to a computer; must have access to the internet; and be able to read, write, and understand English, the language in which the current study will be carried out. English did not need to be the participant’s primary language.
Data Collection and Instrumentation

For the purposes of this study a quantitative design was used (Creswell, 2009). This study primarily gathered quantitative data. However, with the intent to more deeply study the questions set forth a qualitative component was included (Creswell, 2009). The quantitative data was derived from combining three statistically valid and reliable instruments operationalized in an earlier section of this paper. The instruments used are: the EDRSQ (Pinto & DiClemente et al., 2006); the SONI (Banai, et al., 2005); and the HAg-II (Luborsky, et al., 1996). SONI) (Banai, et al., 2005) is a psychometric instrument composed of 38 self statements to assess an individuals approach and avoidance orientations regarding the selfobject needs of mirroring, idealization and twinship. This measure asks each participant to rate the degree to which they agree with each self statement using 1: strongly disagree through 7: strongly agree. The SONI combines items which “reflect a person’s hunger for a particular selfobject provision as well as a person’s avoidance of that corresponding need” (p. 228). Banai et al. (2005) developed the SONI as a self-report measurement corresponding with Kohut’s self psychology selfobject constructs. The SONI measures respondents according to their approach or avoidance of each of the selfobject needs. During construction of the SONI, the authors conducted seven corresponding studies to confirm its validity and reliability. Factor analysis revealed five subscales:

1. Hunger for twinship (HT);
2. Hunger for idealization (HI);
3. Hunger for mirroring (HM);
4. Avoidance of idealization twinship (AIT);
5. Avoidance of mirroring (AM).

All five subscales had acceptable coefficient alpha scores ranging from .79 to .91. Test-retest reliability was confirmed with high reliability coefficients between 1 and 2 and concurrent validity was established comparing the SONI with scales of superiority, goal instability, and lack of connectedness.

It is important to note that the SONI has not been previously evaluated outside of the series of studies completed by the authors (Banai et al., 2005). The five subscales of the SONI were used in the current research for multiple regression analysis. Further, the researcher of the current study received a recommendation from one of the SONI authors (M. Mikulincer, personal communication, March 12, 2012) to combine subscales of HM, HI, and HT for a Hunger for selfobjects needs ‘super’ score (HSO); and combine AIT and AM subscales resulting in an Avoidance of selfobject needs ‘super’ score (ASO).

Each of these instruments were scored according to each instrument’s individual scoring methods (see Appendix B). Further, demographic information was collected from each participant.

Additionally, qualitative data was derived from open ended questions designed to cultivate and enhance statistical and demographic data (Creswell, 2008). The organization of instrument questions, demographic questions and open ended text questions was based on recommended best internet survey practices according to Couper (2008). Couper recommends that demographic questions be placed at the end of internet surveys, and that depending on study methodology (for the current research concurrent embedded strategy, prioritizing quantitative data) placing instrument questions first on the survey helps to ensure completion of information sought. The open ended questions
were placed after instrument questions and before demographic questions. The open ended questions had text boxes with unlimited text characters available for participants to respond to the questions. The open ended questions for Group 1 (participants reporting a history of or current therapy) were: what was the most helpful aspect of your experience in therapy?; what did you find to be least helpful in your therapy?; and how would you describe your experience of eating disorders recovery? Group 0 (participants reporting no history of or current therapy) were asked to describe how they viewed eating disorders recovery; and what are the reasons you have not sought out psychotherapy or counseling?

Further, the website survey was formulated according to the guidelines and best practices outlined by Couper (2008) and Sue and Ritter (2007). Internet surveys have gained popularity in recent years (Buchanan & Hvizdak, 2009; Couper, 2000, 2008). Similarly, Buchanan and Hvizdak (2009) state regarding online surveys, “[online surveys] have been embraced by an array of disciplines and professions as a sound way to conduct both formal scientific, survey research as well as informal questionnaires” (p. 37). Similarly, internet based surveys allowed participants to answer all questions privately. Internet surveys have been found to yield comparable results to those of phone, in person, or mailed survey instruments (Braunsberger, Wybenga, & Gates, 2007). Likewise, the current study design is specifically formulated to target a sample population of individuals (experiencing eating disorders and eating disorders recovery) who may be prone to social desirability bias. Data was collected using an online survey to capture a larger sample of the population. Also, with close to 80% of the United States population of adults (Madden, 2006) having online access, collecting data by way of an internet survey questionnaire can assist in more adequately reaching this unique sample
population of women. This study’s design was further developed to limit interviewer variance; to improve reporting of potentially sensitive information (Buchanan & Hvizdak, 2009); increase the ability to generalize and replicate the findings (Couper, 2008); and ultimately, to increase the pool of knowledge regarding the treatment of eating disorders.

Participants completed the survey by way of an online survey website www.surveygizmo.com. An Advanced Encryption Standard (AES) 256 bit encryption on a secured server, which is the highest level of data encryption, was used to ensure confidentiality of information gathered. Participants’ email addresses were stored separately from responses to survey questions and participants’ IP addresses were recorded and stored with corresponding informed consent agreements. All data that was transmitted between www.surveygizmo.com and uploaded to primary researcher’s secured computer server for data analysis, was encrypted to further ensure confidentiality. www.surveygizmo.com is a professionally administered survey server with expertise in computer internet security. www.surveygizmo.com servers are firewall protected and are scanned daily to detect and prevent viruses and hacker intrusion. Likewise, the primary researcher has requested that all data, email addresses and additional response information be deleted from www.surveygizmo.com servers as the data collection process and data transmission has taken place and transferred to the researcher’s fire-walled secured computer server. Before the website survey was launched, this research project and website survey were approved by the Institutional Review Board. Also, as recommended by Couper (2008), although website surveys are no longer considered a unique data collection instrument (Buchanan and Hvizdak, 2009).
pilot testing was completed to ensure usability and workability (reliability) of website survey.

The online website survey was launched on July 25, 2011. The first online survey was completed on July 26, 2011 at 2:19 am. The last participant completed the online survey on October 31, 2011 at 10:17 pm at which time the survey site was closed for participation. Overall, 287 individuals accessed the qualifying questions webpage to participate in the study. One hundred fifty one participants completed the survey. Subsequently, all sources that were marketing the survey research were alerted that participant recruitment had ended. The main webpage also posted a message that the study had successfully completed participant recruitment and thanked everyone that participated.

Data Analysis

Data analysis in this study relied upon 1) the summary of demographic data obtained from a website survey questionnaire; 2) examination and scoring of instrument responses for the SONI, the EDRSQ, and the HAq-II; and 3) examination of written text responses to open ended question on website survey questionnaire. The following sections describe the data analysis for quantitative and qualitative data.
Quantitative Data

For the purposes of the current study, this researcher used an ‘enter method’ multiple regression (Creswell, 2009; Field, 2009) research design to further understand the relationship between eating disorder recovery, therapeutic alliance, and selfobject needs. Multiple regression analysis was applied in this study because it is appropriate for examining the predictive value of sets of predictor variables (Creswell, 2009; Field, 2009). Aiken and West (1991) identified three general uses of multiple regression analyses in psychological research: 1) description-to provide a statistical summary of dependent and independent variables; 2) prediction-to provide an equation that generates predicted scores on a future outcome; and 3) explanation or theory testing. The last application, the sign and magnitude of predicted relationship, can be tested using actual observed data (p. 350). Further, to strengthen the statistical validity of data collected, a between-group design (Field, 2009; Rubin & Babbie, 2001) was used in which participants are placed into Group 1 (history of or current therapy) or Group 0 (no current or history of therapy). The quantitative data were derived from combining psychometric instruments testing self efficacy in eating disorder recovery, therapeutic alliance and selfobject needs.

The instruments used to obtain the data are the Selfobject Needs Inventory (SONI) (Banai et al., 2005); the Helping Alliance Questionnaire (HAq-II) (Luborsky, et al., 1996); and the Eating Disorder Recovery Self-Efficacy Questionnaire (EDRSQ) (Pinto & DiClemente et al., 2006). Data were then transferred from www.surveygizmo.com survey software server to the researcher’s local secured Statistical Package for the Social Sciences (SPSS) version 19.0 database. The data gathered were then analyzed using the SPSS software. Specifically, using principles outlined in Creswell (2009), Field (2009), and Rubin and Babbie (2001) SPSS software was then used to clean data, run frequencies, properly identify, label and describe all variables. According to Creswell (2009) and Field (2009) variables were categorized as predictor variables or criterion variables. Then, using individual scoring instructions for each instrument, each of the
variables was transformed to calculate total score (or subscale scores) for each instrument. For example, for the SONI, scores on questions 1, 7, 11, 29, 33, and 35 were combined to formulate the need for mirroring (NM) subscale as defined by Banai et al. (2005) and for the HAq-II, item numbers 4, 8, 11, 16, and 19 should be reverse scored (Luborsky et al., 1996). All instruments are provided at the end of this paper (see Appendix B).

Next, the distribution characteristics of each variable were examined. Frequencies were computed for all predictor variables and univariate statistics were obtained for criterion variables. For the purposes of this study, the criterion variable (or dependent variable) was recovery from eating disorders, as described by EDRSQ total score. Predictor variables (or independent variables) are therapeutic alliance score and selfobject needs inventory subscale scores and ‘super’ scale scores. Further, internal consistency analysis, calculating the Cronbach Alpha coefficient, was completed for all items on each instrument for the study sample.

At this point, associations between variables were examined using chi-square tests and Pearson’s product-moment correlation coefficient or Pearson’s r. Further, to determine linearity, or to determine if predictor variables increase or decrease criterion variables and will affect the criterion variable, scatterplots were created in SPSS. Next, using multiple regression analysis, the hypotheses and research questions were tested to determine if the predictor variable could predict recovery from eating disorders in the population that was sampled (Field, 2009; Rubin & Babbie, 2001). Lastly, assumptions for regression analytics were verified just before regression statistics were run on SPSS.
Qualitative Data

Qualitative data were derived from open ended text questions which respondents answered in unlimited field text boxes with the website survey. The text was then analyzed and used to further support or negate the qualitative research questions (Rubin & Babbie; Thayer et al., 2007; Weber, 1985):

1. How do recovered patients view the therapeutic relationship and its impact on their recovery?
2. What did women who received treatment most value in the treatment process?
3. What did women who received treatment find least helpful in the treatment process?
4. Is there a difference in how women who did not receive treatment define recovery from eating disorders compared to those who did receive treatment?

The open ended questions for Group 1 (reporting a history of or current therapy) were: what was the most helpful aspect of your experience in therapy?; what did you find to be least helpful in your therapy?; and how would you describe your experience of eating disorders recovery? Group 0 (reporting no therapy) were asked to describe how they viewed eating disorders recovery; and to describe reasons for not having sought psychotherapy or counseling. Each participant’s response was analyzed for manifest and latent forms of content (Thayer et al., 2007). Manifest analysis involves counting words, identifying phrases, and looking at superficial qualities of the text (e.g. pronouns, informal punctuation, passive or active voice clauses). Latent analysis is defined by
Thayer et al. (2007) as interpreting the underlying meanings in the text. These authors further suggest that latent analysis allows for the emergence of masked themes and values within the text. For the purposes of the current study, the text fields were analyzed, using open coding, for categories or specific phenomena consistent with recovery from eating disorders. Open coding is the part of the analysis concerned with identifying, naming, categorizing and describing phenomena found in the text (Creswell, 2009; Thayer et al., 2007). The data were then arranged using selective coding to determine possible story lines or narratives. Further, responses were categorized according to the categories encompassed in SONI, HAq-II, and EDRSQ questionnaires when applicable. Thayer et al. also suggest using emergent coding. They state, “inductive measurement, or emergent coding, entails creating coding categories during the analysis process, [and] emergent coding is useful in exploratory content analysis” (2007, p. 270).

As discussed, this research study originated to generate quantitative, evidence based research studying selfobject needs, the therapeutic relationship, and eating disorders recovery. The researcher anticipated that the scope of questions on the online survey would generate significant predictive information regarding the therapeutic alliance, individuals’ ability to have their selfobject needs met, and eating disorders recovery. Several additional outcomes were expected. Specifically, the researcher anticipated a strong relationship between an individual’s ability to have her selfobject needs met (as measured by SONI), therapeutic alliance (as measured on HAq-II), and eating disorder recovery (as measured by EDRSQ score). The researcher also expected that a significant relationship with the therapist (high *HAq-II score) would predict an individual’s ability to have her selfobject needs met (as measured on SONI), and a strong
relationship with the therapist (as measured by HAq-II) would predict recovery from eating disorders (as measured by EDRSQ). Similarly, as the focus of the data collected from the online survey was quantitative in nature, the researcher anticipated that qualitative data derived from open ended text questions would be informative, but primarily supplemental.
CHAPTER IV

RESULTS

The results of this study will be presented in three sections. First, the demographic statistics of participants will be reported; second, the quantitative data will be exhibited; third, qualitative data will be presented. Further, quantitative and qualitative data analysis results will be displayed according to research hypothesis and related questions.

Participant Demographic Statistics

Sixty-two participants who had no current or history of therapy (Group 0) and 89 participants who have a history of or current therapy (Group 1) took part in the study (N=151). Most of the participants in group 0 had an income of less than $25,000 (33, 54.1%), which was similar to the income of most of the participants in Group 1 (48, 53.9%). Many of the Group 0 participants had either a Bachelor’s degree (24, 39.3%) or at least some college (16, 26.2%), which is also similar to the educational level in Group 1. 33.7% of Group 1 reported having a Bachelor’s degree (30) and 36.0% of the group had at least some college (32). Most of the participants in both groups were single—32 (51.6%) in Group 0 and 59 (66.3%) in Group 1. The majority of the participants in both groups were Caucasian—52 in Group 0 (83.9%) and 84 in Group 1 (94.4%). Most of the
participants were employed outside the home in both groups as well—41 in Group 0 (66.1%) and 63 in Group 1 (70.8%). Age ranged from 19 to 61 for Group 0 and 19 to 57 for Group 1. The average age for Group 0 was 29.13 ($SD = 8.96$) and 30.37 ($SD = 8.34$) for Group 1. Frequencies and percentages for group demographics are presented in Table 1.

Table 1. *Frequencies and Percentages for Group Demographics*

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Group 0</th>
<th>Group 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>%</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; $25,000</td>
<td>33</td>
<td>54.1</td>
</tr>
<tr>
<td>25,000 – 34,999</td>
<td>10</td>
<td>16.4</td>
</tr>
<tr>
<td>35,000 – 49,999</td>
<td>9</td>
<td>14.8</td>
</tr>
<tr>
<td>50,000 – 74,999</td>
<td>4</td>
<td>6.6</td>
</tr>
<tr>
<td>75,000 – 99,999</td>
<td>3</td>
<td>4.9</td>
</tr>
<tr>
<td>100,000 – 124,999</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>125,000 – 149,999</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>&gt; 150,000</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12$^{th}$ grade or less</td>
<td>1</td>
<td>1.6</td>
</tr>
<tr>
<td>High school</td>
<td>3</td>
<td>4.9</td>
</tr>
<tr>
<td>Some college</td>
<td>16</td>
<td>26.2</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>4</td>
<td>6.6</td>
</tr>
<tr>
<td>Bachelor degree</td>
<td>24</td>
<td>39.3</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>13</td>
<td>21.3</td>
</tr>
<tr>
<td>Doctoral degree</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
**Relationship status**

<table>
<thead>
<tr>
<th>Status</th>
<th>Group 0</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>32</td>
<td>51.6</td>
<td>59</td>
<td>66.3</td>
</tr>
<tr>
<td>Living as domestic partners</td>
<td>8</td>
<td>12.9</td>
<td>7</td>
<td>7.9</td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td>21.0</td>
<td>17</td>
<td>19.1</td>
</tr>
<tr>
<td>Divorced</td>
<td>7</td>
<td>11.3</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>3.2</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>2.2</td>
</tr>
</tbody>
</table>

**Ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Group 0</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>2</td>
<td>3.2</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>Black/African American</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Caucasian</td>
<td>52</td>
<td>83.9</td>
<td>84</td>
<td>94.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4</td>
<td>6.5</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Native American/Alaskan Native</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Other/Multi-racial</td>
<td>2</td>
<td>3.2</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Decline</td>
<td>2</td>
<td>3.2</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

**Employed outside the home**

<table>
<thead>
<tr>
<th>Status</th>
<th>Group 0</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41</td>
<td>66.1</td>
<td>63</td>
<td>70.8</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>33.9</td>
<td>26</td>
<td>29.2</td>
</tr>
</tbody>
</table>

**Age**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29.13*</td>
<td>8.96**</td>
<td>30.37*</td>
<td>8.34**</td>
</tr>
</tbody>
</table>

*Note.* * represents the mean. ** represents the standard deviation.

**Quantitative Results**

There were 10 subscales for group 0 and 11 subscales for group 1 (group 0 did not have the HAQ Alliance subscale). Participant responses to these subscales were very similar among the groups. The largest difference in the average scores was a 0.77 point
difference in the SONI avoidance of mirroring subscale. The least difference was for the
SONI hunger for twinship subscale. Means and standard deviations for the 11 subscales
are presented in Table 2.

Table 2. Means and Standard Deviations for Subscales

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Group 0</th>
<th></th>
<th>Group 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>Range</td>
<td>M</td>
</tr>
<tr>
<td>SONI Hunger for twinship</td>
<td>37.42</td>
<td>8.62</td>
<td>15 - 56</td>
<td>37.45</td>
</tr>
<tr>
<td>SONI Avoidance of idealization</td>
<td>36.23</td>
<td>10.14</td>
<td>17 - 61</td>
<td>36.69</td>
</tr>
<tr>
<td>&amp; twinship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SONI Hunger for idealization</td>
<td>27.13</td>
<td>7.19</td>
<td>10 - 42</td>
<td>27.31</td>
</tr>
<tr>
<td>SONI Hunger for mirroring</td>
<td>27.94</td>
<td>7.11</td>
<td>8 - 39</td>
<td>27.97</td>
</tr>
<tr>
<td>SONI Avoidance of mirroring</td>
<td>18.31</td>
<td>6.80</td>
<td>6 - 42</td>
<td>17.54</td>
</tr>
<tr>
<td>SONI Hunger ‘super’ scale</td>
<td>92.48</td>
<td>17.79</td>
<td>48 - 137</td>
<td>92.73</td>
</tr>
<tr>
<td>SONI Denial ‘super’ scale</td>
<td>54.53</td>
<td>12.62</td>
<td>28 - 92</td>
<td>54.22</td>
</tr>
<tr>
<td>HAQ Alliance Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>84.70</td>
</tr>
<tr>
<td>EDRSQ Total</td>
<td>1.64</td>
<td>0.58</td>
<td>1 - 3.57</td>
<td>1.89</td>
</tr>
<tr>
<td>EDRSQ Normal Eating Scale</td>
<td>1.68</td>
<td>0.69</td>
<td>1 - 3.86</td>
<td>2.03</td>
</tr>
<tr>
<td>EDRSQ Body Image Scale</td>
<td>1.58</td>
<td>0.54</td>
<td>.89 - 3.22</td>
<td>1.64</td>
</tr>
</tbody>
</table>
Pearson correlations were conducted between the research variables for both groups separately. For group 0, SONI hunger for twinship was significantly positively related to SONI hunger for idealization, SONI Hunger for mirroring, SONI hunger ‘super’ scale, and significantly negatively correlated with SONI Denial ‘super’ scale. The SONI avoidance of idealization & twinship scale was positively significantly correlated with the SONI denial super scale. The SONI hunger for idealization subscale was significantly positively correlated with the SONI hunger ‘super’ scale. The SONI hunger for mirroring subscale was significantly positively correlated with the SONI hunger ‘super’ scale and significantly negatively correlated with the SONI hunger for mirroring subscale, the SONI denial ‘super’ scale, and the EDRSQ body image scale. The SONI avoidance of mirroring subscale was significantly positively correlated with the SONI denial ‘super’ scale and significantly negatively correlated with the SONI hunger super scale. The SONI hunger ‘super’ scale was significantly negatively correlated with the SONI denial ‘super’ scale. The EDRSQ total scale was significantly positively correlated with the EDRSQ normal eating scale and the EDRSQ body image subscale. The EDRSQ normal eating scale was significantly positively correlated with the EDRSQ body image subscale.

For group 1, the SONI hunger for twinship subscale was significantly positively correlated with the SONI hunger for idealization subscale, the SONI hunger for mirroring subscale, and the SONI hunger ‘super’ scale, and significantly negatively correlated with the SONI avoidance of idealization and twinship subscale and the SONI denial ‘super’ scale. The SONI avoidance of idealization and twinship subscale was significantly positively correlated with the SONI hunger for mirroring subscale and the SONI denial
‘super’ scale, and significantly negatively correlated with the HAQ alliance, EDRSQ total, EDRSQ normal eating scale, and the EDRSQ body image scale. The SONI hunger for idealization subscale was significantly positively correlated with the SONI hunger for mirroring subscale and the SONI hunger ‘super’ scale, and significantly negatively correlated with the SONI avoidance of mirroring subscale and the HAQ alliance total scale. The SONI hunger for mirroring subscale was significantly positively correlated with the SONI hunger ‘super’ scale and significantly negatively correlated with the SONI avoidance of mirroring subscale. The SONI avoidance of mirroring subscale was significantly positively correlated with the SONI denial ‘super’ scale, the EDRSQ total, the EDRSQ normal eating scale and the EDRSQ body image scale. The EDRSQ total was significantly positively correlated with the EDRSQ normal eating scale and the EDRSQ body image scale. The EDRSQ normal eating scale was significantly positively correlated with the EDRSQ body image scale. Pearson correlations are presented in Table 3.
Table 3. *Pearson Correlations between Variables*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>-0.23*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.11</td>
<td>0.12</td>
<td>0.08</td>
</tr>
<tr>
<td>2</td>
<td>-0.18</td>
<td></td>
<td></td>
<td>0.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0.53**</td>
<td>-0.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>0.47**</td>
<td>0.02</td>
<td>0.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>-0.21</td>
<td>0.07</td>
<td>-0.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>0.89**</td>
<td>-0.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>-0.26*</td>
<td>0.84**</td>
<td>-0.13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>0.07</td>
<td>-0.19</td>
<td>0.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>0.09</td>
<td>-0.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>0.01</td>
<td>-0.21</td>
<td>0.13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* 1 = SONI Hunger for twinship. 2 = SONI Avoidance of idealization & twinship. 3 = SONI Hunger for idealization. 4 = SONI Hunger for mirroring. 5 = SONI Avoidance of mirroring. 6 = SONI Hunger ‘super’ scale. 7 = SONI Denial ‘super’ scale. 8 = HAQ Alliance Total. 9 = EDRSQ Total. 10 = EDRSQ Normal Eating Scale. 11 = EDRSQ Body Image Scale.

* *p < .05. ** *p < .01. † correlations below are for group 0. Correlations above are for group 1.

Research Question 1

What is the relationship between an individual’s ability to have her selfobject needs met, therapeutic alliance, and eating disorder recovery?

In order to assess research question 1, three multiple linear regressions were conducted to assess if the 5 SONI subscales (hunger for twinship, avoidance of idealization & twinship, hunger for idealization, hunger for mirroring, and avoidance of
mirroring) and alliance predicts the three recovery scales (EDRSQ total, normal eating scale and body image scale) for group 1 participants only. An additional regression was conducted to assess if the SONI ‘super’ scale (hunger and denial) predicts the EDRSQ total recovery scale for group 1 participants only. Prior to analysis, the assumptions of normality and homoscedasticity were assessed with scatterplots. The scatterplots showed little deviation from normality and little signs of heteroscedasticity, and the assumptions were met. Multicollinearity was examined for through variance inflation factors (VIFs). The VIFs were all under 10, verifying the absence of multicollinearity.

The first regression examined if the 5 SONI subscales and HAQ alliance predicted the EDRSQ total scale. The results of the regression were significant, $F(6, 77) = 3.75, p = .003$, suggesting that the 5 SONI subscales and alliance accounted for $R^2$ 22.6% of the variance in EDRSQ total. SONI avoidance of mirroring significantly predicted the EDRSQ scale, $B = 0.07, p = .008$, suggesting that for every one point increase in the SONI avoidance of mirroring subscale, the EDRSQ increased by 0.07 points. No other predictors were found to be significant. Results of the first regression are presented in Table 4.
Table 4. *Regression with the SONI Subscales and Alliance Predicting EDRSQ Total*

<table>
<thead>
<tr>
<th>Source</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>SONI Hunger for twinship</td>
<td>0.01</td>
<td>0.02</td>
<td>0.05</td>
<td>0.36</td>
<td>0.719</td>
</tr>
<tr>
<td>SONI Avoidance of idealization &amp; twinship</td>
<td>-0.02</td>
<td>0.01</td>
<td>-0.25</td>
<td>-1.86</td>
<td>0.067</td>
</tr>
<tr>
<td>SONI Hunger for idealization</td>
<td>0.01</td>
<td>0.02</td>
<td>0.05</td>
<td>0.49</td>
<td>0.625</td>
</tr>
<tr>
<td>SONI Hunger for mirroring</td>
<td>0.03</td>
<td>0.03</td>
<td>0.19</td>
<td>1.07</td>
<td>0.286</td>
</tr>
<tr>
<td>SONI Avoidance of mirroring</td>
<td>0.07</td>
<td>0.03</td>
<td>0.41</td>
<td>2.74</td>
<td>0.008</td>
</tr>
<tr>
<td>HAQ Alliance Total</td>
<td>0.01</td>
<td>0.01</td>
<td>0.17</td>
<td>1.58</td>
<td>0.118</td>
</tr>
</tbody>
</table>

The second regression examined if the 5 SONI subscales and alliance predicted the EDRSQ normal eating scale. The results of the regression were significant, $F(6, 77) = 3.33, p = .006$, suggesting that the 5 SONI subscales and alliance accounted for ($R^2$) 20.6% of the variance in EDRSQ normal eating. SONI avoidance of mirroring significantly predicted the EDRSQ normal eating scale, $B = 0.08, p = .020$, suggesting that for every one point increase in the SONI avoidance of mirroring subscale, the EDRSQ increased by 0.08 points. No other predictors were found to be significant.

Results of the second regression are presented in Table 5.
Table 5. *Regression with the SONI Subscales and Alliance Predicting EDRSQ*

**Normal Eating**

<table>
<thead>
<tr>
<th>Source</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>SONI Hunger for twinship</td>
<td>0.01</td>
<td>0.02</td>
<td>0.10</td>
<td>0.75</td>
<td>0.458</td>
</tr>
<tr>
<td>SONI Avoidance of idealization &amp; twinship</td>
<td>-0.02</td>
<td>0.02</td>
<td>-0.21</td>
<td>-1.60</td>
<td>0.114</td>
</tr>
<tr>
<td>SONI Hunger for idealization</td>
<td>0.00</td>
<td>0.02</td>
<td>0.00</td>
<td>0.03</td>
<td>0.980</td>
</tr>
<tr>
<td>SONI Hunger for mirroring</td>
<td>0.02</td>
<td>0.03</td>
<td>0.13</td>
<td>0.72</td>
<td>0.477</td>
</tr>
<tr>
<td>SONI Avoidance of mirroring</td>
<td>0.08</td>
<td>0.03</td>
<td>0.36</td>
<td>2.37</td>
<td>0.020</td>
</tr>
<tr>
<td>HAQ Alliance Total</td>
<td>0.01</td>
<td>0.01</td>
<td>0.15</td>
<td>1.40</td>
<td>0.166</td>
</tr>
</tbody>
</table>

The third regression examined if the 5 SONI subscales and alliance predicted the EDRSQ body image scale. The results of the regression were significant, $F(6, 77) = 3.32, p = .006$, suggesting that the 5 SONI subscales and alliance accounted for $R^2 = 20.6\%$ of the variance in EDRSQ body image. SONI avoidance of mirroring significantly predicted the EDRSQ body image scale, $B = 0.07, p = .005$, suggesting that for every one point increase in the SONI avoidance of mirroring subscale, the EDRSQ body image increased by 0.07 points. No other predictors were found to be significant. Results of the third regression are presented in Table 6.
Table 6. Regression with the SONI Subscales and Alliance Predicting EDRSQ Body

The fourth regression with the SONI ‘super’ scale and alliance predicting the EDRSQ total was not significant, \( F(3, 80) = 2.49, p = .067 \). Results of the regression are presented in Table 7.

Table 7. Regression with the SONI ‘super’ scale and Alliance Predicting EDRSQ Total

<table>
<thead>
<tr>
<th>Source</th>
<th>( B )</th>
<th>( SE ) ( B )</th>
<th>( \beta )</th>
<th>( t )</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>SONI Hunger ‘super’ scale</td>
<td>0.00</td>
<td>0.01</td>
<td>0.00</td>
<td>-0.04</td>
<td>0.972</td>
</tr>
<tr>
<td>SONI Denial ‘super’ scale</td>
<td>-0.01</td>
<td>0.01</td>
<td>-0.09</td>
<td>-0.76</td>
<td>0.430</td>
</tr>
<tr>
<td>HAQ Alliance Total</td>
<td>0.02</td>
<td>0.01</td>
<td>0.26</td>
<td>2.33</td>
<td>0.022</td>
</tr>
</tbody>
</table>
Research Question 2

Does the relationship with the therapist predict an individual’s ability to have her selfobject needs met?

To assess research question 2, five simple linear regressions were conducted to assess if there was a relationship between HAQ alliance total and the five SONI subscales for Group 1 participants only. Prior to analysis, the assumptions of normality and homoscedasticity were assessed with scatterplots. The scatterplots showed little deviation from normality and little signs of heteroscedasticity, and the assumptions were met.

The results of the first regression with the HAQ alliance score predicting SONI hunger for twinship was not significant, $F(1, 82) = 0.30, p = .584$, suggesting that alliance scores did not predict the SONI hunger for twinship score. Results of the regression are presented in Table 8.

Table 8. *Regression with the Alliance Predicting SONI Hunger for Twinship Subscale*

<table>
<thead>
<tr>
<th>Source</th>
<th>$B$</th>
<th>$SE$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAQ Alliance Total</td>
<td>-0.03</td>
<td>0.06</td>
<td>-0.06</td>
<td>-0.55</td>
<td>0.584</td>
</tr>
</tbody>
</table>

The results of the second regression with alliance predicting SONI avoidance of idealization & twinship were significant, $F(1, 82) = 8.54, p = .004$, suggesting that alliance scores accounted for ($R^2$) 9.4% of the variance in SONI avoidance of idealization.
& twinship. For every one point increase in alliance, SONI avoidance of idealization &
twinship decreased by \((B) 0.20\) points. Results of the regression are presented in Table 9.

Table 9. *Regression with the Alliance Predicting SONI Avoidance of Idealization &
Twinship*

<table>
<thead>
<tr>
<th>Source</th>
<th>(B)</th>
<th>(SE)</th>
<th>(\beta)</th>
<th>(t)</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAQ Alliance Total</td>
<td>-0.20</td>
<td>0.07</td>
<td>-0.31</td>
<td>-2.92</td>
<td>0.004</td>
</tr>
</tbody>
</table>

The results of the third regression with the alliance predicting SONI hunger for
idealization was not significant, \(F(1, 82) = 1.18, p = .280\), suggesting that alliance scores
did not predict the SONI hunger for idealization score. Results of the regression are
presented in Table 10.

Table 10. *Regression with the Alliance Predicting SONI Hunger for Idealization*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>(B)</th>
<th>(SE)</th>
<th>(\beta)</th>
<th>(t)</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAQ Alliance Total</td>
<td>-0.05</td>
<td>0.04</td>
<td>-0.12</td>
<td>-1.09</td>
<td>0.280</td>
</tr>
</tbody>
</table>

The results of the fourth regression with the alliance predicting SONI hunger for
mirroring was not significant, \(F(1, 82) = 2.95, p = .090\), suggesting that HAQ alliance
scores did not predict the SONI hunger for mirroring score. Results of the regression are presented in Table 11.

Table 11. Regression with the Alliance Predicting SONI Hunger for Mirroring

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Source</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAQ Alliance Total</td>
<td></td>
<td>-0.07</td>
<td>0.04</td>
<td>-0.19</td>
<td>-1.72</td>
<td>0.090</td>
</tr>
</tbody>
</table>

The results of the last regression with the alliance predicting SONI avoidance of mirroring was not significant, $F(1, 82) = 3.08, p = .083$, suggesting that alliance scores did not predict the SONI avoidance of mirroring score. Results of the regression are presented in Table 12.

Table 12. Regression with the Alliance Predicting SONI Avoidance of Mirroring

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Source</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAQ Alliance Total</td>
<td></td>
<td>0.06</td>
<td>0.04</td>
<td>0.19</td>
<td>1.76</td>
<td>0.083</td>
</tr>
</tbody>
</table>
Research Question 3

Does the relationship with the therapist predict recovery from eating disorders?

In order to assess if HAQ alliance scores predicted the three recovery scores (EDRSQ total, EDRSQ normal eating, and EDRSQ body image), three linear regressions were conducted for group 1 participants only. Prior to analysis, the assumptions of normality and homoscedasticity were assessed with scatterplots. The scatterplots showed little deviation from normality and little signs of heteroscedasticity, and the assumptions were met.

The results of the first regression, with HAQ alliance score predicting EDRSQ total scores was significant, $F(1, 82) = 6.91, p = .010$, suggesting that HAQ alliance scores accounted for ($R^2$) 7.8% of the variance in EDRSQ total scores. For every one unit increase in HAQ alliance scores, EDRSQ total scores increase by ($B$) 0.02 points. Results of the linear regression are presented in Table 13.

Table 13. Regression with the Alliance Predicting EDRSQ Total

<table>
<thead>
<tr>
<th>Source</th>
<th>$B$</th>
<th>$SE$</th>
<th>$β$</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAQ Alliance Total</td>
<td>0.02</td>
<td>0.01</td>
<td>0.28</td>
<td>2.63</td>
<td>0.010</td>
</tr>
</tbody>
</table>

The results of the second regression, with HAQ alliance score predicting EDRSQ normal eating scores was significant, $F(1, 82) = 5.78, p = .018$, suggesting that HAQ alliance scores accounted for ($R^2$) 6.6% of the variance in EDRSQ normal eating scores.
For every one unit increase in HAQ alliance scores, EDRSQ normal eating scores increase by \((B) 0.02\) points. Results of the linear regression are presented in Table 14.

**Table 14. Regression with the HAQ Alliance Predicting EDRSQ Normal Eating Scores**

<table>
<thead>
<tr>
<th>Source</th>
<th>(B)</th>
<th>(SE)</th>
<th>(\beta)</th>
<th>(t)</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAQ Alliance Total</td>
<td>0.02</td>
<td>0.01</td>
<td>0.26</td>
<td>2.41</td>
<td>0.018</td>
</tr>
</tbody>
</table>

The results of the third regression, with alliance score predicting EDRSQ body image scores was significant, \(F(1, 82) = 6.41, p = .013\), suggesting that HAQ alliance scores accounted for \(R^2 7.3\%\) of the variance in EDRSQ body image scores. For every one unit increase in HAQ alliance scores, EDRSQ body image scores increase by \((B) 0.01\) points. Results of the linear regression are presented in Table 15.

**Table 15. Regression with the Alliance Predicting EDRSQ Body Image Scores**

<table>
<thead>
<tr>
<th>Source</th>
<th>(B)</th>
<th>(SE)</th>
<th>(\beta)</th>
<th>(t)</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAQ Alliance Total</td>
<td>0.01</td>
<td>0.01</td>
<td>0.27</td>
<td>2.53</td>
<td>0.013</td>
</tr>
</tbody>
</table>
Ancillary Quantitative Analyses

To assess if there were differences in the five SONI subscales and the three EDRSQ scales by group (Group 0 vs. Group 1), eight independent sample t tests were conducted. The assumption of normality was assessed with eight Kolmogorov Smirnov (KS) tests. The results of the tests were significant for the three recovery scales, violating the assumption. However, Pallant (2007) suggests that with 30 or more participants, the t test is robust against normality violations. The assumption of equality of variance was assessed with eight Levene’s tests. The results of the tests were significant for the three recovery scales, and thus the Welch estimate for the t test was used instead. The result of the t test showed significant differences for the EDRSQ total scale and EDRSQ normal eating scale (see Table 16). For both of these recovery scales, Group 0 had significantly lower scores than Group 1. Results of all of the t tests are presented in Table 16.

Table 16. Results for t Tests for 5 SONI Subscales and 3 EDRSQ Recovery Scales by Group

<table>
<thead>
<tr>
<th></th>
<th>Group 0</th>
<th></th>
<th>Group 1</th>
<th></th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SONI Hunger for twinship</td>
<td>37.42</td>
<td>8.62</td>
<td>37.45</td>
<td>7.55</td>
<td>-0.02</td>
<td>149</td>
<td>0.982</td>
</tr>
<tr>
<td>SONI Avoidance of idealization &amp; twinship</td>
<td>36.23</td>
<td>10.14</td>
<td>36.69</td>
<td>10.05</td>
<td>-0.28</td>
<td>149</td>
<td>0.783</td>
</tr>
<tr>
<td>SONI Hunger for idealization</td>
<td>27.13</td>
<td>7.19</td>
<td>27.31</td>
<td>5.88</td>
<td>-0.17</td>
<td>149</td>
<td>0.862</td>
</tr>
<tr>
<td>SONI Hunger for mirroring</td>
<td>27.94</td>
<td>7.11</td>
<td>27.97</td>
<td>5.76</td>
<td>-0.03</td>
<td>149</td>
<td>0.977</td>
</tr>
</tbody>
</table>
Qualitative Results

Open ended text questions were selected for each of the two groups. Questions were formulated to enrich the instruments and broaden the researcher’s ability to effectively answer the research questions. The following are the frequencies of themes participants reported based on the open ended text questions they were asked. Research questions, along with frequencies from participants, are presented below. After each frequency table, corresponding statements from participants are presented.

Research Question 4

How do participants view the therapeutic relationship?

Table 17. Descriptions of Therapeutic Relationship

<table>
<thead>
<tr>
<th>Themes</th>
<th># Participants Reporting Theme</th>
<th># Themes Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration or length of treatment</td>
<td>40</td>
<td>49</td>
</tr>
</tbody>
</table>

Question: “How would you describe your work with your therapist?” (n=89)
Multiple therapists or treatments

Food, eating, weight, or symptom focused

Therapist as a person/How participant felt responded to in relationship

Duration or length of treatment

I have had an ED/ depression for 13 years, moved cross-country a few times, been in tx several times, etc, so I've had a lot of them.

Slow... painful... hopeful

At first, we focused mainly on my eating disorder and finding how to move forward in a healthy way. Over time, we have progressed from that and now mainly discuss my relationships, my anxiety, ptsd that I suffer as a result of an abusive relationship, and my future.

I'm on medicaid, so I don't actually have a therapist. My answers relate to the (all too sparse) counseling sessions that I have with my psychiatrist, whom I value more than any other medical professional I've encountered since I went on disability 7 years ago.

Progress seems slow at times but feel like I am heading in the right direction

I have been seeing my current therapist for almost two years, and she is the first therapist I have seen in my adult life whom I have kept seeing for more than a few months. I first started seeing her after an inpatient hospitalization for my eating disorder. At first, we focused mainly on my eating disorder and finding ways to move forward in a healthy way.

Right now I am not working with a therapist. I am in the process of finding a new one. My answers are based on the last therapist I saw. I felt that all we were doing was making small talk and not working on anything important. With that said the therapist I worked with while I was in treatment were excellent
Slow, stifled, she just wants me to agree with her.

I have been seeing my therapist on a weekly basis for a year and a half. After I got out of the hospital, because of my ED, there was a period of time where I didn't see anyone and fell back. I started seeing her and had a tough time adjusting and trusting, but then I did begin to start complying with the therapy after about 6-8 months.

The work with my therapist has been long. It's taken me a lot of time to trust her but she said she doesn't mind because I need to feel comfortable.

It is much like life in general. Good days, bad days, and in between days.... Sometimes I feel more connected to what we are talking about and to my therapist and other times I feel less connected. I have worked with her on and off for a fairly long period of time (7 or 8 years).

My therapist shares my faith and that puts us in agreement on life. She clearly cares about me and never wants to stop seeing me even though I haven’t reached recovery in 10 yrs.

I just started with her a few months ago, and I feel I am still trying to gain mutual trust with her in order for it to be more effective. Sometimes I feel she just wants me to go to inpatient therapy and I feel she doesn't want to have to deal with me.

Long term and intense before getting to eating disorder recovery due to previous abuse by prior therapist

Multiple therapists or treatments
Once I found a therapist I like, I would say that I have felt incredibly comfortable with them and I love how personal they make it.

With my current therapist (a second-year master's student), I feel like she isn't grasping the complexity of having an Eating Disorder.

While at Remuda Ranch I had several great therapist and a couple that did not do much for me.

I had several different therapists - the work was intense and not always relevant.

I just started with a new therapist, whom I like so far but don't have a lot of experience with; thus I mostly had past therapists in mind when answering. My previous experiences with therapists have been neutral (particularly when I wasn't in a place to accept help) to good (particularly when I worked with the person for a long period of time).

It is good so far, but I just started with a new therapist because my other one got a new job, so I am just getting to know her it's kind of hard.

In a word - frustrating. Since I don't fit the mold of a typical patient, my therapist (and others previously) don't know what to do with me.

Food, eating, weight, or symptom focused

he allows me to choose what direction I want to take things, and has been patient w/me when I was actively symptomatic-not willing to change. i.e.: he helped me work to improve my life even when I wasn't willing to give up puking, we worked on addressing the depression, etc.

She breaks it down into simple things, like "purging / no purging" "losing weight / putting on weight" and doesn't understand how precarious of a balance it is.

some of my thoughts that I take as truth are actually distortions and I'd forgotten (e.g., I must work out an hour and half, I don't need to eat more than one meal a day). He gently helps me see things I am scared of--he really holds the experience. It's taken almost a year, but I trust him greatly.
We hardly ever talked about the ed in fact. She believed, as I do, that the ed was just a symptom of a bigger problem. I have been recovered for over 11 years.
Therapist as a person/How participant felt responded to in relationship

If I had to sum up our relationship in a metaphor, it would be "He waited for the mountain to come to Mohammed." Over the two years we've been working together, he has always gently made concrete recommendations (check out this article, seek spirituality, volunteer) for living. He has given me the time I needed to accept my own powerlessness and the unmanageability of my illness.

Of course he's also done his duty as an MD in ordering tests, rxing meds, and advising additional professional help for my ED and SA (easier said than done under adult Medicaid) but *always* as a fellow traveller. He has never threatened to fire me for expressing my opinion/ experience and disagreement.

She is trying to get me to see that my eating disorder doesn't define who I am, and trying to get me to focus on the other aspects of my life that are important to me.

A partnership built on mutual respect and confidence.

she and I are able to connect on many levels, and I believe that she genuinely likes and respects me. She is encouraging and helps me to focus on the positive changes I have made since leaving the hospital.

He gently helps me see things I am scared of--he really holds the experience

My therapist is considered a national and international expert in the field of eating disorders. I came to her knowing that she would push me harder than any other therapist I had ever seen before- and would give me a chance at recovery. However, a lot of times I resist change and that creates some tension. She questions what I am doing in therapy if I don't want to get better- or why I keep coming back if I won't listen to what my treatment team says I need

His genuine hope for me to have a better quality of life combined with his no bull sh!t approach are exactly what I need.

like someone cares and is trying to help me
I am very open to book recommendations and other activities the therapist recommends. I enjoy seeing my therapist as I feel like she understands me and I feel less alone.

She wants me to "lead" the sessions a lot of the time, and if I am not talking there will be very long silences that frustrate me. I am having a hard time trusting her, not because of something she did, but because of issues I have, and because of other experiences with therapists.
Research Questions 5 and 6

What did women who received treatment most value and least value in the treatment process?

Table 18. Most & Least Valued in Therapeutic Relationship

<table>
<thead>
<tr>
<th>Themes</th>
<th># Participants Reporting Theme</th>
<th># Themes Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating disorders labeled as ‘ED’</td>
<td>35</td>
<td>39</td>
</tr>
<tr>
<td>Hope</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>Specific techniques or type of treatment</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Duration or length of treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressing or experiencing difficult emotions</td>
<td>58</td>
<td>62</td>
</tr>
<tr>
<td>Food, eating, weight, or symptom focused</td>
<td>56</td>
<td>67</td>
</tr>
<tr>
<td>Therapist as a person/How participant felt responded to in relationship</td>
<td>79</td>
<td>83</td>
</tr>
</tbody>
</table>
Food, eating, weight or symptom focused

he still seems to think it's all about the weight, when I know, deep down inside, it's really not.

I expect to be able to eat like a normal person and not think about food all the time. I am frustrated because no matter how much I intellectually understand my problem, I still can't do the right thing and forget about food and eating.

arguing about my weight, body image exercises

therapists who weigh you

Eating disorders labeled as ‘ED’

pointing out the ways in which engaging in ED behaviors limits my life

I don't feel like ED has been addressed at all

If he doesn't want to deal with ED issues I wish I could be referred to someone who does

Feeling that someone other than ED is able to understand and comfort you are also essential points.

she helped me to see the irrational nature of my ED thoughts but did not push recovery on me

I have been able to manipulate treatment providers in a way that only kept me sick. She won't put up with my ED fighting- and as long as I remember why I wanted to see her in the first place, its helpful for her to be strong and stand up against ED. The least helpful aspects of my therapy are the moments when I don't feel heard. Sometimes I think its too easy to pass things off as the "ED talking” but its me talking.

Hope

Problem solving together. Feeling that I am listened to.

joining a support group led by my therapist
I guess the most helpful aspect has been that my therapist has herself recovered from an eating disorder, and she really understands what I'm talking about and really knows how to get through to me.

Never been as close to being recovered before and it was amazing.

I guess having a safe place to talk and not feeling alone.

Eating with her and when she pushes me to do things, like not weighing myself are helpful.

Validation, the freedom to express myself without being judged

Specific techniques or type of treatment

The therapist is very nice and personable. I feel comfortable talking to him. He's very academic, logical, and goal-oriented (like me) and has helped me to stay on track with school.

The homework exercises are most beneficial to me, they force me to think about things more thoroughly and thoughtfully

Most helpful was roleplaying and strategies for when I was constantly b/ping and needed to break the cycle

being taught something I didn't know..ex. somatic experience

Most: getting homework assignments and learning tools to cope. DBT skills, food challenges.

Least helpful - Homework assignments

Most helpful has been art therapy

therapist identifying cognitive distortions during session; therapist leading me to talk about difficult things

The most helpful aspects of my therapy are my weekly homework assignments that my counselor and I come up with in the last 5 or 10 min of therapy.
Clear cut defined boundaries, concrete steps to change, and talking things out are among the most helpful aspects of therapy.

The willingness to work with a team-your doctor, RD, psych etc. was a great help. DBT trained therapists who actually used it correctly were much more helpful than other ways.

Focusing on measurable goals was the most helpful.

I think the verbal and nonverbal communication and behavior between my therapist and I have also helped, specifically with interventions.

Most helpful are when she discusses with me what she sees and understands about me and my recovery.

One therapist required me to stand up and scream at a teddy bear. I couldn't do it. I thought the exercise was silly and couldn't stop focusing on how stupid I must have looked. I will talk something out with you but don't make me look like a fool.

Expressing or experiencing difficult emotions

She doesn't take my bullshit answers and calls me out.

I also hate therapy exercises that require me to become emotional, either angry or crying.

It's good to be able to verbally vomit (no pun intended) some of my feelings regarding my family and trauma I've faced in the past and try to get around the feelings of inadequacy and self-hatred I've developed.

Finding out things in my past that has influenced my eating disorder, has been really hurtful but also helpful.

Most helpful: identifying the extent to which I was having difficulty with dissociation and verbal communication, learning not to dissociate, working out communication problems, working on feeling connected and present in the relationship.
We talk about how I did the next time and work through issues that came up or if I felt uncomfortable

having an unbiased person to vent to about my problems, knowing I always had at least one person on my side, getting validation that I was really in need of help and deserved it

Though having her intervene (at the time) looks like it could make the situation worse, and it does before it gets better, they're key and it wasn't only helpful in means that I didn't go through with self infliction. But, it showed me how I can calm down and get control of myself and the situation before it escalates.

Duration, time, or length of treatment

Being there for me consistently, reminding me of my long term goals

I recently was able to go a few weeks going twice a week, once on Tuesday and once on Friday--this was great. I also started going for an hour and half on Friday--this has greatly improved our sessions; it gives me a little time to really settle in and not be so on guard.

I think spending too much time on the situation or problem not only can be seen as its being sugar coated, but other underlying issues aren't being addressed

Taking so much time on each issues once I got going though, was irritating and kinda made me shut down.

being late on a regular basis and then always looking at the clock to end EXACTLY on time...it made me feel like I was being shorted on time. I think that the little things that probably seem like they don't matter at all matter most of all

our relationship over the past 2+ years.

When looking at how long I've been in therapy and how far I've come, I can see and understand what helps me feel positive or anxious, as well as accepting my strong and weak points. Identifying the different feelings and ways I thinking over time have become better and it's helped me without a
doubt when it comes to coping with difficult situations when I'm outside of session.

the time aspect and distance between sessions and feeling on my own at times, explaining my history and why I am different

Going through and picking through the issues isn't easy. It's been great that she has been willing to wait until I am comfortable to talk about issues and not saying I just need to talk about it

Therapist as a person/How participant felt responded to in relationship

Being understood and heard, having someone validate my feelings.

she is nice and friendly, she gives me all her attention, she helps me see other ways of thinking, she questions me

most helpful is when my therapist can share personal experiences she has overcome

Most helpful was the relationship and my therapists experience

Feeling like my therapist really truly cares about me no matter what. Being there even when I have nothing to say. Her openness, not feeling like I am being judged. Her honesty with me

aspects are that my therapist really listens to what I'm saying and tries to offer advice based on her knowledge of me. I don't feel like she just gives the same advice to everyone in every situation, the way I've felt with other therapists before.

The fact that my therapist has recovered from an eating disorder has been very, very helpful in building rapport.

My therapist didn't judge

in a way, knowing that I was in therapy validated my need to have it recognized that I have a problem.
Most helpful was learning to open up in a trusted relationship and explore my problems more in depth
------------------------------------------------------
She often points out things that perhaps I didn't realize. I leave therapy session thinking outside the box, having been introduced to new perspectives
------------------------------------------------------
The therapist is real good in listening to me, letting me speak out. But if I give too much space to my anxieties and don't try to explain them, I'll choose to shut down
------------------------------------------------------
my therapist's genuine care for me as a human being is apparent; there have been times where i couldn't pay and his trust that i would eventually and continued availability showed me that he believed in me.
------------------------------------------------------
Most helpful: compassionate demeanor, actually telling me how concerned she was for my well-being, having struggled with an ED herself a long time ago, appropriate boundaries
------------------------------------------------------
Most helpful is feeling like she understands what i am saying, as she has extensive experience
------------------------------------------------------
Most helpful aspect of my therapy is trust and honesty between my therapist and me, She truly cares for my well being
------------------------------------------------------
Making me feel safe was the most helpful. I've seen a lot of therapists over the years, and the one I'm referencing while answering these questions was the only one I ever trusted or that was able to make me feel safe. I felt more confident and happier just by seeing her, most of the time what was discussed in the sessions wasn't as important as just my being there. Which is what I needed at that time.
------------------------------------------------------
feeling validated and having my feelings acknowledged as my own unique experience without judgment
------------------------------------------------------
Most helpful is her experience and concern and challenging me to try new foods. Honesty about the severity of my condition is very important as well
------------------------------------------------------
Being encouraged and having my feelings validated.
------------------------------------------------------
The most helpful aspects of therapy are the feelings of support and encouragement given and the reassessment of
hope in the recovery process. Knowing that you are not alone is so important.

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

sometimes seeing things from a different perspective someone who listens
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

The rapport we had developed by working together so intensely for such a long time
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

having a good relationship with my therapist, her ability to not push too hard when talking about the trauma I experienced, her complete consistency when working with me, her genuine concern for helping me
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

someone who cared and who unconditionally advocated for me when I could not for myself. She let me go at my own pace, while encouraging me to find recovery.
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

empathetic feelings, re-mothering techniques, real life stories
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

People who I feel really 'get me' and understand how I tick, who use personal experience to form a bond without over sharing, who call me on my bullshit but are also gentle. People who talk back and share anecdotes/ analogies/ insight rather than forcing me to come up with everything; but who also ask intelligent questions that will help me come to conclusions on my own
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

I think sometimes my therapist has been too caring and too re-assuring in a way that possibly makes ED worse, in the sense that I want to stay sick to continue to receive her care.
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

I still have walls up that prevent me from opening up fully. I'm rarely completely honest and I need a therapist that will call me out on it.
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

I know I'm expecting too much but just once in my life I'd like someone to recognize that this isn't just a "turn off a button and let's go home happy" kind of thing, it's really complex and deeper than most therapists (I believe) realize.
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Although I felt confident in his continued presence even when I was still coming in to every appointment saying, "yes, but" - I have been totally bowled over by the cavalry he's called in to assist me in seeking finding appropriate treatment since I have started to open my appointment with Guess
what?! (new tool I'm adopting for my recovery toolbox!). s  I guess he respects that I'm an expert in my own life and screw-ups, which is why he didn't push solutions for which I KNEW I was unready. Now that I've finally come far enough out of the fog to notice how dark it is behind me, he is doing an enormous amount to respond, without judgment, to my rather specific (verbal) cries for help
--------------------------------------------

The most helpful aspect would be how he seems to pretty much understand me and doesn't overreact to things I say

I don't feel like ED has been addressed at all. If he doesn't want to deal with ED issues I wish I could be referred to someone who does.

the use of a cookie cutter [all ED patients tx'd in same way] mentality, a therapist saying she wished she was as smart as I was, a therapist telling me she went into LCSW bc she didn't get into med school [I'm a doctor]

She was of the school of thought that pretty much every issue was a result of some sort of horrible childhood experience; I tend to disagree, and regardless, I think it's important to learn new ways of coping now. So her focus on my past (despite my good childhood) was frustrating.

she just wants me to agree with her, I don't think she really cares or really thinks that I have a big problem

being talked down to or babied was the least helpful

Least helpful was when I was not being authentic

Least helpful is my own fault because I have really hidden the fact how sick I have gotten and therefore not gotten as intense therapy as I should have gotten.

Among the least helpful is the inability to relate to my condition

the least helpful have just been when I get in a place where nothing she says can get through to my mind....we try to work on things and talk....and its like I don't let it help me.
I am not good at talking to people I don't know. The therapy was very talk based. The therapist saw it as her role to listen but I had nothing to say!

------------------------------------------------------------------------

When I try to tell her something that I think is important, often she either misses the point, or focuses on some very small aspect that is beside the point or interrupts me before I can really get to the point... in this way I feel like my effort to be candid has been in vain and my concerns dismissed

------------------------------------------------------------------------

LEAST HELPFUL--The cost of therapy. I can't afford the treatment I need at the moment; it's very frustrating because I finally WANT to live in a way I never have. And I need more support than I'm able to afford and it just makes things much more difficult and precarious. I feel if i could have a month of seeing my Therapist 2-3 times a week and my nutritionist once a week for three months or so, I'd be in a much better place. Lack of money is a bitch.

------------------------------------------------------------------------
Research Question 7

What are the reasons participants did not seek psychotherapy or counseling?

Table 19. Reasons for Not Seeking Psychotherapy or Counseling

<table>
<thead>
<tr>
<th>Themes</th>
<th># Participants Reporting Theme</th>
<th># Themes Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question: “What are reasons for not seeking psychotherapy?” (n=61)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>Health insurance</td>
<td>25</td>
<td>31</td>
</tr>
<tr>
<td>Lack of resources</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Shame of others finding out or stigma of eating disorders</td>
<td>43</td>
<td>46</td>
</tr>
<tr>
<td>Seeking help is viewed as weakness</td>
<td>26</td>
<td>34</td>
</tr>
<tr>
<td>Fear</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>Disparaging view of therapeutic profession and health care profession</td>
<td>25</td>
<td>38</td>
</tr>
<tr>
<td>Eating Disorders recovery is not possible</td>
<td>28</td>
<td>35</td>
</tr>
<tr>
<td>Time, age, and duration of eating disorders</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>Thin as ideal</td>
<td>20</td>
<td>40</td>
</tr>
</tbody>
</table>
Cost

Cost primarily.
-----------------------------------------------
It is expensive and hard to schedule around
cost.
-----------------------------------------------
Money, bad insurance are the main reasons.
-----------------------------------------------
If it was free and readily available, I would definitely try.
-----------------------------------------------
I cannot afford therapy, and at my age now, I just quit trying
to find non existent help and gave up. it is what it is
-----------------------------------------------
No money.
-----------------------------------------------
I cannot afford it and my insurance will not cover it.
-----------------------------------------------
Lack of money and crappy insurance :-(
-----------------------------------------------
I'm worried it will cost too much and my insurance won't
cover it.
-----------------------------------------------
Financial and because up until now
-----------------------------------------------
no money or insurance
-----------------------------------------------
It is expensive and hard to schedule around work
-----------------------------------------------
I just don't see where it will be worth the investment of
money and time to go.
-----------------------------------------------
money, discomfort.
-----------------------------------------------
I do not have insurance or monetary means to pay for
psychotherapy
-----------------------------------------------
I am so much in debt because of my viscous binge/purge
cycles that I use the excuse of "not having the money" or "not
having insurance" to keep from seeking out help.
Health insurance

once I went to college I sought out support groups because that was what I could afford. The free counseling center at my school did not treat people with eating disorders (they referred them to psychologists, which I couldn't afford regularly without help from my parents, whose insurance I was under).

I cannot afford it and my insurance will not cover it.

My family does not have medical insurance so we have absolutely no money to send me to a recovery or treatment center.

Money, bad insurance are the main reasons.

Lack of money and crappy insurance :-(

Don't have health insurance.

I feel as though insurance companies don't cover a lot of costs associated with getting help for eating disorders.

I do not have insurance or monetary means to pay for psychotherapy

I have not had health insurance for year and I cannot be in a room with a stranger and expect to tell them about my flaws

Lack of resources

there are no ED therapists near me.

I am living on s.s.i and my only insurance is Medicaid. nobody accepts Medicaid.

I'm really scared to, there's only one ED therapist in my town too, and it's crazy expensive.

First of all, because I do not have the economical resources.
Seeking help is viewed as weakness

I am embarrassed to tell anyone of my problems. I don't want to be seen as weak.

I do not want help, I want to be able to take the help from my friends and family instead of doctors.

I see it as a personal failure to need that kind of help. I've always been seen as a strong person. The one that everybody else could lean on. I don't like being the "needy" person. My identity as being a strong person is very important to me. I do not wish to be perceived as being weak.

I always thought it was something I could overcome myself because I am a smart, rationale person.

I want to know that I can do it on my own. I have in the past, and was successful for six months so I know I can. I just need to do it.

Shame of others finding out or stigma of eating disorders

I do not want my family to know about my problem, and the most important reason is because my husband thinks that I am recovered from bulimia.

The fear I have is so deep and I feel so gross and disgusting. I know people would judge me and I already judge myself constantly :-(

Mostly because I am embarrassed and no matter what I don't think I can stop the eating habits I have.

Embarrassment and anxiety.

Due to my social status and family, I did choose to keep it to myself.

I am embarrassed by the thought of getting help. I am afraid to try medications but recognize that it is probably necessary. I have a very high-stress and demanding job and am afraid to give up some of my high-strung tendencies.
And I am so ashamed over my bizarre eating habits that I do not know who I would want to "confess all." to.

It is important for me to maintain the illusion of having my life in order. I'm also in college and applying to PhD programs, so now just doesn't seem like a good time.

I'm so ashamed of my problem, because I understand that the root of my overeating is just simple laziness or blindness in realizing that I have a disorder.

Also, I don't want family/friends to find out, especially my Mum as she is a Mental Health Nurse herself.

Disparaging view of therapeutic profession and health care professionals

I don't like going to therapists. I've had them accuse my father of sexually abusing me as a child and my mother making an infection in my leg worse when I was a teenager. They've told me I was a drug seeker even though I never ask for pain meds and haven't been on anything for 5 years and live with a very painful disease.

Because psychotherapists are idiots of epic proportions. They have evil intentions. They want me to be fat and disgusting and to hate myself. They have no clue how great it is to be skinny.

I have spoken to several medical doctors concerning my ed related health issues only to be told "you don't have that. that is a teen disorder". I just say to myself "yes, I was born this age" and roll my eyes. Programs that give scholarships, or places such as mercy ministry, has an age limit and I cannot get in.

Friends and family have a very negative perception of psychotherapy.

Most psychotherapists are complete idiots about eating disorders. They tell you to talk about your feelings but nobody wants to hear you whine about your feelings. Psychotherapists just try to fatten you up and they don't care if that makes you hate yourself. Mostly they are clueless. One therapist asked me, "Do you throw up before or after you eat?" Another one said she wanted to figure out what's at
the bottom of my bulimia. What the hell kind of question is that?

I don't think it will help. Seems like a waste.

Because I picture it being long, drawn out, controlled by other people, where I will be made to gain a lot of weight and forced to do a lot of things that I don't want to do and treated like I am 5 and have to be "re-parented" and "learn how to eat again", and that nothing I do will be right and everything about my life will have to be fixed and overhauled. That's way too much to handle, and I can't imagine revealing certain details of my life to some stranger!!

Don't see how they can really help. I have a hard time expressing myself, am very shy, self conscious. Tried help once for Anxiety, medications help most. Talking didn't do anything.

Though I would like to actually see a therapist, many have testified to their inefficacy's, or that therapists have no idea about eating disorders, GPs are condescending etc.

i have spoken to several medical doctors concerning my ed related health issues only to be told "you don't have that. that is a teen disorder". i just say to myself "yes, i was born this age" and roll my eyes. programs that give scholarships, or places such as mercy ministry

I do not think it will work and I do not look anorexic right now.

I was subjected to some unwilling family therapy following a long hospital stay as a teen that cemented my view of therapists as devils incarnate

Thin as ideal

I am not thin enough. I am not sick enough. Even if I could get thin enough I would not have enough money to see anyone. And no one can really help me.

When I had a period of over-exercising and meals restrictions I thought it's normal, I thought I did it for being healthy and beauty.
I don't feel my eating problem is severe enough to warrant therapy, most of the time I don't think I have a problem and feel that if I did seek help I'd be laughed at because my weight isn't low enough to be considered ill.

No one would love me if I was fat, and I sure wouldn't be able to stand me if I was fat. Recovery means people are trying to make you fat like them. One part of me knows I have a problem, but if you think about it, EVERYONE has a problem. And I'd rather have a problem being skinny than have a problem being fat like most other people. I really cannot eat as much as other people. I've heard people claim they are on a diet and they are eating 1200 calories! That's about what I eat in an entire week. The experience of eating disorder recovery would be terrible for me, and all it would do is make it take more time to disappear completely.

Sometimes I imagine myself “recovered” but plump, wearing mum-pants and not giving a shit.

I have not sought out psychotherapy because I neither want nor need it. Fat people don't go to therapy and I believe they have a much larger (no pun intended) problem than I do. Someone telling me I'm too thin and need to eat and trying to make me eat; that will just make me eat less. People tell you that you are too thin because they are jealous and want to make you fat like them. I'm not too thin, there is no such thing as too thin. I have fat everywhere on me but at least I'm trying to do something about that fat. Fat people need psychotherapy, not me.

Time, age, and duration of eating disorders

I'm 50 years old, have read all sorts of books on other ED's but they never apply directly to mine. So far all I found are a couple of article on Purging disorder

I have had my eating disorder for 8 years, and within these 8 years I have never gone one day without bingeing and purging. To go even one day where I can eat balanced meals and not feel guilty or anxious is a accomplishment for me.

I received psychotherapy treatment when I was first diagnosed 7 years ago for 4 years. Since then, I have slipped a little back into my old habits. I am not seeking out help because I know what my triggers are, and I know how to get
better. The ball is in my court, and I currently do not have the strength to fight back.

My eating disorder is based on control and giving my recovery to someone else to help aid me feels like I'm being 'babied' and controlled by others. I am not one who takes advice and criticism lightly. I am also not one who shares a lot of feelings because for the last 8 years this has been my outlet and my secret and sharing feelings about that is hard and difficult to explain.

---

*Eating Disorders recovery is not possible*

I am embarrassed and no matter what I don't think I can stop the eating habits I have.

No reason really. It just takes effort that I don't want to make.

I don't think about that because I don't see that as something I would be willing to do. I feel like I eat and do the only way I know how and don't think I could learn a new way.

I imagine recovering from disordered eating to be near impossible.

i will never be able to recover. i was 12 years old when a specific comment was made, and i cannot forget that. i may stop one ed behavior, but replace it with another. it is all i know. i will never recover. i don't have a clue what "normal" means.
Research Question 8

Is there a difference in how women who did not receive treatment define recovery from eating disorders than those who did receive treatment?

Table 20. Differences in How Participants Describe Eating Disorders Recovery

<table>
<thead>
<tr>
<th>Themes</th>
<th># Participants Reporting Theme</th>
<th># Themes Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time involved</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>Fear of feelings associated with eating disorders recovery</td>
<td>29</td>
<td>33</td>
</tr>
<tr>
<td>Change is not possible or not desired</td>
<td>20</td>
<td>44</td>
</tr>
<tr>
<td>Hope for change</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Eating disorders symptoms are valued</td>
<td>39</td>
<td>48</td>
</tr>
<tr>
<td>Weight, body image, normal eating</td>
<td>19</td>
<td>24</td>
</tr>
</tbody>
</table>

Group 0

(n=62)

| Time involved                                                          | 40                              | 42                 |
| Hope for change                                                        | 34                              | 41                 |

Group 1

(n=89)
Time involved

Group 0

I don't think I'll have even try to make a full recovery. I've been bouncing back and forth for 20 years now.
---------------------------------------------
I can't. I have been this way for 21 years and don't see the light at the end of the tunnel.
---------------------------------------------
I have had anorexia for nearly eleven years; I am 23 now. I used to be able to eat and not feel guilty, I guess knew that I had to. I can no longer do that.
---------------------------------------------
I have been dealing with this for years and I don't want it to get any worse. I do not want to be dealing with this in twenty years still.
---------------------------------------------
Recovery is not a destination it is a journey. I was first diagnosed with anorexia nervosa 7 years ago and have not had a day since where I have had to combat thoughts.
---------------------------------------------
I think recovering will be scary because I feel like I've had this mind set since I was a little girl, so I feel like it is deep with in me.
---------------------------------------------
I have had my eating disorder for 8 years, and within these 8 years I have never gone one day without bingeing and purging.

Group 1

I've been working hard every day for six months on this though, and I thought the behaviors would be completely gone by now and I'd just be working on the fears about weight and stuff.
---------------------------------------------
I had nine months without symptoms after having 15 years of heavy bulimia (vomiting hundred times a day from age 15 to 31) and anorexia at the same time. I also have 19 month sober from alcohol and crack addiction.

I was formally diagnosed with BN in 1988 at the age of 12, just a few years after my initial mood disorder dx

I really believe that recovery becomes harder and harder to achieve the longer you have struggled with an eating disorder. I have been struggling for over 15 years now. If I had known 15 years ago that it would still be this much of a struggle maybe I would have put more effort into trying to recover at a young age

_Eating disorders symptoms are valued_

Group 0

Purging is relatively straightforward and a bit of a ritual developed over the long time spent in the bathroom.

Purging at home is a comfort, almost a luxury I can look forward to.

Privacy, a cup, antacids, containers and other technicalities. I even time myself sometimes to make sure I hit the 50 minute mark. I judge/analyze my vomit (yes. I really do) obsessively and with the eye of an experienced purger

Memory of purging is comfort. In knowing that I can purge quite well, I can therefore binge. Momentary amnesia of all the mental/physical repercussions wrought on the human body. Binges are completely impulsive but too comfortingly FAMILIAR.

I will never forget how delectable food is. And that I can eat and eat and eat and can get rid of it all, provided it happens under my “ideal binge/purge condition”.

I dream to be recovered and that's definitely what I want but I struggle with feeling that I am damned if I do and damned if I don't; if I eat, I'm going to get fat and I can't deal with that, and if I don't eat then I'm letting my boyfriend down and I berate myself whichever way I turn. All I see for now is that there's a long way to go.
Change is not possible or not desired

Group 0

I honestly don't think it will happen to "recover", I will probably just learn to manage my disordered eating better and cause less harm. I do not trust someone else to understand what I am going through and refuse to give up Not resort to food as an emotional crutch on the days I feel like a failure or useless or trapped or anxious or pissed as hell or bored, to stop bingeing and purging for no reason, I can’t see it.

I don't imagine anyone can really help me because this is a wound that is too deep.

It's hard to imagine recovery. I feel I will be stuck in a pattern of eating disorders until one of them kills me.

I don't feel like recovery would be easy or even possible.

I think that recovery would be very hard for me to learn to cope with life without my ed and I have no idea what its like any more to eat normally.

Group 1

In my mind an eating disorder isn't something you can ever recover from fully so I don't see how I will get to a point of acceptance and even happiness with my body

I don't think it will ever happen...it always comes back, even when I'm "recovered." I'm "recovered" now and I still b/p when things are very stressful, although now I try smoking first to calm down.

Hope for change

Group 0

I know that it will be hard but it's something that I so want to achieve and be able to say that I overcame that I would be willing to try my hardest.
just praying it will be successful

If I achieve a significant amount of recovery (in terms of achieving a healthy sense of self, cessation of eating disorder behaviors, and accepting myself as more than my body, then I believe I will find peace in my life

It is something that I have the power to overcome, but I have to want to do that. I have to make a choice every day to live in recovery.

I recently was able to go a few weeks going twice a week, once on Tuesday and once on Friday--this was great. I also started going for an hour and half on Friday--this has greatly improved our sessions; it gives me a little time to really settle in and not be so on guard.

It has been a long process but I'm recovered now for the most part.

I imagine it will be very challenging but worth it in the end! I know I'll have to deal with underlying trauma and with my anxiety but I'm prepared

As freedom from food. I will have time for everything else life has to offer.

I imagine it is going to be very challenging and emotionally laden.

Group 1

I hope to some day recover-

freedom...freedom of obsessing and confidence to try new things. no moodiness, to laugh at every opportunity... to have child.. to be in love again with my partner.. to love me.. to take care of parents... to do something with my life...to be...

don't honestly see any way around developing into a person that other people want to know. I've started wanting to know myself.

Eating disorders are incompatible with success. I want to be successful and be free not only of the physical manifestations of an eating disorder but also the thoughts, feelings,
insecurities, and obsessions that continually hold me back from being the successful person that I could be.

I see recovery as a time when I can love myself unconditionally and see myself as deserving of happiness.

Learning to accept yourself, flaws and all is key in treatment and a huge step in finding you.

I imagine recovery as...waking up content...thinking about the day...in a positive way...instead of obsessing.

I imagine recovery is a beautiful thing, which I want SO much. I think recovery is living a life where food and body image does not control me. I very much look forward to that day.

Eating disorder recovery is like running in a marathon that seems to be a million miles long! Your life and freedom from the darkness and suppression of ED's hold lay at the finish line. Similar to the challenges real runners must face in a race of great length and intensity, fighting ED requires an enormous amount of both physical and mental energy. A consistent supply is necessary in order to keep a pace going. In recovery feeling motivated and supported serves as fuel, adding power and strength to the fight.

I imagine eating disorder recovery will be waking up being okay with myself. Being able to say, "I matter", "Oops! I made a mistake.", "It's good enough" and "I'm lovable". Living instead of hiding. Not being afraid of people or change. Accepting of myself. I imagine a 'SMILE'!

I believe that eating disorder recovery is 100% possible. My therapist and I have both acknowledged that I am recovered. I have fully accepted myself, my new body, the new number on the scale, and I am not afraid. I am an advocate and speak out about body image and eating disorder awareness, prevention, and recovery in my work and in my free time. It is possible. There is hope. I am proof. :)

Fear of feelings associated with eating disorders recovery

Group 0

The thought of it is somewhat horrifying I can't imagine going through it. I also am skeptical as to how effective it would be.

I want to recover, but at the same time I am terrified of relinquishing control.

It will be very uncomfortable, and I imagine lots of guilt and suicidal feelings will happen.

The idea of the experience scares me to death.

Very difficult. I am afraid of feeling hopeless; that this disease will just be so overwhelming that I'll never have a future that is bright.

Group 1

Scary, lonely, feeling bloated all the time, not being able to cope, feeling overwhelmed and angry and frustrated. People just assuming that you're okay when you don't feel very good.

Feeling fat and big all the time. Being uncomfortable. Having clothes feel too tight. Being scared to step on the scales.

I hope to accept myself as a person without hurting myself when coping with certain feelings.

Scary, intimidating, life changing,

I envision recovery to be emotionally painful and physically exhausting, however, when I am in the right mindset, I can understand that it will be worth it. Right now, recovery has me feeling lost-like I don't know who I am or what to do without the eating disorder.

It feels overwhelming how intensely painful and anxiety laden dealing with a flood of backed up emotions is. I picture myself trying to stay afloat as waves and waves of stormy feelings continually crash over my drowning head. Much of recovery is associated with negativity and hardship.
Eating disorders as regulator

Group 0

When I am stressed out the urge is very strong because it is my coping mechanism in life.

I want to stop and I will stop but I will have to remember that it is a part of me that I cannot ignore and will always deal with. I stopped cold turkey for six years and now it is back rearing its ugly head because I’ve been going through 'stress full' times. So I think about doing it constantly but I don't want to and I haven't yet, but all the feelings all the thoughts are there.

Group 1

To be happy with myself as a person, and not to base my judgment of myself on the mirror or scales.

I expect the best I can truly expect will be an ability to cope better with the thoughts I have to avoid bulimic behaviors.

Being able to eat a normal intake without constant strong emotional reactions. I would like to be able to make a decision about food without feeling anxiety about it, over thinking it, regretting it, crying, or feeling physical discomfort.

I would like to be able to compartmentalize food and my emotions separately and have one not affect the other.

Also, I will have better control of the voices that tell me to act on the behaviors that cause me to have an eating disorder.

I would really like to be able to eat food again without feeling so freaking anxious. I even feel anxious just thinking about it.

i first of all imagine silence in my thoughts. No counting calories, no thinking about burning them, no feeling fat, no seeing myself as a fat girl, no need to fade away, no hiding so people won't see me eat (I don't want them to, because that only make me think they'll get more reason to think I’m fat/ugly),
I'm going to eat or how people will judge me or looking up the menu beforehand so I can calculate calories. It would involve being able to gain a few pounds and not subsequently feeling like my worth as a human being has plummed. It would involve being able to feel beautiful in a size 6 (I am now a 0-2). It would involve being able to feel beautiful...period.

Eating disorders recovery is being happy with who you are regardless of what you weigh or how you look. Being confident in yourself and not always trying to be perfect. More easy-going, and don’t care as much what others think of you.

I often wonder if once the depression is lessened if the eating disorder will just fade away.

_Eating disorders recovery as a fluid experience_

Group 0

I hope it will turn out positively in the end but I know it will require time and lots of hard work!

I imagine the eating disorder recovery will take time and be a long process for me because I have so many issues I need to work on and I need to sort out.

It will be a challenge. There will be ups and downs along the way. Recovery is an ongoing, life-long process, which I expect will be a journey that will have several setbacks in it, as well as many times that will help me to move forward and on with my life.

Recovery time is different for each individual. Every life story comes with its own variables, issues and struggles.

What I imagine will be the result of my experience of eating disorders recovery will be a healthy, fun, and fulfilling life, without the symptoms, thoughts, or worries of an eating disorder.
I imagine it to be a gradual decrease in the loudness of the "eating disorder voice" in my head and in the amount of constant focus and effort it takes to stay out of unhealthy behaviors. I imagine that when I'm "recovered" So far, I've noticed it to be a change in what my "good days" and "bad days" are.

This is a lot harder and slower than I thought it would be! (it looked to me in the beginning like this was giving up and taking the easy way out, compared to continuing to "be in control," but recovery is actually a lot harder than continuing in the disorder!!!!)

I struggle between denial and acceptance and I need to be pushed into understanding the gravity of my situation. I imagine recovery will entail simply being happy.

I don't think there is a right or wrong answer because its different for everyone, but I do think there is a recovery. I think recovery is a time in a persons life where you find yourself, who you really are. Its a time when you don't have to like everything about yourself, but its a time where you can accept yourself and not feel the need or desire to be someone different.

Being weighed...This has never been helpful to me; I understand why it is sometimes necessary, but to me it just puts the focus back on weight as being an indicator as level of sickness. I'm not sure of the best solution for this. but I just get anxious before and then the whole session is dealing with that of sorts?

It's also a point where you can eat in front of people, look in the mirror, go outside in a bikini that flaunts the figure you have and be ok with it. Ex: You can go to your best friend's bridal shower.. Eating the morning of and day before not having a fear you will gain 15 pounds.. When you go, you eat what is there, not because its low fat or diet food but because you need to eat, you like the food etc..

I see ED recovery as process whose length depends on the unique individual involved.
It is a learning experience. It is not a smooth road. There are always bumps along the way. It can take a very long time to let go of the eating disorder.

I think it is a nonlinear process. I know that full recovery is possible because I've seen it happen.

I believe ED recovery has to do with not only a decrease in symptoms, but above all a decrease in the need to revert to ED thoughts. In other words, the ED is not the primary goal or function in life.

A life long process. Like an alcoholic, someone suffering from an eating disorder will always have to work on being healthy and not falling back into old patterns.

I consider recovery to be a continuum. do I still have major body image issues? yes. do I still restrict some? yes. but it is much more balanced. I can go out to eat and I don't have to starve myself for days or throw up or exercise to deal with it. everything evens itself out and I have learned to trust my body so my fears aren't holding me back from experiencing life. I may not be thrilled with my body, but it no longer determines whether I have a good day or a bad day or even what i eat or don't eat. I would say I am about 90% recovered and that is good enough for me right now.

I imagine recovery to be a life long journey. A self discovery, really. I understand for me I stopped growing emotionally the same time I developed an eating disorder, so for me it is about appealing to my inner child and trying to help discover who I am. I do not know who I am currently. I know there will be setbacks.

a long, tough, but rewarding journey. learning to love yourself, find hope in your future without your eating disorder. managing depression, anxiety, and any other contributing/coexisting disorders. feeling free from the obsession about food. I’m definitely not there yet, but I’m in the process. hopefully some day I will have more "ups" than "downs' and won't just feel like I’m putting a Band-Aid over the symptoms or trading one addiction for another (a common pattern for me).

I wish it was easy, but it was the hardest thing I ever did. There was a lot of tears. There were many times I
contemplated throwing in the towel. But something in me kept me chugging along. Eating disorder recovery needs to address the whole person. Physically, mentally, and spiritually. All three has to be taken care of.

_Weight, body, eating, and food_

**Group 0**

I think it will make me a more confident person if I am able to have self control and also if I mess up and eat bad food still have the self control not to purge.

Recovery to me, means being gaining weight. Gaining weight means being fat. I would rather be exhausted than fat, anxious than fat, and I would probably even rather be dead than fat. What's the point in living if you are fat, anyways?

My idea of recovery is to stop bingeing and purging and to starve myself to death.

At this point, I am not entirely sure. Filling out the survey was a good start in that it helped me to understand the lack of confidence I have and anxiety that is brought on by 'unhealthy' foods, even in moderation.

To go even one day where I can eat balanced meals and not feel guilty or anxious is a accomplishment for me.

**Group 1**

To me that means not focusing, worrying, obsessing about food and weight. It also means that I an eat a meal without instantly feeling that I need to purge.

Complete recovery would be to not think about food and weight anymore.

I won't have the anxiety about weight and the panic sometimes when faced with food situations.

It's been an increase in my physical health and a decrease in the mental fogginess, an increase in the frequency of "healthy meals" at decent times, and a decrease in the frequency of bingeing and purging.
Maybe freedom from food/exercise/weight thoughts. Not caring about the fat/calorie content of what you're eating or how many calories your burning, what your body looks like. I can't imagine not giving thought to those things when I'm sitting down to a meal.

I hope for it to be complete freedom from calorie counting, weight concern and bingeing and purging, and the ability to enjoy a truly fulfilling life without the barriers imposed by an eating disorder.

I would imagine that it is going through the day and enjoying what you are doing without having the constant chatter in your head that is talking about calories, size, weight, etc...

I believe recovery is being about to love and accept my body, to eat when I'm hungry and stop when I'm full. It is being able to eat a bowl of ice cream because it sounds good and not obsess about it's effect on my weight or feel guilty.

I also thought that my body looked ok and had started working out at a gym to tone up and was feeling ok about myself. So I guess recovery would be to accept my body shape and it's flaws and be able to eat what I want, when I want it, without fear of gaining weight.

I imagine just being over this-- eating like a "normal" person, enjoying foods, being thin/attractive, being fed enough to not be in too much of a fog to do my work, having it not take over my life, not owning a closet full of clothes to fit a 50 lb weight range, not having to make excuses...

I experience recovery as having a healthy relationship with food, eating when I'm hungry and stopping when I'm full and not being obsessed with over and under eating.

Being able to not constantly think about my body as fat. Being able to try new foods without worrying about calories. Not feeling guilty about eating. Being able to exercise without overdoing it.
Conclusion

The results described in this chapter were produced using standard statistical analysis techniques as described by Creswell (2009), Pallant (2007) and Thayer et al. (2007). In addition to the research questions that were developed to test the overall hypothesis, additional analyses were conducted to thoroughly explore the data set population of women secured through this study. The primary finding from this study was that eating disorders recovery self efficacy was higher for women who have received or are currently receiving psychotherapy. Additionally, key findings described in this chapter related to dimensions of selfobject needs in eating disorders and participants’ subjective understanding of eating disorders recovery. Interpretation of the results described in this chapter, including implications for the field of social work and recommendations for future research, will be discussed in detail in the next chapter.
CHAPTER V

DISCUSSION AND CONCLUSION

There are many ways and means of practicing psychotherapy.
All that lead to recovery are good.
~Sigmund Freud

Introduction

This exploratory study provided some interesting results describing potential predictive factors in recovery from eating disorders, the therapeutic alliance, and selfobject functions. Data generated from the internet survey resulted in intriguing findings related to the overarching research question: What is the relationship between an individual’s ability to have her selfobject needs met, the therapeutic alliance, and eating disorder recovery? There were also notable emergent themes within the qualitative data captured from open ended questions describing subjective, relational and behavioral narratives within this sample of individuals dealing with eating disorders, and eating disorders recovery. Many of the psychometric findings and many narrative findings are consistent with the primary theoretical frame of self psychology. Other findings generate more general questions yet to be answered about this population of individuals.
In this chapter, the findings will be discussed and presented regarding the initial quantitative and qualitative research questions. These findings include: the relationship between an individual’s ability to have her selfobject needs met (as measured on SONI), therapeutic alliance (as measured on HAq-II), and eating disorder recovery (as measured on EDRSQ); the therapeutic alliance and eating disorders recovery; participants’ subjective view of the therapeutic relationship; and the impact of the therapeutic alliance on selfobject needs and eating disorders recovery.

Further, there will be sections addressing the limitations of this research study, as well as implications and recommendations for future research. Interestingly, ancillary qualitative information was collected from a hard to reach population. Individuals dealing with eating disorders can be prone to factors related to social desirability, making the internet an ideal environment for participants to answer questions openly and honestly. The results presented in Chapter IV related to the overarching research hypothesis in this study: High scores on selfobject needs inventory scales (SONI) and helping alliance scale (HAq-II) will be significantly related to high scores in eating disorder recovery self-efficacy questionnaire (EDRSQ). Substantive significance of association between the variables, as well as statistical significance of regression models presented in Chapter IV, will be discussed. Substantive significance involves the real-world relevance of the statistical findings (Miller, 2005; Miller & Rodgers, 2008). With regards to the results of this study, substantive significance involves real world relevance in the context of eating disorders treatment.

Overall, the psychometric scores suggest that there is a relationship between an individual’s ability to have her selfobject needs attended to, the therapeutic relationship,
and eating disorders recovery. These findings will be discussed in greater detail in the following sections. The findings also suggest support for theoretical assertions of eating disorders being linked to selfobject deficits and self structure weaknesses (Connors, 2011; Geist, 1989; Goodsitt, 1985; Sands, 2003). Statistical analysis of Group 1 scores regarding the therapeutic relationship being a positive predictive factor of eating disorders recovery was also supported and consistent with previous research (Herzog et al., 1999; Kordy et al., 2002; Vanderlinden et al., 2007; Zaitsoff et al., 2008). Further, t tests calculated between Groups 1 and 2 showed that Group 1 consistently scored higher on EDRSQ. A closer look at the EDRSQ scores for both Groups 1 and 2 support previous outcome studies in which body image symptoms are last to remit (Clausen, 2004).

Content analysis of website survey open ended text questions produced substantiating and enriching findings. Subjective reports from both groups provided a myriad of information and insights about eating disorders recovery. Examination of participants’ responses to open ended questions found the therapeutic relationship to be an integral component of eating disorders recovery. Overall and not surprisingly, the quantitative and qualitative results suggested that women who have had or are currently in psychotherapy show higher eating disorders recovery self efficacy, increased hope, and deeper levels of motivation for change.

The findings and the original research conception are centrally situated in the clinical work of this researcher. During the late 1990s, when this researcher began training in the field, literature was heavily populated with evidence based support for cognitive behavioral techniques (Mitchell & Peterson, 1997; Ricca, Mannucci, Zucchi,
Rotella, & Faravelli, 2000) in the treatment of eating disorders. This researcher observed during training that cognitive behavioral techniques and interventions, although useful for some, did not appear to be useful for all. This researcher began to notice a trend in eating disorders populations. Some techniques and interventions implemented did not appear to have the same value as the therapeutic relationship that was formed between patient and therapist. The inception of similar ideas became a focus and persistent curiosity for this researcher: How is it that some patients recover and others appear to be caught in a battle between eating disorders symptoms, eating disorders as identity, and inability to regulate one’s self without using maladaptive coping techniques? Does the therapeutic relationship mediate or somehow shore up the selves of eating disordered patients? If so, in what ways? The purpose of this study was to examine and understand the relationship between selfobject needs, the therapeutic alliance and recovery from eating disorders. The intent was to be able to describe the psychodynamics of selfobject needs met within the therapeutic alliance between an eating disorder patient and a therapist.

Discussion of Results

The findings pertaining to the relationship between an individual’s ability to have her selfobject needs met, therapeutic alliance, and eating disorder recovery were thought provoking, showing multiple statistical outcomes which support ideas of selfobjects needs and the therapeutic relationship being factors potentially contributing to eating disorders recovery. There was a statistical significance in several of the multiple linear regression models conducted. SONI avoidance of mirroring significantly predicted the EDRSQ scale. As discussed in earlier sections of this paper, an overall hunger for
selfobject needs is associated with the potential development of psychological maladjustment. This is also true for avoidance of selfobject needs. Interestingly, the authors of the SONI reported similar results during the SONI instrument construction. Banai et al. (2005) found that avoidance of selfobject needs was significantly related to avoidant attachment, various manifestations of narcissistic personality (self-admiration, arrogance, and entitlement), and signs of emotional maladjustment, including anxiety, depression, and feelings of hostility toward others. However, avoidance of selfobject needs was not significantly related to scores on measures of self-esteem, cognitive interference, self-discrepancies, self-differentiation, and problems in affect regulation following failure. Moreover, variations in self-esteem failed to explain the association between avoidance of selfobject needs and emotional maladjustment, implying that an avoidant stance may contribute to anxiety, depression, and hostility without necessarily involving a lack of self-esteem. These findings, during the SONI construction, provide only partial support for Kohut’s (1971) ideas about avoidance of selfobject needs as a pathogenic agent. On the one hand, the findings showed that an avoidant stance is related to problems in interpersonal functioning and mental health and to the development of a narcissistic personality. On the other hand, they also suggested that these avoidant defenses were at least partially successful, protecting individuals from the conscious experience of low self-esteem and from cognitive interference and helping to maintain a sense of self-cohesion (Banai et al., 2005).

In the current study, as operationalized by the SONI (Banai et al. 2005), elevated scores on the avoidance of selfobject needs for mirroring were positively associated with EDRSQ total and both subscales measuring normal eating self efficacy and body image.
self efficacy. Of note, from a theoretical perspective it is not clear how to interpret avoidance of selfobject needs of mirroring as a potential predictive factor in eating disorders recovery, especially given that the authors of the SONI seemed to face similar outcome findings regarding avoidance of selfobject needs. Likewise, the SONI has not been evaluated outside of the original studies completed during its construction.

This researcher fully expected that SONI scores of participants, for hunger towards selfobject functions of mirroring, twinship and idealization, would be consistent with self psychology constructs. Similarly, this researcher expected that SONI scores would accurately reflect theoretical assertions made regarding selfobject functioning and eating disorders.

The results regarding avoidance of selfobject mirroring being positively related to eating disorders recovery were not anticipated. For example, using Kohut’s idea of inability to satiate the self, Goodsitt (1983) describes eating disordered patients’ relationship to their bodies and sensations of hunger as often being suppressed or ignored, until ultimately patients give in to the extreme need to eat. The eating disordered patient eats without recognition or response to bodily sensations of fullness, thus illuminating the hallmark of eating disorders: a profound inability to self regulate (Goodsitt, 1983). Individuals with eating disorders are attempting to compensate for the internal psychological deficits and an inability to maintain a sense of vitality and internal affective regulation. Following these theoretical tenets, SONI scores and ‘super’ scale scores of hunger for mirroring, idealization and twinship were expected to be predictive of positive therapeutic relationship and eating disorders recovery.
Dimensions of Selfobject Needs and Eating Disorders

Qualitative results did, however, support previous assertions that eating disorder symptoms are an attempt to restore or fill in what is structurally missing (Bruch, 1978; deGroot & Rodin, 1994; Geist, 1985; Goodsitt, 1985). The findings in this study found that 56% of participants (N=151) made statements consistent with concepts surrounding eating disorders and selfobject deficits. For example, participants stated:

[therapy was] unhelpful for the most part, but I think that was in large part because I wasn't ready to get well at the time. I was so sick that it was impossible to get underneath the immediate problem.

[regarding therapy] I felt that I should be trying to work on the parts of my past that still haunt me and drive me to not being able to cope with the world.

I hit rock bottom and wanted to get better, so I was giving it my all in my recovery. We worked on many coping strategies for when I felt an urge to engage in an eating disorder behavior.

The work with my therapist has been long. It's taken me a lot of time to trust her but she said she doesn't mind because I need to feel comfortable.

most helpful was when the therapist believed in you, even in times you were feeling shitty and couldn't believe in yourself and when they treated you as an individual rather than blanketing stereotypes..

I imagine if I go in for a medical exam, nothing will be wrong with me and I will be embarrassed that I had been poked and prodded with the examiner knowing I'm screwy in the head and finding nothing wrong with my body.

I will be very anxious and I don't imagine anyone can really help me because this is a wound that is too deep.

I think that recovery would be very hard for me to learn to cope with life with out ed and I have no idea what its like any
more to eat normally. I think that I would give up trying to recover.

Similarly, 82% (N=151) of participants reported eating disorders symptoms provided comfort, self esteem, affect regulation, and control. Participants said:

I imagine recovery is a beautiful thing, which I want SO much. I think recovery is living a life where food and body image does not control me. I very much look forward to that day.

[regarding recovery] when I can stand on my own two feet without holding on to an eating disorder and a poor self image as an excuse for not being good enough. I imagine recovery to be complete freedom from the chains that have bound me and that I have become so dependent on.

I want to recover, but at the same time I am terrified of relinquishing control. The moment I let go of control is the moment I fail and gain weight.

My eating disorder has done what self injury, what drugs, what prescriptions have NEVER done for me -- given me more control over my life than any other way I've known. I don't know how to give up that control. I believe recovering from an eating disorder is allowing myself to give up that control, then take it back slowly and in a healthy manner

I can imagine that it will be very hard and that I will have to face feelings I have been trying to avoid my whole life.

More generally, eating disorders symptoms are related both to emotional regulation (idealizing selfobject functions) and to self-esteem regulation (mirroring selfobject functions). Although these results are far from definitive, they are consistent with the interpretation that eating disorders symptoms can regulate emotions and self-esteem. In other words, it is probable that eating disorders help individuals cope with negative, painful emotions; and can be a source of self esteem and affect regulation.
Several participants communicated insight into eating disorders being a coping mechanism for painful emotions with statements such as:

This disorder has become rather ingrained in my behavior and thought patterns and undoing that will be no easy task.

While I no longer give in to the ED behaviors I still have many emotional ties and struggle to fight the voice in my head. It is hard and frustrating. Some days I don't think about it but most days I still have thoughts.

The results of this study also offered substantial evidence that supported Kohut’s (1971) central tenet regarding selfobjects. He says, “some of the most intense narcissistic experiences relate to objects; objects, that is, which are either used in service of the self and the maintenance of its instinctual investment, or objects which are themselves experienced as part of the self…” (p. xiv). Or as participants stated:

I don't think [recovery] will ever happen...it always comes back, even when I'm "recovered." ...I'm "recovered" now and I still b/p when things are very stressful.

When I imagine ed recovery, I imagine silence in my thoughts. No counting calories, no thinking about burning them, no feeling fat, no seeing myself as a fat girl, no need to fade away, no hiding so people won't see me eat (I don't want them to, because that only make me think they'll get more reason to think I'm fat/ugly), enjoying exercising, no 'list' of do's and don’t when it come to food,... so many things. And maybe after a great deal of those things are changed, maybe that's when I want to gain weight and can start to enjoy food again.

Sometimes I wonder if I will ever truly escape this monster.

Another important distinction, Kohut did not consider narcissism to be necessarily pathological but at times was an appropriate defense mechanism or reaction to unmet selfobject needs (1971, p. 481). Likewise, Wolf (1988) states, “Along with food and
oxygen, every human being requires age appropriate selfobject experiences from infancy to the end of life” (p. 11).

The results of this study also suggest that both groups at some point in time, suffered from absence of empathic attunement to needs for soothing, partnering, and sustaining functions or response to selfobject needs. Also notable are the results of qualitative data from both groups which strongly supported Bruch’s (1978) assertion regarding lack of responsiveness to one’s needs. She aptly stated, “[the lack of responsiveness] can result in disturbed psychological functioning, severe disturbances in the way one sees, oneself, misinterpretation of internal and external stimuli, and a paralyzing sense of helplessness” (p. 18). Evidence of severe disturbances and misinterpretation of internal and external stimuli are striking in participants’ statements such as:

Recovery to me, means gaining weight. Gaining weight means being fat. I would rather be exhausted than fat, anxious than fat, and I would probably even rather be dead than fat. What's the point in living if you are fat? No one would love me if I was fat, and I sure wouldn't be able to stand me if I was fat. Recovery means people are trying to make you fat like them. I'd rather have a problem being skinny than have a problem being fat like most other people.

[regarding desired therapist qualities] someone who can teach me how to be healthy, something that I never learned from my parents. Lose weight.

Learn to let go and not be angry at my family, past or even myself.

I honestly don't think it will happen to recover, I will probably just learn to manage my disordered eating better and cause less harm.

I do not trust someone else to understand what I am going through and refuse to give up.
From these statements alone, it appears clear that as Kohut (1971) states, “failures in empathic mirroring and idealizing and appropriate transitional experiences during childhood create deficiencies that interrupt development of the self” (p. 166).

Hopelessness, Helplessness and Ego Syntonic Symptoms

Not unexpected, but jarring nonetheless, were assertions made by participants in Group 0 when asked how they imagined eating disorders recovery:

I will never be able to recover. I was 12 years old when a specific comment was made, and I cannot forget that. I may stop one ed behavior, but replace it with another. it is all I know. I will never recover.

Terrifying. Unimaginable. Requires that I "reprogram" all kinds of fundamental beliefs (e.g., that no achievement is as important as thinness, that being fat is a moral failing, etc.) and very ingrained behavior.

I want to eat very badly, but it is like there is something stopping me. I am dying.

I don't think about [recovery] because I don't see that as something I would be willing to do. I feel like I eat and do the only way I know how and don't think I could learn a new way.

My idea of recovery is to stop bingeing and purging and to starve myself to death.

These statements reveal a potential link between unconscious factors of unmet selfobject needs and the resultant solidified eating disorders attitude, behaviors, and thoughts. These statements are not only lacking hope, but they appear to be clear examples of the deleterious effects of eating disorders on both overall functioning and general well being.
Likewise, 53% (n=62) of participants from Group 0 (see Table 20, p. 91) stated that they do not think eating disorders recovery was possible or that they did not desire change. We see evidence in statements such as:

- It's hard to imagine recovery. I feel I will be stuck in a pattern of eating disorders until one of them kills me.
- I don't feel like recovery would be easy or even possible.
- I honestly don't think it will happen to recover I will probably just learn to manage my disordered eating better and cause less harm.

Further statements by participants in Group 0 supported theoretical assertions made by Sugarman (1991). He posits that individuals with eating disorders fail to develop the ability to communicate affect states, as well as needs and desires, through verbalization. Instead, the body becomes the means of communicating unconscious conflicts (Sugarman, 1991). Participants stated:

- [eating disorders recovery] is a rough road especially when no one else knows what it is like to experience an eating disorder. You can't put your feelings into words.
- Don't know how to get help, not good at discussing issues.
- The fear I have is so deep and I feel so gross and disgusting. I know people would judge me and I already judge myself constantly.
- I am quiet and don't like talking about myself.
- I am not good at talking to people I don't know. The therapy was very talk based. The therapist saw it as her role to listen but I had nothing to say!

Also in these statements we can see unmet selfobject needs of twinship in the statement ‘no one else knows’ what it is like to have an eating disorder. In Group 0, 62% (see Table 20, p. 91) made statements expressing their value of eating disorders
symptoms. The value participants found in eating disorders symptoms was reflected in statements such as:

Purging at home is a comfort, almost a luxury I can look forward to, memory of purging is comfort. In knowing that I can purge quite well, I can therefore binge. Binges are completely impulsive but too comfortingly FAMILIAR.

I will never forget how delectable food is....and that I can eat and eat and eat and can get rid of it all.

Notably, when we look at these statements using a self psychological lens, what resonates is the selfobject function that eating disorders can temporarily mimic. Krueger (1997) describes this pathological striving when he states, “Individuals with eating disorders use food to soothe, to reward, to distract, or to substitute... It is an attempted selfobject experience” (p. 620). We can also experience a clear pattern of striving for comfort in a depleted self. Or as Kohut (1978) states, “It is the tragedy of all these attempts at self cure that the solutions they provide are impermanent, that in essence they cannot succeed... They are repeated again and again without producing the cure of the basic psychological malady... No psychic structure is built; the defect in the self remains” (p. 425).

Reigniting Dimensions of Selfobject Needs in the Therapeutic Alliance

It has been clearly articulated by several authors that eating disordered patients can be best understood as having deficiencies in self-organization and self-regulation and can be subject to profound states of overstimulation fragmentation, and tension (Connors, 1994; deGroot & Rodin, 1994; Goodsitt,1997). Similarly, Kohut (1971) states, “failures in empathic mirroring, idealizing and appropriate transitional experiences during childhood create deficiencies that interrupt development of the self” (p. 166).
A pivotal finding in this study suggests that this interruption may be reignited or continued within the therapeutic alliance between eating disordered patient and therapist. Or as Kohut (1984) articulated, “while a nuclear self cannot be created by the therapy, the patient can still use the therapist as a selfobject to build up new defensive structures, and especially, to firm already existing defensive structures” (p. 9). Quantitative and qualitative results suggest that a positive therapeutic alliance is a significant mediator in eating disorders recovery. Results of the three linear regressions looking at HAQ alliance score predicting EDRSQ total scores and subscores were all found to be significant (see Tables 13-15, p. 68).

Likewise, eight independent sample t tests were conducted to determine if there were differences in between Group 1 and Group 0 in SONI scores and EDRSQ scores. The result of the t test showed significant differences the EDRSQ total scale and EDRSQ normal eating scale (see Table 16, p. 70). For both of these recovery scales, Group 0 had significantly lower scores than Group 1. Or stated another way, Group 0, with no treatment or history of treatment, consistently scored lower on a psychometric instrument assessing levels of eating disorders self efficacy. Participants who have had or are currently in psychotherapy scored higher when rating their belief in their ability to engage in activities without using eating disorders, thought, behaviors or attitudes. Similarly, when we look to qualitative results we find consistent descriptions of eating disorders recovery self efficacy.

The findings of this study offer potential statistical evidence of the therapeutic relationship as restorative. Or as Sands (1989) describes, “The first goal of treatment must be to convince the patient through our understanding of her hopes and fears that she
should give human beings another chance; to rekindle the hope that at least one human being, the therapist, can provide the attuned responsiveness that will allow her development to begin again where it was derailed in early life” (p. 93). Several participants describe hope and commitment to the process of recovery (see Table 17, p. 72). Participants’ statements included:

- My therapist shares my faith and that puts us in agreement on life. She clearly cares about me and never wants to stop seeing me even though I haven’t reached recovery in 10 yrs.
- My present therapist is extremely helpful; he operates from a relational psychodynamic approach. His genuine hope for me to have a better quality of life combined with his no bull shit approach are exactly what I need. I often don't even realize right away when I'm lying to myself.
- I've struggled for 11 years; She is trying to get me to see that my eating disorder doesn't define who I am, and trying to get me to focus on the other aspects of my life that are important to me. She and I are able to connect on many levels, and I believe that she genuinely likes and respects me. She is encouraging and helps me to focus on the positive changes I have made since leaving the hospital.
- My therapist is an amazing woman. We have been working together for three years, since I got out of treatment. She was an integral part of my relapse and prevention team, and now is a great support. My work with her has been meaningful, and she continues to help me work through each layer of my person and my past to help facilitate an even healthier me.
- Having a good relationship with my therapist, her ability to not push too hard when talking about the trauma I experienced, her complete consistency when working with me, and her genuine concern for helping me.
- Most helpful was learning to open up in a trusted relationship and explore my problems more in depth.

These participants’ subjective reporting on the survey’s open ended questions are consistent with self psychological ideas of self regulation, approach towards selfobject
functions being responded to, or self esteem building strategies. The participants’ experience of this connectedness within the therapeutic relationship will likely continue or reignite the previously stalled psychological structure building. Or as Kohut aptly stated: “a person will only experience life as a cohesive, optimistic, and productive self, if he experiences his environment and people in his life as responding to him in a joyful way and providing strength and calmness as idealized figures, being present for him, and able to perceive and value his inner life, being aware of his needs, and allowing him into their inner life when his is in need of nourishment” (1984, p. 52). When we look at other participants’ statements, we can appreciate the resonance of Kohut’s descriptions:

My therapist has been incredibly helpful to me. She is very empathic but has solid boundaries that make me feel comfortable - I know even if she feels sad about something we talk about, she'll be fine at the end of the day.

Problem solving together. Feeling that I am listened to

She's very supportive of my decisions usually and reminds me that I've made a lot of progress in figuring out what I want versus what I feel like I should want...

Goldberg (1983) says, “The term selfobject, which usually connotes another person who is experienced as performing a necessary psychic function for the self, would include the range of functions that have to do with impulse control, limit setting, and others dealing with the containment of action and behavior” (p. 161). As one participant emulates this very idea, “He gently helps me to see things I am sacred of – he really holds the experience.”
Limitations of the Study

In a study using an experimental quantitative design, a large number of randomly selected and randomly assigned participants yields results with minimized type II errors, that are representative of the population being examined and, thus, generalizable to that population (Creswell, 2003; Rubin & Babbie, 2001). There are certain limitations that are inherent to a study of this kind. For example, because this study used an online survey to collect data, there was little ability to process or explore data. Furthermore, because this is a cross sectional study there will not be long term data to derive more specific conclusions about what factors can predict long term stable recovery from eating disorders, as was evident in the research conducted by Olmstead & Kaplan (1994).

Further, the anticipated predictor variables in some of the regression models were not found to be significant, as was expected. There are several possible reasons why a coefficient might not have been statistically significant. In some studies standard errors are too large. Other reasons for a lack of statistical significance relate to study design, measurement of variables, or model specification. These are key issues in an explication of the substantive significance of regression results. It is important to reiterate that this study was the first time the SONI has been fielded since being constructed through a series of seven studies conducted by Banai, et al. (2005). Therefore, the mean scores of the SONI subscales in this study cannot be compared with previous studies. Lastly, the apparent lack of comparison data should not be considered a limitation because comparing the SONI scores from this study with a different population might not have any significant utility. Of note, and as can be seen in Table 2, the mean scores for the subscales of the need for twinship, need for idealization, and need for mirroring were all
above the midpoint of the range of scores indicating elevated selfobject needs in these three domains.

Implications for Social Work Practice and Policy

Findings in the current study report on 97% of Group 0 reported cost, lack of health insurance or cost of health insurance as part or all of reasons why they have not previously sought psychotherapy or counseling. Statements such as:

- My family does not have medical insurance so we have absolutely no money to send me to a recovery or treatment center.
- I have been reluctant to ask for help (thinking I could do it on my own), my insurance benefits are not optimal, and I'm scared. I'm worried it will cost too much and my insurance won't cover it...
- I feel as though insurance companies don't cover a lot of costs associated with getting help for eating disorders.
- I cannot afford it and my insurance will not cover it.
- ...I was a minor and my parents, who were hesitant to put me in psychotherapy (I am not sure of their reasons for this; it is a sensitive topic). So my primary treatment was medical and focused on weight restoration and dealing with the physical consequences of the anorexia. Once I went to college I sought out support groups because that was what I could afford. The free counseling center at my school did not treat people with eating disorders (they referred them to psychologists, which I couldn't afford regularly without help from my parents, whose insurance I was under).

In the previous statements we also hear lack of resources, not just around health insurance and costs of treatment, but lack of professional understanding of eating disorders. Participants’ comments included:
Limited, time, money, and finding a therapist with an ED specialty always have hindered my progress in therapy. Either I can't afford enough sessions to be effective or by the time I'm able to feel open enough in each session the time is over (this tends to be the case seeing a non-ed therapist. They have knowledge of eating disorders but are typically not able to understand them!). Having a good connection with one's therapist is so critical!!

If I have tried to talk about how I feel to family member and PCP [primary care physician] all I have received is ‘don't worry about how you look, just go for a walk instead of purging. You look fine’, even though I am heavier now than 10 years ago. I am scared to eat (properly) don't want to gain any more weight even though purging doesn't stop gaining weight on a whole. I do not have insurance or monetary means to pay for psychotherapy.

I'm really scared to, there's only one ED therapist in my town too, and it's crazy expensive. I just don't see where it will be worth the investment of money and time to go.

These are all obvious implications for the profession of social work as well as the general mental health profession. Further, there may be unseen reasons participants have not sought out psychotherapy or counseling that may be better addressed from a sociological perspective or are perhaps issues of public policy. There are however, several initiatives continuing to address mental health parity issues as they relate to the treatment of eating disorders. Further, several coalitions and associations continue to appeal to federal and state lawmakers to increase education, research funding, and prevention efforts for eating disorders, including a recent announcement by the National Eating Disorders Association (NEDA). NEDA and the American Medical Association developed a course for Screening and Managing Eating Disorders. The goal of the course is to educate physicians about eating disorders, and to assist in early detection and intervention.
Similarly, an increased awareness of the psychodynamics of selfobject needs of individuals dealing with eating disorders could help social workers and social support programs address not only eating disorders, but issues in personal relationships and other components of individuals, and families of individuals, dealing with eating disorders. And lastly, as previously discussed, many participants discussed fear or shame either as a concern in their therapeutic relationship, or as a reason for not seeking out psychotherapy. A critical implication of this study is the need to develop more specialized training programs that can teach and enable clinicians to creatively respond to individuals with particular sensitivities of shame and fear with regards to receiving treatment for eating disorders. Training should also facilitate increased development of empathy among professionals working with eating disorders.

Conclusions and Implications for Future Research

The individual’s experience of this connectedness becomes the foundation on which psychological structures are built. The development of the self is built upon the attunement and responsiveness of the individual's selfobject environment (Kohut, 1971). We can speculate from the findings presented in this study that selfobject needs may be responded to in the therapeutic dyad of eating disorders patients and therapist. However, there is not substantial evidence to determine which selfobject functions are being responded to and how they are activated, or reactivated, in therapeutic alliance. Therefore, it is difficult to translate these findings into specific therapeutic interventions. Although this study does provide evidence that the therapeutic alliance is positively associated with eating disorders recovery, it is necessary to continue empirical efforts to
distinguish how and which selfobject needs can be responded to in the treatment of eating disorders patients. Further, more research needs to be done to assist clinicians in understanding and appreciating the intricacies of vulnerabilities faced by eating disorders patients during the therapeutic process. Moreover, the extent that we can continue to understand dimensions of selfobject needs and the therapeutic relationship in eating disorders increases the possibility of creating hope for recovery.
APPENDIX A

INFORMED CONSENT
Purpose of the Study:
The purpose of this study is to examine the relationship between the therapeutic alliance and eating disorders recovery. This is a study being conducted by Kathleen Check, MS, LCPC under the direction of dissertation committee chairperson R. Dennis Shelby, PhD towards the fulfillment of the degree of Doctor of Philosophy from the Institute for Clinical Social Work, Chicago, Illinois. 200 participants will be recruited for this study.

What will you be asked to do:
You will complete a survey, which will take approximately 25-30 minutes to complete. The survey includes questions about your relationship with your body, food, and eating. Other questions will address your history of therapy and your perceptions about therapy and your relationship with your therapist if you have participated in therapy (aspects of your treatment experience that were helpful or less helpful). You will also be asked some demographic information (e.g., age, marital status, education level) so that we can accurately describe the general traits of the group of people who participate in the study.

Benefits of this Study:
You will be contributing to knowledge about eating disorder recovery and assisting in creating a deeper understanding of factors within the therapeutic relationship that aid in the treatment of eating disorders.

You will also have the opportunity to gain insight into your relationship with your therapist as well as your individual experience with eating disorders and eating disorder recovery.

In addition, all participants who complete the online questionnaire will receive a $10 gift certificate to Gürzc Books (www.bulimia.com) a long standing resource in the eating disorder field. After completing the online questionnaire you will receive your gift certificate, within 48 hours, via email. After we have finished the data collection, you will have the choice of being provided more detailed information about the research findings.

Risks or discomforts:
No risks or discomforts are anticipated from taking part in this study. However, if you feel uncomfortable with a question, you can skip that question or withdraw from the study altogether at any time. You will have the ability to save and exit from the questionnaire, should you need to stop at any time.
The unique secured password you will be given at the onset, will assist you in returning to your saved questionnaire so that you may complete the survey. Once you complete and submit the survey, you will be eMailed your gift certificate within 48 hours. You will have ongoing access to a resources website page containing helpful website links and telephone numbers, as well as contact information for the primary researcher should you have questions about the survey.

Confidentiality:
Your responses will be kept completely confidential. Your IP address will not be recorded when you respond to the Internet survey. You will be asked to provide your eMail address when you complete the Internet survey so that you can be sent an invitation to participate in the study via email. However, once you complete the survey, your eMail address will not be stored with data from your survey. Instead, you will be assigned a participant number, and only the participant number will appear with your survey responses. Only the researchers will see your individual survey responses. Email addresses will be stored electronically in a password protected folder on a secured server that only the lead researcher and internet administrator will have access to. A hard copy will be stored in a locked filing cabinet for five years. After we have finished data collection we will destroy the list of participants’ eMail addresses and no names or identifying information are requested or revealed.

Decision to quit at any time:
Your participation is voluntary; you are free to withdraw your participation from this study at any time. If you do not want to continue, you can simply close the website window. If you do not click on the "submit" button at the end of the survey, your answers and participation will not be recorded. When you click on the "submit" button at the end of the survey, you will receive your gift certificate within 48 hours.

How the findings will be used:
The results of the study will be used for scholarly purposes only. The results from the study will be presented in educational settings and at professional conferences, and the results might be published in a professional journal in the field of psychology.

Contact information:
If you have concerns or questions about this study, please contact Kathleen Check, MS, LCPC at kathleencheck@gmail.com (312-701-0727) or the Institute for Clinical Social Work Committee chairperson, Dr. R. Dennis Shelby, PhD at rdshelby@icsw.edu (312-935-4232).

I have read and understand the above information and verify that I am 18 years or older.
APPENDIX B
INSTRUMENTS
Appendix Selfobject Needs Inventory (English Version)

1. I feel hurt when my achievements are not sufficiently admired.
2. It's important for me to be around other people who are in the same situation as me.
3. When I have a problem, it's difficult to accept advice even from experienced people.
4. Associating with successful people allows me to feel successful as well.
5. I don't need other people's praise.
6. I would just not be involved with people who suffer from problems similar to mine.
7. I'm disappointed when my work is not appreciated.
8. I seek out people who share my values, opinions, and activities.
9. I find it difficult to accept guidance even from people I respect.
10. I identify with famous people.
11. I don't function well in situations where I receive too little attention.
12. I feel good knowing that I'm part of a group of people who share a particular lifestyle.
13. I feel bad about myself after having to be helped by others with more experience.
14. It's important for me to feel that a close friend and I are “in the same boat.”
15. When I'm doing something, I don't need acknowledgment from others.
16. It bothers me to be in close relationships with people who are similar to me.
17. I am attracted to successful people.
18. I have no need to boast about my achievements.
19. I feel better about myself when I am in the company of experts.
20. I would rather not be friends with people who are too similar to me.
21. I feel better when I and someone close to me share similar feelings to other people.
22. It's important for me to be part of a group who share similar opinions.
23. I don't really care what others think about me.
24. I know that I'm successful, so I have no need for others' feedback.
25. I'm bored by people who think and feel too much like me.
26. It's important for me to be around people who can serve as my role models.
27. I feel stronger when I have people around who are dealing with similar problems.
28. It's difficult for me to belong to a group of people who are too much like me.
29. In order to feel successful, I need reassurance and approval from others.
30. When I'm worried or distressed, getting advice from experts doesn't help much.
31. I try to be around people I admire.
32. I gain self-confidence from having friends whose beliefs are similar to mine.
33. I need a lot of support from others.
34. I find it difficult to be proud of the groups I belong to.
35. Most of the time I feel like I'm not getting enough recognition from my superiors.
36. It's important for me to belong to high-status, “glamorous” social groups.
37. I don't need support and encouragement from others.
38. I would rather not belong to a group of people whose lifestyle is similar to mine.
THE HELPING ALLIANCE QUESTIONNAIRE
Patient Version

INSTRUCTIONS: These are ways that a person may feel or behave in relation to another person -- their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. Please mark every one.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel I can depend upon the therapist.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I feel the therapist understands me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I feel the therapist wants me to achieve my goals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. At times I distrust the therapist's judgment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I feel I am working together with the therapist in a joint effort.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I believe we have similar ideas about the nature of my problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I generally respect the therapist's views about me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. The procedures used in my therapy are not well suited to my needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I like the therapist as a person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. In most sessions, the therapist and I find a way to work on my problems together.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. The therapist relates to me in ways that slow up the progress of the therapy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. A good relationship has formed with my therapist.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. The therapist appears to be experienced in helping people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I want very much to work out my problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. The therapist and I have meaningful exchanges.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. The therapist and I sometimes have unprofitable exchanges.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. From time to time, we both talk about the same important events in my past.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. I believe the therapist likes me as a person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. At times the therapist seems distant.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix A. EDRSQ

Instructions: The following items describe behaviors, thoughts, and feelings that individuals with eating disorders may face. The phrase “balanced meal” refers to the amount and type of food that a typical normal-weight person who is not a dieter might eat. Please rate how confident you feel right now about your ability to do the following. If you are currently in the hospital (day hospital or inpatient), please rate how confident you feel right now about your ability to do the following if you were discharged today.

Circle the number that best describes your confidence level. Use the following scale:

1 = Not At All Confident
2 = Somewhat Confident
3 = Moderately Confident
4 = Very Confident
5 = Extremely Confident

<table>
<thead>
<tr>
<th>Item</th>
<th>Not At All Confident</th>
<th>Somewhat Confident</th>
<th>Moderately Confident</th>
<th>Very Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) I can eat a family meal at a normal rate.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2) I can feel proud of how I look.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3) I can look at my stomach or thighs without wondering if I've gained or lost weight.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4) I can look in a full-length mirror without thinking about where I want to lose weight.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5) I can try new foods without feeling anxious.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6) I can eat a cheeseburger without compensating by restricting, exercising excessively, or purging.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7) I can eat when I feel hungry and stop eating when I feel satisfied.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8) I can eat holiday desserts this year and not compensate by purging, exercising excessively, or restricting.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9) I can feel that my body is attractive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10) I can eat one serving of ice cream without feeling guilty or anxious.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11) I can eat from a buffet without feeling anxious.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12) I can buy food based on what I feel like eating, not because it is low fat and/or low calorie.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13) I can eat a high fat/high calorie food without worrying that I will gain weight.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14) I can wear a swimsuit in public.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15) I can accept my “figure flaw”.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16) I can feel OK about my stiff my stomach is not fat.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17) I can eat lunch without thinking about how many calories I’m consuming.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18) I can eat 3 balanced meals a day without binging/purging, exercising excessively, or taking diuretics or laxatives.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19) I can accept a dinner invitation to somebody’s house and eat without restricting, binging, or purging.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20) I won’t compare my body shape to other thin/attractive females I see.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21) I can eat high fat/high calorie foods in moderation without binging/purging, taking laxatives or diuretics, or exercising excessively.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22) I can see that my weight is not the most important part of me as a person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23) I can go to a restaurant with friends who are not dieters and eat a normal, balanced meal.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

EDRSQ Scoring Information

Factor 1 Normative Eating Self-Efficacy (14 items)
Items: 1, 5, 6, 7, 8, 10, 11, 12, 13, 17, 18, 19, 21, 23

Factor 2 Body Image Self-Efficacy (9 items)
Items: 2, 3, 4, 9, 14, 15, 16, 20, 22

To obtain a subscale (factor) mean that ranges from 1 to 5, sum item scores for each subscale and divide by the number of items in that subscale.
APPENDIX C

WEBSITE PAGES
### EDRS: Group 1 (copy - April 22, 2012)

**How would you agree with the following statements?**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Neutral</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel hurt when my achievements are not sufficiently admired.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>It's important for me to be around other people who are in the same situation as me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>When I have a problem, it's difficult to accept advice even from experienced people.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Associating with successful people allows me to feel successful as well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I don't need other people's praise.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleenchock@gmail.com or 312-701-0727

---

### EDRS: Group 1 (copy - April 22, 2012)

**How would you agree with the following statements?**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Neutral</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would just not be involved with people who suffer from problems similar to mine.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I'm disappointed when my work is not appreciated.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I seek out people who share my values, opinions, and activities.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I find it difficult to accept guidance even from people I respect.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I identify with famous people.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleenchock@gmail.com or 312-701-0727

---
EDRS: Group 1 (copy - April 22, 2012)

How would you agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Neutral</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t function well in situations where I receive too little attention.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel good knowing that I’m part of a group of people who share a particular lifestyle.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel bad about myself after having to be helped by others with more experience.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It’s important for me to feel that a close friend and I are “in the same boat.”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I’m doing something, I don’t need acknowledgment from others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EDRS: Group 1 (copy - April 22, 2012)

How would you agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Neutral</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It bothers me to be in close relationships with people who are similar to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am attracted to successful people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have no need to boast about my achievements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel better about myself when I am in the company of equals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would rather not be friends with people who are too similar to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## EDRS: Group 1 (copy - April 22, 2012)

### How would you agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Neutral</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel better when I and someone close to me share similar feelings to other people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It's important for me to be part of a group who share similar opinions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don't really care what others think about me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know that I'm successful, so I have no need for others' feedback.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I'm bored by people who think and feel too much like me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### EDRS: Group 1 (copy - April 22, 2012)

### How would you agree with the following statements?

<table>
<thead>
<tr>
<th>Importance statements</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Neutral</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It's important for me to be around people who can serve as my role models.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel stronger when I have people around who are dealing with similar problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It's difficult for me to belong to a group of people who are too much like me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In order to feel successful, I need reassurance and approval from others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I'm worried or distressed, getting advice from experts doesn't help much.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kateleencheck@gmail.com or 312-701-0727.
How would you agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Neutral</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I try to be around people I admire.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I gain self-confidence from having friends whose beliefs are similar to mine.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I need a lot of support from others.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I find it difficult to be proud of the groups I belong to.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Most of the time I feel like I’m not getting enough recognition from my superiors.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleencheck@gmail.com or 312-707-0727

How would you agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Neutral</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It's important for me to belong to high-status, &quot;glamorous&quot; social groups.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I don't need support and encouragement from others.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I would rather not belong to a group of people whose lifestyle is similar to mine.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleencheck@gmail.com or 312-707-0727
The following items describe behaviors, thoughts and feelings that individuals with eating disorders may face. The phrase "balanced meals" refers to the amount and type of food that a typical normal-weight person who is not a dieter might eat. Please rate how confident you feel right now about your ability to do the following.

<table>
<thead>
<tr>
<th></th>
<th>Not At All Confident</th>
<th>Somewhat Confident</th>
<th>Moderately Confident</th>
<th>Very Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can eat a family meal at a normal rate.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I can feel proud of how I look.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I can look at my stomach or thighs without worrying if I've gained or lost weight</td>
<td>0 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I can look in a full-length mirror without thinking about where I want to lose weight</td>
<td>0 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I can try new foods without feeling anxious.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleenchck@gmail.com or 312-761-0727.
The following items describe behaviors, thoughts and feelings that individuals with eating disorders may face. The phrase "balanced meals" refers to the amount and type of food that a typical normal-weight person who is not a dieter might eat. Please rate how confident you feel right now about your ability to do the following:

<table>
<thead>
<tr>
<th>Item</th>
<th>Not At All Confident</th>
<th>Somewhat Confident</th>
<th>Moderately Confident</th>
<th>Very Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can eat from a buffet without feeling anxious.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can buy food based on what I feel like eating not because it is low in fat and/or low calorie.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can eat a high-fat/high calorie food without worrying that I will gain weight.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can wear a swimsuit in public.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can accept my &quot;figure flaws&quot;.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EDRS: Group 1 (copy - April 22, 2012)

The following items describe behaviors, thoughts and feelings that individuals with eating disorders may face. The phrase "balanced meals" refers to the amount and type of food that a typical normal-weight person who is not a dieter might eat. Please rate how confident you feel right now about your ability to do the following:

<table>
<thead>
<tr>
<th>Item</th>
<th>Not At All Confident</th>
<th>Somewhat Confident</th>
<th>Moderately Confident</th>
<th>Very Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can feel OK about myself if my stomach is not flat.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can eat lunch without thinking about how many calories I’m consuming</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can eat 3 balanced meals a day without binging, purging, exercising excessively, or taking diuretics or laxatives.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can accept a dinner invitation to somebody's house and eat without restricting, binging, or purging.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I won’t compare my body shape to other thin/attractive females I see.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The following items describe behaviors, thoughts and feelings that individuals with eating disorders may face. The phrase "balanced meals" refers to the amount and type of food that a typical normal-weight person who is not a dieter might eat. Please rate how confident you feel right now about your ability to do the following.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not At All Confident</th>
<th>Somewhat Confident</th>
<th>Moderately Confident</th>
<th>Very Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can see that my weight is not the most important part of me as a person.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I can go to a restaurant with friends who are not dieters and eat a normal, balanced meal.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I can eat high fat/high calorie foods in moderation without binging, purging, taking laxatives or diuretics, or exercising excessively.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleenchack@gmail.com or 312-701-0727

These are ways that a person may feel or behave in relation to another person – their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree.

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel I can depend on the therapist.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I feel the therapist understands me.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I feel the therapist wants me to achieve my goals.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>At times I distrust the therapist’s judgement.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I feel I am working together with the therapist in a joint effort.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleenchack@gmail.com or 312-701-0727
These are ways that a person may feel or behave in relation to another person – their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe we have similar ideas about the nature of my problems.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I generally respect the therapist’s views about me.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The procedures used in my therapy are not well suited to my needs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I like the therapist as a person.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>In most sessions, the therapist and I find a way to work on my problems.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleencheck@gmail.com or 312-701-0727

---

These are ways that a person may feel or behave in relation to another person – their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The therapist relates to me in ways that slow up the progress of the therapy.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A good relationship has formed with my therapist.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The therapist appears to be experienced in helping people.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I want very much to work on my problems.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The therapist and I have meaningful exchanges.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleencheck@gmail.com or 312-701-0727
These are ways that a person may feel or behave in relation to another person – their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The therapist and I sometimes have unprofitable exchanges.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>From time to time, we both talk about the same important events in my past.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I believe the therapist likes me as a person.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>At times the therapist seems distant.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

If you have questions or comments please contact Kathleen Check, MS, LCPC at kathleench ck@gmail.com or 312-701-0727

What would you describe your work with your therapist?

What were the most helpful aspects of your therapy?
What were the least helpful aspects of your therapy?

How do you imagine eating disorders recovery?
Please be as specific as you are able to be about how you experience or think about eating disorders recovery.
What is your marital status?
- Single
- Living as domestic partners
- Married
- Divorced
- Widowed
- Other

What is your race or ethnicity?
- Please Select -

Are you employed outside of the home?
- Yes
- No

What is your occupation?

Thank you for participating!!!

Once results are verified, your gift certificate to Glaze Books will be emailed to your address.

For assistance, please call or email:
Kathleen Check
kathleenchek@gmail.com
312-761-0727
edrecoverystudy.com
tsktherapyschicago.com

Please click here to return to the edrecoverystudy.com site.

LINKS:
- www.tsktherapyschicago.com
- www.aastweb.org
- www.bulimia.com
- www.add.org
- therapists.psychologytoday.com/ma
- www.nationtreatngobdersons.org
- www.integrativehealthpartners.org
What is your marital status?

- Single
- Living as domestic partners
- Married
- Divorced
- Widowed
- Other

What is your race or ethnicity?

- Please Select -

Are you employed outside of the home?

- Yes
- No

What is your occupation?


Thank you for participating!!!

Once results are verified, your gift certificate to Glaze Books will be emailed to your address.

For assistance, please call or email:
Kathleen Check
kathleencheck@gmail.com
312-761-0727
edrecoverystudy.com
bsktherapychicago.com

Please click here to return to the edrecoverystudy.com site.

LINKS:
www.talktherapychicago.com
www.aeatweb.org
www.bulimia.com
www.amed.org
therapists.psychologytoday.com/us
www.nationtreatmentfonders.org
www.integrativehealthpartners.org
APPENDIX D
MARKETING FLYER
FEMALE PARTICIPANTS NEEDED FOR:
EATING DISORDERS RECOVERY STUDY

200 Female Participants
Needed!!!

To participate in a study about the relationship between eating
disorders recovery and the therapeutic relationship. Participants will
complete a questionnaire online. It will take approximately 30 minutes
to complete the online questionnaire. Potential participants must have
access to internet and past or present experience of eating disorders
symptoms.

We are looking for 100 participants who have had therapy or
counseling and 100 participants who have NOT had therapy or
counseling

By participating in this study you will obtain:

• $15 Gürze Books Gift Certificate (upon survey completion)
• Ability to help further eating disorders treatment!!
• Opportunity to gain personal knowledge of your own
  experience with eating disorder recovery!

Log on anytime to: www.edrecoverystudy.com
to learn more about how to participate!!!!
Or Call Kathleen Check at 312-701-0727

Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
Call Kathleen Check
312-701-0727
REFERENCES


