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Can methods that focus on eating behaviour and individual agency improve success rates in eating disorder recovery?

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Abstract
Success rates in eating disorder treatments are disappointing, and many calls have been made in recent research literature for innovative approaches to improve outcomes. This Comment article offers an argument for the importance of behaviour and agency in supporting eating disorder recovery, where *behaviour* encompasses eating and other everyday actions and habits and *agency* is an individual's capacity to set priorities and intentions, generate insights, draw conclusions, make decisions, and perform actions. Current treatments often deprioritize eating and other behaviours as well as individual agency for the patient/client, with lower importance often attributed to behavioural change than to physiological or psychological change. Reasons for deprioritizing behaviour may include beliefs about the therapeutic alliance, the intellectual appeal of psychological exploration, and the ready measurability of physiological factors. Reasons for deprioritizing personal agency may relate to an only partial shift away from the paternalistic model of medicine, influenced by the physical severity of EDs and by gender dynamics between clinician and client/patient. Drawing on principles and practices from solution-focused coaching and solution-focused brief therapy, we argue that low-agency forms of healthcare are likely to perform poorly in general, given the problematic effects that typically result from the giving and following of advice. Low-agency and low-behaviour approaches are also likely to work poorly for EDs in particular, thanks to both the centrality of eating behaviours and the fact that EDs are often experienced as initially egosyntonic exercises of personal agency. We describe how a high-agency-high-behaviour model of ED treatment could help improve recovery rates by scaffolding a process of progressive empowerment in which the affected individual identifies how personal agency has been lost in the experience of their ED and decides whether, why, and how they wish to reassert it. We survey existing applications of solution-focused methods in the ED domain and suggest ways of testing the proposed ideas. We conclude by sketching broader ways for the field to continue its evolution towards higher-behaviour and higher-agency methods, as part of a general shift to forms of healthcare that are truly responsive to the individual and firmly grounded in the realities of practical change.

Keywords Advice, Behaviour, Control, Eating disorder treatment, Medical paternalism, Personal agency, Recovery, Solution-focused brief therapy, Solution-focused coaching

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The state of the field: a mandate for innovation

This article is a response to the fact that mainstream treatments for eating disorders (EDs), especially anorexia nervosa (AN), do not work reliably despite decades of systematic effort. Those with severe symptoms are rarely treated effectively [1, 2] with either talk therapy or pharmaceutical therapy. A recent review showed very limited efficacy of drug therapies particularly for AN and bulimia nervosa (BN) [3, 4]. Placebo and active control treatments typically perform as well as specialized ED modalities [5, 6], with a possible exception of family-based therapy for very mildly affected young adolescents with AN or BN [7]. Short-term symptom improvement is common [8], but where follow-ups do take place, relapse is also common, with estimates as high as 52% [9–12]. Where they are reported, dropout rates in treatments range from 20% to 73% [13–18]. During and after treatment, mortality rates for EDs are amongst the highest of any behavioural or psychiatric condition [5, 19–22].

In light of these patterns, recent reviews and meta-analyses are filled with calls to action. Authors speak of an “urgent need” [7, abstract; 23, p215], a “pressing need” [24, p309], and a “grave responsibility” [19, p1] to innovate. They conclude that “better or alternative treatments for eating disorders are needed” [25, p97] and that “improving treatment outcomes is a critically important endeavor across all ED phenotypes” [26, p2]. In response, we propose to concentrate on two often overlooked concepts in ED treatment and research: eating and related behaviours (practical everyday changes being made) and personal agency (the changes being designed and carried out by the individual).

Returning to first principles

There are many ways for a scientific field to go astray. A common way is to become unnecessarily complex. The proliferation of therapeutic modalities for EDs over the past 20 years is in some ways a reasonable response to the manifest failure of a narrowly biomedical approach; embracing the full range of biopsychosocial and multidisciplinary possibilities makes sense when the opposite extreme has demonstrably failed. But it is now common for an individual with an ED to interact during treatment with a primary care physician, a nurse, a psychiatrist, a clinical psychologist or psychotherapist, a dietician, and potentially other specialists for supplementary therapies. Treatment has thus become extremely expensive [27–32] and therefore inaccessible to many. And as we have seen, the proliferation and the corresponding expense have not yielded reliably effective treatments.

Faced with the problem of complex and costly inefficacies, we can apply Occam’s razor to seek the simplest solution. Doing so yields two axioms:

1. EDs are eating problems, so recovering from an ED must centre on learning how to eat well.
2. An individual with an ED knows their ED better than anyone else does, so they should take the lead in the process of learning how to eat well.

If we provisionally accept these axioms to find out where they might lead, two core principles emerge: from the first, the importance of behaviour (especially the eating itself, as well as exercise and related everyday habits and actions) and from the second the importance of agency (i.e. the individual’s capacity to set priorities and intentions, generate insights, draw conclusions, make decisions, and perform actions). In the next section, we ask how present or absent these two factors, eating behaviour and individual agency, are in current ED treatments.

Behaviour and agency in ED treatment

Eating behaviour turns out to be oddly peripheral in many ED treatments. Psychotherapy for EDs often involves extensive discussion of potential causes of the eating problems, treating the eating as a symptom that can be expected to resolve itself, or at least be more amenable to resolution, once the “root causes” have been addressed—an endeavour that can take years and still fail to yield the intended outcome of the individual ceasing to have an ED. CBT for EDs has, in recent decades, moved increasingly far from its roots in changing eating behaviour [5, 33–35]. In theory and especially in practice, cognitive factors (which we here treat synonymously with psychological factors) tend to be privileged over behavioural factors, thus narrowing the gap between CBT and other talk therapies and leading the eating itself to be “surprisingly neglected” [35]: “Evidence-based CBT is behavioral at its core […] but it is uncommon in everyday practice” [35]. Helping an individual (re)learn how to eat well is apparently rarely at the centre of ED treatment.

As for the personal agency component, little research exists on high- versus low-agency methods in ED treatment, but a 2023 study [36] generated some striking findings. Geller and colleagues characterize *collaborative care* in terms of “showing curiosity and concern for patient experiences, providing choices, and supporting patient autonomy” (p1), whereas a *directive approach* involves “using demanding statements that inhibit patient autonomy, and unsolicited opinions that may be experienced as judgmental or critical” (p2). They conclude (1) that patients and clinicians typically claim to believe that collaborative care is most helpful, (2) that collaborative care is in fact more acceptable and produced better outcomes than directive care, but also (3) that in practice clinicians are often directive, “resulting in negative patient attitudes toward treatment and poor adherence” (p1).

Some assert that cognitive behavioural therapy (CBT) for EDs is a non-directive, high-agency approach; for example, Dalle Grave claims that "[CBT-E] never uses 'prescriptive' procedures" [37, p7]. But the CBT-E paradigm is founded on an expectation that the recovering individual will shape their actions and beliefs to the CBT-E protocols and the expertise of the professional administering them. In Fairburn's widely used treatment manual [38], for example, we find expressions of higher-agency perspectives competing with indications that the individual's role is to acquiesce rather than to decide: "Explaining what treatment will involve", "check back that the patient is 'on board'", "on occasions we do have to be quite insistent", "*Remember, we are experts and we think that your problem merits treatment*" (original emphasis) (pp48–56). Similarly, in the 4th edition of the APA Practice Guideline for EDs [39], recommendations of "care that is respectful of and responsive to individual preferences, needs, and values and ensures that an individual's values guide clinical decisions" (p26) conflict with references to "collateral informants" (p26), "locked" and "unlocked" wards (pp29–30), and "careful monitoring [...] done directly after the patient voids, with shoes and outerwear removed" (p27).

Asking how eating behaviour and individual agency interrelate in ED treatment, we find that appropriating agency from the recovering individual and bypassing eating behaviours or relegating them to a lower status than other factors often go hand in hand. Our reading of the clinical literature combined with our direct observations of clinical practice reveal three common variations on these patterns:

1) *Remove personal agency and ignore behavioural change in favour of physiological change.* The most obvious example of the common clinical instinct to bypass the behavioural and leap straight to physical treatment is the use of nasogastric tube feeding, where the individual is passively fed, sometimes entirely against their will. In this case, none of the behavioural skills of eating are relearnt, and long-term outcomes are typically poor [40].

2) *Remove personal agency and relegate behavioural change below physiological change.* A therapist or dietician may impose targets for calorie intake, create a meal plan, or set other behavioural rules that the client/patient is expected to follow in order to change their weight, with few opportunities to discover or express their own preferences in treatment. Here the agency lies with the professional, and although change to eating behaviours is involved, it is viewed primarily as a means to achieve bodyweight change, which may be a defining criterion for treatment success. In residential settings, any behavioural focus may take the form primarily of compliance monitoring for prohibited behaviours such as vomiting, exercising, or restrictive eating, as well as for prescribed behaviours such as eating designated servings of food in their entirety. Similar forms of agency appropriation may apply in family-based treatments, where responsibility for monitoring and enforcement is shifted to parents or carers. Individuals' experience with these types of behaviour monitoring is often of punitive and adversarial surveillance. Further, because decision-making about food consumption is often also numerically driven (whether involving calorie counting or a food "exchange" or other measurement system), the individual's capacity to listen to their bodily signals is made irrelevant to decision-making about their own recovery. This approach may exacerbate the mind/body alienation already manifest in the ED experience.

3) *Remove personal agency and relegate both behavioural and physiological change beneath psychological change.* Psychotherapists often take on the bulk of the psychological work involved in ED recovery, including the processes of both achieving insight and defining goals [41]. As noted above, and especially in cases considered to be less severe, therapists who consider the interpretive mandate to lie with themselves often neglect behavioural and physiological change in the therapy that they offer, seeking to identify plausible historical causes in the belief that this will reveal effective strategies for generating present solutions. Conversely, in cases perceived as the most severe, professionals may decide on the client/patient's behalf that harm reduction rather than full recovery is the appropriate goal, blocking the changes in eating and other behaviours that would make full recovery possible.

Accounting for low-behaviour and low-agency tendencies in current ED treatments

Three hypotheses present themselves to explain the common downplaying of the significance of behaviour in ED treatments (see also [5]):

1. Some practitioners may believe that staying in the less threatening domain of talking about behavioural change is good for the therapeutic alliance between clinician and patient/client [42] rather than understanding the alliance as dependent on successful progress in recovery [43].

2. Some may find the process of generating, or helping their clients generate, linguistically mediated insights into the characteristics and histories of their mental states more intellectually compelling than helping them to change their behaviours.
3. Physiological factors (bodyweight, blood markers, bone density, etc.) have the benefit of being more easily measurable—and often more financially incentivized—than behavioural patterns and may therefore take precedence.

In the domain of personal agency, a broader perspective on trends in healthcare may help us understand why collaborative care is the exception in ED treatment despite being preferred by all parties and being potentially more effective than directive care. Recent decades have seen a pronounced shift away from the paternalistic model of medicine (also known as the parental or priestly model [44]) in which the patient is weak and ignorant and needs rescuing by the strong and knowledgeable doctor. Yet there is still a high level of ambiguity in how clinicians' and patients'/clients' roles are defined. Although some form of shared decision-making is now taken to be the default, the practical implications of appealing terms like "shared decision-making" and "person-centred care" are often left unexplored, and "the process of medical decision making remains nebulous" [45, p582]. "Selective paternalism" can be a position to which one reverts when shared decision-making breaks down, or in emergency settings [44], but it may also be a more pervasive default, such that in practice, defaulting to a process highly restrictive of personal agency is common [45].

EDs are often classified as "mental health conditions" but have significant physical components, so the field's sizeable inheritance from the paternalistic model of medicine is unsurprising. The manifestations of AN in particular, where an individual is often reduced in physical size and strength by malnutrition, may further encourage the rescuer role—sometimes known as the "righting reflex"—in clinicians. Given the higher rates of EDs in females, this impulse to rescue may also be exacerbated by the on-average smaller physical size of females, as well as by sociocultural power imbalances that may be in play when a senior male clinician treats a young female patient. Faced with frighteningly low bodyweight and other pronounced markers of chronic malnutrition, common reactions include "beleaguerment, demoralization, and excessive need to change the patient" [39, p39]. This felt need often translates into agency-reducing practices implemented in the name of medical urgency.

Why low-agency and low-behaviour healthcare can be expected to perform poorly in general, and for EDs in particular

The instinct to give advice is widespread in human life: We see another individual in difficulty, we believe that we have insight into their difficulties and their potential solutions, we want to help, and we suggest solutions. In general, this does little harm because the individual to whom the advice is given typically ignores the advice. In contexts where change is urgently needed, however, the failures of advice-giving do more harm, by mechanisms such as the following [see also 46, pp7–9, 25–33]:

- *Advice not taken*: The advice-receiver does not follow the suggestions made by the advice-giver, because they (a) feel unable to or (b) resist the idea of doing so. Both perceived inability and resistance may block the development of personal efficacy. In both cases, the temptation to be dishonest about the "failure" to follow the advice, linked to guilt and/or a fear of eliciting judgement or disappointment, may also interfere with the building of trust and a working alliance.
- *Advice taken to "good" effect*: The recipient follows the advice and doing so has short-term benefits, reinforcing the recipient's dependence on the giver and their belief that they are incapable of taking care of themselves or of generating the "right" ideas to heal themselves.
- *Advice taken to "bad" effect*: The recipient follows the advice and, in so doing, creates short-term harms, creating resentment towards the giver and damage to their relationship and to belief in the possibility of future healing.

This triad of scenarios suggests that no wholly good outcome can result from advice-giving. Hence, as a widely used coaching handbook has it, "the first step to establishing trust is to abandon advice-giving as a coaching tactic" [46, p27]. Note that advice-giving is distinct from information-giving, which can often be highly beneficial, for example as a way of enhancing an individual's problem-solving process by flagging relevant factors or illustrating possible options.

All three advice-giving scenarios are commonly present in ED treatment. The first is often found in the oft-discussed form of "resistance to treatment", a term applied to both individuals and their EDs (e.g. [2, 47–49]). In the second, often thought of as the "best", case, the recipient's resourcefulness is short-circuited and their subordinate relationship to an authority figure in the domain of their own health is reinforced. This creates an unconducive foundation for future problem-solving once the hierarchical relationship is ended; after all, the skills of

identifying problems, articulating goals, and generating solutions have been trained only for the advice-giver. One aspect of the damage done by exercising these skills on behalf of another individual, by making decisions for someone else who has to live the life that results, can be observed in the high relapse rates evidenced in data on mainstream treatment: initial patient "compliance" gives way to "a second phase after discharge at home where the 'uncontrolled' patient often relapses" [37, p2]. Across therapeutic modalities, we suggest that many ED treatments "rely heavily on therapist insight and directive advice" and often seek to "convince or persuade" [41, p2] rather than to help the individual explore, discover, and decide.

In the ED context, the dangers of an approach that features low personal agency and low focus on eating behaviour are arguably even greater than in other healthcare contexts, for reasons that relate directly to the significance of eating and other behaviours in the nature of EDs. First, EDs are more profoundly behavioural than any other "mental" illness: they are substantially defined by the actions of eating, fasting, bingeing, vomiting, and exercising, which in turn have profound physiological and psychological effects that rapidly generate entrapping feedback dynamics. Second, these behaviours are not experienced as straightforwardly aversive. The term *egosyntonic* refers to behaviors, values, and feelings that are acceptable to the needs and goals of the self, or consistent with one's ideal self-image. The experience of an ED typically involves many such elements [50], bolstered by the sheer scale of the prestige and hence the material benefits now attaching to thinness, especially for women [51]. In this light, EDs can be understood in part as progressive misdirections of agency for the individual. In a typical progression, agency is first exercised in egosyntonic and socioculturally validated ways by individual (e.g. via restrictive eating and exercise practices intended to generate weight loss). Over time, the personal cost/benefit ratio of this exercise of agency shifts from positive to negative, as the damage done by the restrictive and/or compensatory behaviours takes hold physically and mentally. The persistence of at least some benefits, however, means that the desire to recover—and the willingness to perform the actions and endure the consequences required to recover—are rarely unequivocal, especially for restrictive EDs in which bodyweight has been lost.

Assuming unambivalent desire and willingness to change is likely to generate resentment and other forms of resistance in an individual with an ED. Yet in practice, the very domains in which negative reactions from an individual are most likely—those behavioural domains where the ED is most directly threatened, and hence where potential benefits to recovery are greatest—are precisely those in which their personal agency is maximally stripped away in treatment. We suggest that the consistent removal of individuals' capacity to decide on and test out crucial recovery-oriented behaviours, with attention to both their personal priorities and their bodily signals, is not merely accidentally correlated with the low success rates for ED treatment.

High-agency and high-behaviour alternatives

High-agency and high-behaviour approaches to helping individuals live better lives are well evolved in areas beyond ED treatment. Solution-focused coaching and solution-focused brief therapy, for example, are supportive/therapeutic modalities in which both behaviour and agency are systematically emphasised in mutually reinforcing ways. They offer an alternative to methods where both are sidelined in favour of psychological and/or physiological change in which the individual has minimal agency.

A contribution to a popular solution-focused coaching handbook [52, pp51–52] offers the following definition, highlighting both practical behaviour change and individual agency: "Solution-focused coaching is a practice that places primary emphasis on assisting the client to define a desired future state and to construct a pathway in both thinking and action to move toward that future state. […] the solution-focused coaching approach sees the client as fundamentally capable of solving their problem." As we touched on in the previous section, one of the primary edicts with which the trainee coach will be confronted is often deeply counterintuitive: *your job is not to tell your client what to do (even if they ask you to).* Provide information, by all means, but resist advising. An influential coaching handbook opens with a "quick answer" to the question of what it takes to be a good coach that foregrounds "the self-discipline to keep yourself out of the way, and the ability to resist giving advice or wanting to be right" [46, p2].

Many of the formalized structures of solution-focused coaching are designed to help the coach resist the natural impulse to give advice and instead to channel and enhance the client's resourcefulness. Popular coaching models such as GROW (Goal, Reality, Options, Will), CLEAR (Contract, Listen, Explore, Action, Review), and OSCAR (Outcome, Situation, Choices & Consequences, Actions, Review) [46, 53] all adopt a solution-focused but also discovery-oriented approach that involves the individual exploring and articulating their current reality and their aspirations. This approach allows the solution to be grounded in present facts as well as guided by a future vision that is meaningful for the individual. The stage of the process in which the individual generates a range of options for practical change, honing their ability to assess for themselves the actions they *could* take before deciding which they *will* take, stimulates creative personal

problem-solving unhampered by a narrow expectation that *the* “correct” answer is waiting to be uncovered.

In conventional ED treatments, some or all steps specified in these coaching models are often omitted. As a result of such omissions, short-term improvements may result, but long-term learning—in crucial life domains of how to eat and move, how to notice and respond to one’s bodily signals, how to reject widespread sociocultural pressures to restrictive eating and body control—is likely prevented. Pending appropriate evaluation of their potential, however, there is no practical reason why such structures should not be introduced.

Solution-focused principles are already applied in a specifically therapeutic context in solution-focused brief therapy [54], and some applications have already been made to ED treatment. An early case study involving AN advocated for an approach that “views the client as the expert on his or her own life” and “proceeds by helping the client develop his or her own solutions” [55, p384; see also 56]. More recently, a case study of a school social worker helping a student with an unspecified ED [57] also argued for solution-focused methods. A 2001 book on solution-focused recovery from eating distress [58] includes case studies to justify applying solution-focused brief therapy to EDs with a matter-of-fact approach in which “solution-focused brief therapy is seen as a perfectly logical and straightforward process and eating disorders are seen as ways of behaving that can be changed” (p5).

In the aetiology of an ED, personal decision-making often degenerates into obsessive-compulsive repetition that is ultimately damaging, distressing, and ego*dystonic* (conflicting with self-image and personal values). We propose that successful healing from such conditions is likely to involve a supported high-agency, high-behaviour process of progressive empowerment. Here, the individual identifies how personal agency has been lost in the experience of their ED and decides whether, why, and how they wish to reassert it. In this context, taking personal responsibility for goal setting at both micro and macro levels (what will I do differently tomorrow? what is this intended to make possible for me next year?) can exist in a mutually reinforcing relationship with assuming responsibility for practical follow-through. This combination allows for further strengthening of personal agency and insight via frequent psychological and behavioural refusals of the ED thoughts, priorities, and reward structures that the individual has identified as worthy of rejection. In this way, a high-agency and high-behaviour approach respects the realities of what makes lasting personal change possible. It shifts the focus from “Is the individual ready to do what we say they should?” (a question to which the answer is often “no”) to “What is the individual ready and even eager to do differently?” (to which the answer is rarely “nothing”).

Eating speed offers one practical example of how the relegation of behaviour below physiology and/or psychology could be reversed in a high-agency, high-behaviour approach. There is evidence that eating rate correlates with and may be causally implicated in problems with hunger/satiety signalling and food intake, and that normalizing eating speed, as well as shifting from a linear to a decelerated rate, can help with healing from eating difficulties (for an overview, see 5). Foregrounding this behavioural element offers a starting point for both physical change (e.g. achieving weight restoration and more reliable satiety signalling via increased food intake) and psychological change (e.g. relaxing distorted notions of control connected with artificially slowed eating rate). Changing eating rate can also lead to other forms of behavioural change (e.g. opening up possibilities for changing meal frequencies and timings once hunger-suppressing slowness or distressing speed are recalibrated). Crucially, explorations of the status quo and potential changes regarding eating rate can be led by the individual. Eating speed is often spontaneously mentioned as a factor that has gone awry, and if not, a simple question about speed of eating or invitation to attend to this variable and its role in the ED often suffices to make positive adjustments both desirable and possible. The individual can also take the lead in designing more creative experiments, involving strategies such as tailored self-reminders, self-observation (e.g. rating hunger levels or identifying delaying tactics), and discovery of aids to lengthening or shortening meal duration (e.g. using a TV or podcast episode to set an endpoint). A high-agency, high-behaviour approach taking eating rate as one focal point can thus help generate helpful cause-effect cascades connecting mind, body, and behaviour.

Eating rate is one ED-specific factor illustrating the potential of behaviour to act as a powerful generator of other kinds of transformation. Beyond eating, an emphasis on behavioural change may extend into other obvious ED-relevant areas such as physical activity and body-checking habits, as well as more expansively to encompass daily routines, social interactions (with or without eating or drinking), and professional and recreational activities and aspirations. Especially in the later stages, ED recovery may thus be contained within and encouraged by broader exploratory processes in which practical experimentation can enhance the rewards of building personal agency in more directly health-related ways.

The contributions that a professional can and should make to an individual’s rediscovery of their own agency through behavioural trial and error are just as existentially nuanced as those involved in more standard psychotherapeutic interactions—yet with the modesty and

simplicity that come from understanding that the process belongs ultimately to the individual. The delicate application of instinct and experience involved in a practitioner's decisions about how to help an individual exercise their own capacity for healing involves, for example, choosing between questioning, listening, challenging, reminding, menuing, information-giving, encouraging, celebrating, echoing, holding silence, and many other variations on in-the-moment non-directive support for change. Professional judgement is valuable, amongst other things, to help the individual gauge whether and to what extent any psychological contributors to the aetiology and maintenance of their ED are worth exploring, and at what point in the recovery process. Such exploration may usefully be guided by a broad preference for present- and future-oriented exploration over the "excavational" work of uncovering causes—work that can only ever be hypothetical, and that can often distract from the work of building a better future by a false equation of historical starting points with clinical focal points. Past-oriented work may risk widening rather than narrowing the "insight/action gap" [59] by accumulating theoretical understanding without aiding its translation into and testing via action. The intent to bridge rather than exacerbate this gap can be borne in mind as a useful heuristic for determining where psychological work promises to support the recovery process rather than distract from it.

In cases of severe physical and cognitive impairment where there is imminent risk of death, bypassing the behavioural to effect more direct physiological change, e.g. via tube feeding for AN, may sometimes be warranted, as may appropriating an individual's agency by feeding them without their consent. However, we argue that such cases should be treated as the exception not the norm, and that behaviourally exercised agency should be restored as rapidly as possible once physical healing is underway. To assist in the titration of higher-agency and higher-behaviour methods, it may be helpful to differentiate amongst layers of active agency, including for example sensorimotor autonomy (e.g. the gestural specifics of spooning or sipping food or drink recommended by others), behavioural decision-making (e.g. choosing food/drink types and quantities), and existential agency (e.g. articulating and acting towards life changes for which recovery is a prerequisite). Clinical skill can be exercised in helping individuals identify moments at which transitions can be undertaken amongst these layers, to benefit from their causal interrelations.

In the most general terms, espousing the core principles of personal agency and behaviour change rejects a damaging disciplinary antagonism between those who celebrate individual agency in the abstract but dismiss the value of behaviour (often via excessive verbally mediated interpretation of past experience) versus those who recognise the value of behaviour but subsume it within physiologically oriented and often top-down methods (especially focused on bodyweight change). A focus on transforming counterproductive behaviours and cultivating personal agency offers a way forward for professionals in the ED field who wish to align themselves with a growing rejection of over-medicalized practice where individuals are given too little credit for their capacity to decide and learn how they wish to live.

Conclusion and ways forward

We have argued that neither behaviour nor agency can be ignored if the chances of full recovery are to be improved in the next phase of ED research and treatment. Mainstream ED treatments downplay the significance of eating behaviour and individual agency, for ED-specific reasons (especially high physical risk intensifying the rescuer reflex) and more generic ones (including the higher cognitive capture of psychological factors, the higher measurability of physiological factors, and beliefs about the therapeutic alliance). We believe that these tendencies may partially account for the disappointing success rates in ED treatment.

These ideas are still evolving, and we welcome both theoretical challenges and empirical evaluations. Empirical testing of what we might label the high-agency-high-behaviour (HA-HB) model could proceed, for example, via an iterative process involving three main steps:

1. theory-building (theoretical integration, construct clarification, systematic mapping of existing evidence),
2. feasibility testing (development of a preliminary intervention model),
3. systematic empirical evaluation (pilot studies and controlled trials).

For now, the mainstream of ED treatment, along with many other areas of healthcare, can be seen as finding its way gradually towards both higher-agency and higher-behaviour methods. In this sense, it is moving towards methods that encourage the professional humility of recognising that one's own expertise is not paramount in the personal evolution of the unwell individual, and that cultivate the excitement of discovery led by the individual who wishes to change.

We suggest that a high-agency plus high-behaviour model could be more successful than its alternatives. Such a model would be naturally aligned with a simpler, more empowering, and more practical understanding of what healthcare needs to be in an era when the paternalist or priestly model is so clearly obsolete and financial barriers to access are escalating. We hope that identifying the potency of both behaviour and agency, separately and

especially in combination, will help accelerate the existing shift towards both that is detectable but not yet fully realized in the ED field.

Abbreviations

ED	Eating disorder
AN	Anorexia nervosa
BN	Bulimia nervosa
HA-HB model	High-agency-high-behaviour model

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ET and ML conceived the article. ET created the first draft; ML edited the draft; ET carried out further edits based on feedback from ML and others; ML reviewed the edits; ET finalized the manuscript. At peer review stage, ET revised the manuscript and drafted responses to reviewers, and ML reviewed the changes.

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