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FROM PARTIAL TO FULL-ENOUGH RECOVERY: A DEVELOPMENTAL MODEL OF RECOVERY FROM EATING DISORDERS

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Abstract
Questions about the nature of recovery from eating disorders have long divided the field. While one view purports that eating disorders are chronic conditions, other viewpoints maintain that full recovery from eating disorders is possible. The literature suggests the existence of levels of recovery: a) "partial" recovery, which includes remission of behavioral and physical of symptoms, in the absence of psychological remission, and b) "full" recovery, which includes remission of behavioral, physical and psychological symptoms.

In-depth interviews with women in long-term recovery from anorexia and/or bulimia were conducted, transcribed and analyzed in order to develop a grounded theory of the progression within the recovery process. This dissertation considers the phenomenology of phases of recovery; individual experiences of levels of recovery; and, how change, specifically from early recovery going forward, occurs.

Findings suggest a developmental process of recovery with central themes defining each stage. Participants' in the study described nuanced experiences of recovery that lay between chronicity and complete freedom from all vestiges of the disorder. The dissertation proposes a model comprised of three-stages: 1) early recovery, which is dominated by a focus on behavioral change and seeking guidance from external sources, 2) transitional recovery in which change processes that introduce an inward focus emerge; and, 3) "full-enough" recovery, a stage marked by the presence of a flexible sense of self-trust. The term, "full-enough" recovery was developed to convey the participants' experiences of a recovery that allows them both to acknowledge the presence of occasional mental remnants of the disorder and engage fully in their lives.

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FROM PARTIAL TO FULL-ENOUGH RECOVERY:

A DEVELOPMENTAL MODEL OF RECOVERY FROM EATING DISORDERS

Martina Verba

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Dedication

This dissertation is dedicated to the women who volunteeered to share their recoveries for this study. I am grateful for your generosity, courage and wisdom. Your abilitty to narrate your journeys is a gift to me and to all those who hear your stories.

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I respectfully acknowledge the courageous women who shared their stories of recovery with me.

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Abstract

From Partial to "Full-Enough" Recovery:
A Developmental Model of Recovery from Eating Disorders

Martina Verba

Jeff Applegate, PhD, Dissertation Chair

Questions about the nature of recovery from eating disorders have long divided the field. While one view purports that eating disorders are chronic conditions, other viewpoints maintain that full recovery from eating disorders is possible. The literature suggests the existence of levels of recovery: a) "partial" recovery, which includes remission of behavioral and physical of symptoms, in the absence of psychological remission, and b) "full" recovery, which includes remission of behavioral, physical and psychological symptoms.

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Objective and Nature of Study

This study of anorexia nervosa and bulimia nervosa shifts the emphasis from effective treatment to effective recovery, seeking in particular a clearer understanding of the progression from early recovery to stable long-term recovery. Relying primarily on open-ended interviews of individuals in long-term recovery, this study provides a detailed account of the developmental stages within the recovery process.

Overview of Project

Anorexia nervosa and bulimia nervosa are psychiatric disorders that threaten the physical and emotional health of those who suffer. Medical consequences include slowed heart rate, electrolyte abnormalities and cardiac arrest (Halmi, 2008). With a mortality rate of 10%, anorexia nervosa has the highest mortality rate of all psychiatric disorders (Birmingham, Su, Hlynsky, Goldner, & Gao, 2005). Anorexia nervosa and bulimia nervosa are associated with higher rates of depression (Godart, 2007; Katsounari, 2009), and trauma (Carter, Bewell, Blackmore, & Woodside, 2006; Everill & Waller, 1995; Kong, & Bernstein, 2009; Neumark-Sztainer, Story, Hannan, Beuhring, & Resnick, 2000; Rayworth, Wise, & Harlow, 2004; Rodriguez, Perez, & Garcia, 2005; Rorty & Yager, 1996; Schmidt, Humfress, & Treasure, 1997; Wonderlich, Brewerton, Jocic, Dansky, & Abbott, 1997). Similarly, suicide rates are higher than in the general population (Pompili, Girardi, Tatarelli, Ruberto, & Tatarelli, 2006).

The literature on recovery from eating disorders varies in terms of findings and methodologies. However, a review of a compilation of literature from diverse sources reveals certain patterns. For one, the literature offers evidence of a progressive developmental process of recovery in which physical and behavioral symptoms remit prior to psychological symptoms. At

the same time, the evidence indicates that a high percentage of individuals in the recovery process do not progress beyond a certain point, but remain in long-term states of partial recovery (a term that will be explored in-depth in chapter 2). Further evidence reveals high relapse rates, especially among those in partial recovery. The impact of treatment on the recovery process is difficult to gauge because results are generally based on assessments, pre- and post-treatment, but rarely considered in terms of how they relate explicitly to the recovery process.

The existing recovery literature focuses predominantly on the movement from being fully engaged in symptoms to symptom remission. Largely absent from the literature are explorations of the progression within the recovery process. As a result of the emphasis on the movement from active eating disorder to recovery, the progression from early recovery to stable long-term recovery remains relatively unstudied. It is clear from the existing literature that those in partial recovery are much improved, but are far from experiencing relief from many of the indices of eating disorders.

This problem led me to the following question: How does the process of moving from early recovery to stable long-term recovery occur? I explored this question by interviewing individuals, who have moved from DSM-IV eating disorder diagnosis, through the early stage of recovery, to what I am calling “full-enough” recovery, about their progression within the recovery process.

Reflexivity Statement

As a therapist and eating disorders specialist, I am aware that the majority of my eating disorders training has focused on symptom management. While I feel highly confident in my ability to help individuals suffering from eating disorder symptoms, several years ago I began to feel a bit stuck in my practice. Many of my patients had significantly reduced or eliminated eating disorder symptoms, but a fair number of them nevertheless experienced "recovery" as miserable. It was at that time that I began training in Accelerated Experiential Dynamic Psychotherapy (AEDP), a treatment model that emphasizes attachment and emotional processing as the route to healing and transformation (Fosha, 2000). As I have incorporated AEDP into my work with eating disorder patients, I have witnessed profound changes: a dramatic shift from approaching recovery mechanically, as a set of instructions to follow, to an experience of feeling emotions viscerally, attuning to their own bodily sensations, and developing a newfound sense of self. The work has led me to new questions about the nature and journey toward fully experienced recoveries, by which I mean recoveries, not only of remission of symptoms, but of profound healing and transformation of self.

Chapter 1: Introduction

For the past several decades, anorexia nervosa and bulimia nervosa have been the only two eating disorders recognized as diagnostic entities with specific criteria. Though there is a growing body of literature about binge eating disorder, it has only recently been recognized as a diagnostic entity, and information about the process of long-term recovery is limited. Because of this lack of existing data, I focused my exploration of the long-term recovery process on anorexia nervosa and bulimia nervosa. The present introductory section includes an overview of diagnosis, medical consequences, prevalence, demographics, and etiology of these two eating disorders.

Overview of Anorexia Nervosa and Bulimia Nervosa

Anorexia Nervosa is characterized by a refusal to maintain body weight at or above a minimally normal weight for age and height, intense fear of gaining weight, distorted thinking around shape and weight, and amenorrhea in post-menarcheal girls and women. The DSM-IV-TR delineates two subtypes: a) anorexia nervosa, restricting type, and b) anorexia nervosa, binge-eating/purging type (APA, 2000). Related medical consequences include osteoporosis, slowed heart rate, electrolyte abnormalities, and cardiac arrest (Halmi, 2008). The estimated standard mortality rate is 10%. Evidence suggests that anorexia nervosa has the highest mortality rate of all psychiatric disorders (Birmingham, 2005). When compared to the general population, both anorexia nervosa and bulimia nervosa are associated with higher suicide rates (Pompili et al., 2006).

Bulimia Nervosa is characterized by recurrent episodes of eating larger amounts of food than most people would in an equivalent discrete period of time. These episodes are marked by a

sense of lack of control and are followed by inappropriate compensatory behaviors, including self-induced vomiting, use of laxatives, ipecac or other medications, excessive exercise, and fasting (APA, 2000). Related medical consequences include tooth enamel erosion, slowed heart rate, electrolyte abnormalities, and cardiac arrest (Halmi, 2008).

Prevalence

A 2007 United States population-based prevalence study found lifetime prevalence rates of .9% for anorexia nervosa, 1.5% for bulimia nervosa, and 3.5% binge eating disorder among women and .3%, .5% and 2.0%, respectively, among men (Hudson, Hiripi, Pope, & Kessler, 2007). Results indicated that 75% of individuals with anorexia nervosa and bulimia nervosa are women. Additionally, researchers found that rates of bulimia nervosa and binge eating disorder have increased during the past three decades. Rates of co-morbid DSM-IV diagnoses are more than 50% among those with lifetime reports of anorexia nervosa, close to 100% among those with lifetime reports of bulimia nervosa, and more than 75% among those with lifetime reports of binge eating disorder. Twelve-month prevalence data indicated that only a minority of individuals with eating disorders sought treatment. In summary, the results suggest that most individuals with eating disorders carry co-morbid psychiatric diagnoses and do not receive treatment. Furthermore, the evidence suggests that the problem is increasing over time.

Though this study found a higher percentage of men with eating disorders than has been found in previous studies, the results support previous findings that women comprise the majority of the eating disorder population (Hsu, 1996). However, the common perception that eating disorders are found only among affluent Caucasian young women and girls is refuted by the increasing body of research on eating disorders across gender (Hay, Loukas, & Philpott,

2005; Lindblad, Lindberg, & Hjern, 2006; McNulty, 1997; Rogers, Resnick, Mitchell, & Blum, 2001; Siever, 1994; Striegel-Moore, 2009) and age (Cohen, 2002; Marcus, Bromberger, Wei, Brown, & Kravitz, 2007). There is similar refutation across race, ethnicity (Alegria, Woo, Cao, et al., 2007; Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001; Granillo, Jones-Rodriguez, & Carvajal, 2005; Kuba & Harris, 2001; Krentz & Arthur, 2001; Lee & Lock, 2007; Miller & Pumariega, 2001; Mulholland & Mintz, 2001; Nicdao, Hong, & Takeuchi, 2007; Petrie & Rogers, 2001; Root, 1990; Striegel-Moore, et al., 2000; Reyes-Rodriguez, Franko, 2010; Talleyrand, 2010; Taylor, Caldwell, Baser, Faison, & Jackson, 2007; Tsai & Gray, 2000; Walcott, Pratt, & Patel, 2003), and socioeconomic class lines (Gard & Freeman, 1996; Gentile, Raghavan, Rajah, & Gates, 2007; Nagel & Jones, 1992; Nevonen & Norring, 2004; Walcott, Pratt, & Patel, 2003).

Eating Disorder Onset and Development

While the etiology of eating disorders remains a topic of debate in the field, research has identified a number of contributing and associated factors. These factors include exposure to media, heredity, personality, family dynamics, trauma history, mood disorders, insecure attachment styles, and high levels of emotional dysregulation. Determining causality is particularly challenging due to the inter-relationship among many of these variables. While the presence of any one factor individually poses minimal risk, common constellations of these factors present a high level of risk. In general, causality is attributed to a confluence of individual and frequently associated factors (Polivy & Herman, 2002).

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1. Exposure to Media

In a prospective cross-sectional design study, Becker, Burwell, Herzog, Hamberg, and Gilman (2002) compared body image and eating attitudes before and after first exposure to television in a population. The authors assessed body and eating attitudes among adolescent girls at two points in time: in 1995, one month after the introduction of television to the region and in 1998, three years later. While the percent of the population who reported some television watching remained constant between 1995 and 1998, the length of time exposed to television served as the independent variable. Results indicate a significant increase in attitudes associated with eating disorders. Additionally, the percentage of respondents reporting self-induced vomiting in order to control weight went from 0% in 1995 to 11.3% in 1998. This groundbreaking naturalistic study presented the rare opportunity of observing a population before and after exposure to a powerful far-reaching media source. The results suggest the profound negative impact of media exposure in a population.

Several studies have shown a direct association between media exposure and indices of eating disorders (Harrison & Hefner, 2008; Levine & Murnen, 2009; Stice, Schupak-Neuberg, Shaw, & Stein, 1994; Tiggemann & Pickering, 1996). Further studies suggest a relationship between media exposure and negative body image, though there is some evidence that this effect is moderated by ethnicity (Bergstrom, Neighbors, & Malheim, 2009; Dalley, Buunk, & Umit, 2009; DeBraganza & Hausenblas, 2010; Hargreaves & Tiggemann, 2009; Swami, Steadman, & Tovee, 2009).

2. Heredity

Research offers some evidence for the existence of a genetic component in the development of eating disorders, though studies have yielded widely ranging results (Bulik, Sullivan, Wade, & Kendler, 2000; Fairburn, Cowen, & Harrison, 1999). The evidence is based predominantly on twin studies that compare rates of concordance and discordance of eating disorder symptomology between monozygotic and dizygotic twin pairs. Though the majority of studies suggest higher rates of concordance between monozygotic twins, some results indicated the reverse (Walters & Kendler, 1995). Variability of results may be the result of small sample sizes and violations of the equal environments assumption, a standard assumption in twin studies which suggests that environment does not exert greater impact on the group of monozygotic twin pairs than on the dizygotic twin pairs (Fairburn et al., 1999).

Findings from current molecular research have identified gene variants associated with specific eating disorder subphenotypes (e.g., restricting anorexia). However, results from studies in progress, as well as further research, are needed to confirm findings (Scherag, Hebebrand, & Hinney, 2010).

3. Personality

Reviews of the literature on personality and eating disorders reveal that certain traits are common in anorexia nervosa and bulimia nervosa. Numerous studies have found high levels of perfectionism among individuals with anorexia nervosa and bulimia nervosa (Bastiani, Rao, Weltzin, & Kaye, 1995; Fassino, Amianto, Gramaglia, Facchini, & Daga, 2004; Halmi, 2000; Halmi, et al., 2005; Lilenfeld, et al., 2000; Pratt, Telch, Labouvie, Wilson, & Agras, 2001). While there is some evidence suggesting that perfectionism remits with recovery (Bardone-Cone,

Sturm, Lawson, Robinson, & Smith, 2010b; Bastiani et al., 1995), contradictory evidence exists that suggests that perfectionism persists (Halmi et al., 2000; Lilenfeld et al., 2000; Stein, et al., 2002; Sutandar-Pinnock, Woodside, Carter, Olmsted, & Kaplan, 2003). These conflicting results may be a reflection of different assessment approaches and the multi-dimensional nature of perfectionism (Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991; Terry-Short, Glynn-Owens, Slade & Dewey, 1995).

Studies have also shown an association between eating disorders and harm avoidance (Cassin & von Ranson, 2005; Fassino et al., 2004). These findings are further supported by genetic studies that have identified specific gene variants associated with harm avoidance in anorexic and bulimic populations (Bailer, et al. 2004; Monteleone, et al., 2006; Ribases, et al., 2005).

Prevalence rates for personality disorders in anorexia nervosa and bulimia nervosa vary widely across studies. Studies have found rates of 30-60% among individuals with eating disorders. Evidence suggests that borderline personality disorder is the most common personality disorder among individuals with bulimia nervosa and bingeing-purging type anorexia nervosa, while obsessive-compulsive personality disorder is the most common personality disorder among individuals with restricting-type anorexia (Carroll, Touyz, & Beaumont, 1996; Godt, 2008; Herzog, Keller, Lavori, Kenny, & Sacks, 1992; Sansone & Levitt, 2005; Schmidt & Telch, 1990; Thornton & Russell, 1997; Wonderlich, Swift, Slotnick, & Goodman, 1990). It is important to note that, similar to other associated factors, the research suggests a strong correlational relationship, but does not determine causality.

4. Family Dynamics

In the 1970s, Bruch, Selvini-Palazzoli and Minuchin each wrote about the importance of understanding the role of family dynamics in the development of eating disorders. Bruch wrote extensively about the mother-child dyad in cases of eating disorders. Bruch described a pattern of maternal intrusiveness and efforts to control (Bruch, 1973). Similarly, Selvini-Palazzoli described mother-child dynamics in terms of excessive maternal demands and lack of emotional responsiveness (1978). Minuchin, Rosman and Baker described families as lacking appropriate boundaries and unresponsive to the needs of the children (1978). The works of these three authors would eventually become seminal in the field of eating disorders.

Though these early clinician-researchers did not test their theories, later studies offer empirical support for their observations. A number of studies have found patterns of parental intrusion (Dare, Le Grange, Eisler, & Rutherford, 1994; Humphrey, 1989; Rorty, Yager, Rossotto, & Buckwalter, 2000) and emotional boundary violations in families with eating disorders (Kog & Vandereycken, 1989; Kog, Vertommen & Vandereycken, 1987; Rowa, Kerig, & Geller, 2001). Additional factors suggested by the evidence are high levels of parental control or coercion (Haworth-Hoeppner, 2000; McEwan & Flouri, 2009; Rhodes & Kroger, 1992; Rorty, Yager, & Rossotto, 1995; Salafia, Gondoli, Corning, Bucchianeri, & Godinez, 2009; Soenens et al., 2008) and conflictual home environments (Kent & Clopton, 1992; Newell, 2005; Ringer & Crittenden, 2007).

5. Trauma History

Numerous studies have found a connection between histories of trauma, specifically child physical, sexual abuse and emotional abuse, and eating disorder psychopathology (Carter et al.,

2006; Everill & Waller, 1995; Kong & Bernstein, 2009; Neumark-Sztainer et al., 2000; Rayworth et al., 2004; Rodriguez et al., 2005; Rorty & Yager, 1996; Schmidt et al., 1997; Wonderlich et al., 1997). Some researchers have questioned the extent of this relationship. Some evidence suggests that certain mediating variables, including depression, anxiety, alexithymia, post-traumatic stress disorder symptoms, and bodily dissatisfaction account for a significant amount of the relationship between histories of abuse and eating disorders (Holzer, Uppala, Wonderlich, Crosby, & Simonich, 2008; Hund & Espelage, 2005, 2006; Kong & Bernstein, 2009; Mazzeo & Espelage, 2002; Mazzeo, Mitchell, & Williams, 2008; Preti, Incani, Camboni, Petretto, & Masala, 2006).

6. Mood Disorders and Related Variables

While significant evidence suggests a correlation between depression and eating disorders (Godart et al., 2007; Katsounari, 2009), the nature of the relationship is widely disputed. According to Polivy and Herman (2002), the relationship may be attributed primarily to depression with eating disorders as a secondary diagnosis, or primarily to eating disorders with depression as a secondary diagnosis, or to a third variable that is associated with both eating disorders and depression. While some of the evidence suggests that onset of depression precedes eating disorders development (Godart et al., 2000), other studies indicate that symptoms of eating disorders result in depressive symptoms in individuals who are not previously depressed (Stice, Hayward, Cameron, Killen, & Taylor, 2000; Polivy & Herman, 2002). Other evidence indicate mixed results with a higher likelihood of developing an eating disorder prior to other Axis I diagnoses among individuals with anorexia nervosa than among those with bulimia nervosa (Braun, Sunday, & Halmi, 1994). Additionally, there is evidence of mood improvement

among individuals with anorexia nervosa who have been weight-restored (Meehan, Loeb, Roberto, & Attia, 2006). These results suggest that among individuals with anorexia nervosa, the eating disorder is a primary diagnosis, while difficulties with mood are associated with low weight.

Results of some studies suggest that there is no direct association between depression and eating disorders. Green et al. (2009) found that social comparison, low self-esteem, and body dissatisfaction account for the correlation between eating disorders and depression. When those three variables were controlled, the correlation between depression and eating disorders disappeared. Troop, Serpell, and Treasure (2001) found that only the cognitive components of depression were associated with eating disorders. In a prospective study, Dobmeyer and Stein (2003) found drive for thinness, which is highly correlated with body dissatisfaction and maladaptive cognitions, was far more predictive of eating disorders than was depressed mood. This evidence calls into question whether depression as a syndrome is associated with eating disorders, or if the mediating roles of other variables, including low self-esteem and body dissatisfaction, account for the majority of the association.

Numerous studies have explored the relationships between these two variables, low self-esteem and body dissatisfaction, and eating disorders. The connection between low self-esteem and eating disorders has repeatedly been validated empirically (Erol, Yazici, Erol, & Kaptanoglu, 2000; Gila, Castro, Gomez, & Toro, 2005; Iniewicz, 2005; Tchanturia, Troop, & Katzman, 2002; Vinuales-Mas, Fernandez-Aranda, Jimenez-Murcia, Turon-Gil, & Vallejo-Ruiloba, 2001; Wilksch & Wade, 2004). At the same time, ambiguity remains as to whether low self-esteem contributes to or results from eating disorders (or both). Several studies indicate that low self-esteem precedes eating disorder development (Cervera, Lahortiga, Martínez-González et al.,

2003; Gual et al., 2002). Nevertheless, there is evidence that low self-esteem persists after remission of bingeing and purging in bulimia nervosa (Daley, Jimerson, Heatherton, Metzger, & Wolfe, 2008). Contradicting those results is evidence that self-esteem improves significantly after resolution of eating disorder symptoms (Halvorsen & Heyerdahl, 2006; Troop, Schmidt, Turnbull, & Treasure, 2000).

Evaluating the role of negative body image in eating disorders is particularly complicated because body image plays a dual role as an associated factor (Garner, Garfinkel, Schwartz, & Thompson, 1980; Striegel-Moore, Silberstein, & Rodin, 1986) and a clinical feature of eating disorders. Numerous studies have found evidence of a connection between body dissatisfaction and eating disorders (Benninghoven, Tetsch, & Jantschek, 2008; Carta, Zappa, Garghentini, & Caslini 2008; Halvorsen & Heyerdahl, 2006; Hrabosky & Grilo, 2007; Peat, Peyerl, & Muehlenkamp, 2008; Varnado-Sullivan, Horton, & Savoy, 2006). Due to vastly conflicting results, however, it is difficult to determine the extent of the connection (Sepuveda, Botella, & Leon, 2002). Similarly, studies examining the relationships among body dissatisfaction, eating disorders and other variables have resulted in contradictory findings. While evidence exists that suggests that body dissatisfaction is a mediating variable between eating disorders and low self-esteem (Chen, Fu, Chen, & Wang, 2007), other studies have found that low self-esteem, unrelated to body image, is significantly linked to eating disorders (Geller, Zaitsoff & Srikameswaran, 2002; Joiner, Schmidt, & Wonderlich, 1997). Other studies suggest that all three variables, eating disorders, body dissatisfaction and low self-esteem, are related (Baile & Osorio, 2008).

7. Insecure Attachment

Attachment Theory is a developmental model which positions experiences in infancy with primary caregivers as central to a person's developing sense of self (Bowlby, 1977). The model evolved to include a system to classify infant-caregiver interactions (Ainsworth, Blehar, Waters, & Wall, 1978). Ainsworth designated three attachment categories that are used to describe predominant attachment styles: secure, insecure-avoidant and insecure-ambivalent. Secure attachment styles are characterized by infant expressions of distress during brief absences of the primary caregiver, and ease of calming, and resumed play upon caregiver's return. Insecure-avoidant attachment styles are characterized by minimal visible infant reaction to caregivers' departures and returns. Insecure-ambivalent styles were characterized by infant reactions of intense distress when caregivers left the room and difficulties in calming upon caregivers' return. Ainsworth observed that the mothers of securely attached infants were attuned and responsive in their interactions with their infants. Mothers of insecure-avoidant infants tended to be rejecting, and mothers of insecure-ambivalent tended to be misattuned and unpredictable. Main and Solomon (1990) added a fourth attachment style: insecure disorganized. Babies with disorganized attachment styles were those who tended to exhibit seemingly inexplicable idiosyncratic responses to caregivers, such as freezing or approaching by walking backwards. Disorganized attachment, more than other attachment styles, is significantly correlated with abuse and neglect (Carlson, Cicchetti, Barnett, & Braunwald, 1989). Main, Hesse, and Goldwyn also adapted Ainsworth's classification system to adult relational patterns (2008).

Studies have shown that eating disorders are highly correlated with insecure attachment styles (Broberg, Hjalmers, & Nevonen, 2001; Chassler, 2007; Eggert, Levendosky, & Klump,

2007; Elgin & Pritchard, 2006; Friedberg & Lyddon, 1996; Ramacciotti et al., 2001). While some evidence suggests a direct relationship between attachment insecurity and eating disorders (Troisi, Di Lorenzo, Alcini et al., 2006), other studies suggest that body dissatisfaction is a significant mediating variable between the two variables (Abbate-Daga, Gramaglia, Amianto, Marzola, & Fassino, 2010; Tasca et al., 2006).

8. Emotional Dysregulation

The affect regulation theory of eating disorders posits that eating disorders serve the function of regulating affect, which is often experienced as overwhelming (Barth, 2008; Bohon et al., 2009; Clinton, 2006; Deaver, Miltenberger, Smyth, Medinger, & Crosby, 2003). This connection between high levels of emotion dysregulation and eating disorders has been documented in numerous studies (Clyne & Blampied, 2004: Safer, Telch, & Agras, 2001; Telch, 1997; Telch, Agras & Linehan. 2000, 2001).

The affect regulation model considers the effects of individual eating disorder symptoms on emotional states as essential factors in maintaining eating disorders. Empirical evidence indicates that vomiting, binge eating, and caloric restriction all have a significant impact on mood (Abraham & Joseph, 1986; Chatoor, Herman, & Hartzler, 1994; Davis & Claridge, 1998; Ericsson, Poston, & Foreyt, 1996; Huebner, 1993; Jonas & Gold, 1988**;** Kaye, Gwirtsman, George, & Weiss, 1986; Walsh, Gladis, & Roose, 1986**).** Studies suggest that binge eating, purging and excessive exercise provide short-term positive affective states that are followed by prolonged negative affective states (Hilbert & Tuschen-Caffier, 2007; Overton, Selway, Strongman, & Houston, 2005; Penas-Lliedo, Vaz Leal, & Waller, 2002; Vansteelandt, Rijmen, Pieters, Probst, & Vanderlinden, 2007). As a result, the individual is vulnerable to engage further

in symptoms and developing a cyclical pattern of symptom engagement. Research in affective neuroscience has traced a connection between affect dysregulation and attachment insecurity (Fonagy & Target, 2009; Sroufe, 1996; Schore & Schore, 2008).

Summary

As a result of multiple overlapping variables, precisely determining etiology in eating disorders is challenging. However, evidence indicates that specific factors, as well as configurations of these factors, contribute significantly to risk. Environmental factors, such as media exposure, have been found to increase risk in a general population. Specific genetic variations, personality traits of perfectionism and harm avoidance, borderline or obsessive-compulsive personality disorder, problems with emotional boundaries within families, trauma histories, depressive symptoms, insecure attachment styles, and deficits in emotional regulation contribute to the level of risk for individuals who present with one or more of these factors.

Chapter 2: Recovery, Relapse and Treatment

In this section, I present a compilation of the recovery literature, drawn from multiple sources of information. These sources include quantitative and qualitative research, as well as literature from popular culture. Additionally, I will review the literature on relapse and treatment. The treatment literature will be explored, specifically, as it relates to the literature on recovery. Through this review, I identify emerging themes related to the recovery process, as well as information gaps that merit further exploration.

Recovery

The earliest recovery studies, completed in the 1970s-1980s, either neglected to operationalize the concept of recovery or relied predominantly on behavioral and physical measures (Herzog, Keller, & Lavori, 1988). More recent studies, on the other hand, tend to include definitions that incorporate multiple dimensions of recovery, including cognitive and psychological factors (Herzog, Dorer, Keel et al., 1999; Kordy, et al., 2002; Strober, Freeman, & Morrell, 1997; Von Holle, 2008). Nevertheless, there remains a lack of consensus in defining and operationalizing the concept. As a result, results of quantitative studies vary widely.

Valuable insights into the recovery process can be gained from the rich body of research of recent years. These include outcome studies, explorations of factors associated with the recovery process, qualitative research on the subjective experiences of individuals in the recovery process, stages of change models, and personal memoirs. While taking into account that relying on multiple sources of information offers greater possibilities for discrepant findings, it also offers the possibility of discovering unifying themes across a larger body of literature. This review represents a compilation of literature gathered from the range of sources cited above. The

aim of the review is to highlight emerging patterns and trends across the different methods and sources. The review focuses primarily on adults. Several long-term outcome studies that span adolescence to adulthood are included in the review and are described specifically as such.

1. Outcome studies

This discussion of eating disorder outcomes includes an exploration of the terms partial recovery and full recovery, which are frequently used to describe recovery levels that are distinguished by the absence or presence, respectively, of remission from psychological components of eating disorders. My discussion highlights comparative rates of partial versus full recovery, as well as differences in the data on outcome in anorexia nervosa versus bulimia nervosa.

Many long-term outcome studies rely on definitions of recovery that, as noted, include multiple levels of the concept. In a prospective longitudinal study of outcomes in bulimia and anorexia nervosa, Herzog et al. (1999) defined partial recovery as a reduction of symptoms to a level beneath full diagnostic criteria for a period of eight consecutive weeks. Full recovery was defined as absence of symptoms or presence of only residual symptoms for eight consecutive weeks. Outcome was based on the 6-point Psychiatric Status Rating Scale (PSR, see Appendix A) (Herzog et al., 1993; Keller, 1987). Those with the highest ratings, 1 and 2, were categorized as in full recovery. Those with ratings of 3 or 4 were categorized as in partial recovery. Among 246 women seeking treatment, researchers found that 74% of individuals with bulimia nervosa and 33% of individuals with anorexia nervosa achieved full recovery during the 7.5-year follow-up period. Rates of partial recovery were higher: 99% for individuals with bulimia nervosa and 83% for individuals with anorexia nervosa. Though the rates of partial recovery were

significantly higher, the definition of partial recovery allowed for a wide range of symptom levels. In a 2005 study in which the PSR was used to assess 4-year outcome among individuals with bulimia nervosa, the authors described those with a 3 rating as having a "good outcome," while those with a 4 rating all met DSM-IV criteria for Eating Disorder Not Otherwise Specified (EDNOS) (Bogh, Rokkedal, & Valbak, 2005). Applying Herzog's classification system to the study by Bogh et al., PSR ratings of 3, indicating "good outcome," and PSR ratings of 4, indicating EDNOS, would both be classified in the category of "partial recovery." This disparity in definitions renders interpretation across studies challenging.

In their study of 1171 individuals diagnosed with anorexia or bulimia nervosa, Kordy et al. (2002) found partial remission rates of 55% among individuals with anorexia nervosa and 60% among individuals with bulimia nervosa at the 2.5-year follow-up mark. Full remission rates were 18% among individuals with bulimia nervosa and 7% among individuals with anorexia nervosa. As in the study by Herzog et al., the gap in the recovery rates between diagnoses was greater in the full recovery category than in the partial category. Poorer outcomes in the study by Kordy et al. may be partially attributed to the more stringent definitions of recovery (or remission, the term used in the Kordy study). Kordy et al. defined a minimum BMI for individuals with anorexia, and a maximum number of binge/purge episodes per week for individuals with bulimia as criteria for partial recovery. While criteria for partial recovery included behavioral/physical symptoms, they did not include psychological or cognitive symptoms. This is an important distinction as it reflects the possibility that the individuals in the partial recovery category improved significantly in the behavioral and physical realms, but did not improve in terms of psychological functioning .The definition of full recovery, in contrast, included additional behavioral/physical improvement, as well as a specification of "no

extremes" in terms of weight-related thinking. Another distinction of the Kordy study is that researchers used a 12-week time frame as opposed to the 8-weight time frame used in the study by Herzog et al. Though specific results vary significantly, higher recovery rates in bulimia nervosa than in anorexia nervosa have consistently been found across studies (Ben-Tovim, Walker, Gilchrist et al., 2001; Herzog et al., 1999; Kordy et al. 2002; Von Holle et al., 2008; Van Son, Van Hoeken, Van Furth, Donker, & Hoek, 2010).

In a retrospective study by Von Holle et al. (2008) of 901 individuals with anorexia or bulimia nervosa, the researchers defined recovery as three years without any behavioral/physical symptoms. The authors chose this conservative definition in order to distinguish between recovery and what they defined as episodes of symptom remission. The authors included individuals who indicated sub-threshold levels of weight-related self-evaluation in the recovery category. This allowance for the presence of some weight-related thinking among those in the recovery category is consistent with the specification of "no extremes" in the full recovery category in the study by Kordy et al., though neither study measured weight-related thinking or self-evaluation as separate variables. Psychological and cognitive factors were included as components of the general eating disorders assessment. Results in the Von Holle et al. study showed 10-year recovery rates of 11% among individuals diagnosed with anorexia nervosa and 10% among individuals diagnosed with bulimia nervosa. Results at the 15-year follow-up mark indicated recovery rates of 16% among individuals with anorexia nervosa and 25% among individuals with bulimia nervosa. Comparison of 10- and 15-year follow-up rates supports results from earlier studies that indicate that recovery is a protracted process (Collings & King, 1994; Fairburn, Cooper, Doll, Norman, & O'Connor, 2000; Sabine, Yonace, Farrington, Barratt, & Wakeling, 1983; Strober et al., 1997).

In a study of 147 patients evaluated by general medical practitioners, van Son et al. (2010) found comparable rates of full recovery between individuals diagnosed with anorexia nervosa and bulimia nervosa. Recovery assessments were based solely on physical and behavioral symptoms. The authors defined full recovery and intermediate recovery categories based on levels of physical and behavioral symptoms. Results indicated full recovery rates of 57% among individuals with anorexia nervosa and 61% among individuals with bulimia nervosa. The narrower margin between recovery rates of the two diagnoses may be related to the exclusion of the psychological aspects of the illnesses in the initial assessment, thus the definition of full recovery in the study was based on behavioral symptoms only. As a result, the full recovery category included individuals who would be categorized in the previously mentioned studies as partially recovered due to the presence of psychological symptoms. However, as in the studies discussed above, the gap between recovery rates for the two diagnoses was narrower among those classified as partially recovered. These results suggest that the psychological aspects of bulimia nervosa may be more amenable to change than those of anorexia nervosa.

In a prospective follow-up study, Clausen (2004) examined time to remission for individual symptoms in a group of 65 individuals diagnosed with anorexia or bulimia nervosa. Supporting findings from previous studies, results at 2.5-year follow-up indicated that recovery rates for bulimia nervosa were higher than those for anorexia nervosa. The low rates of recovery in anorexia are consistent with results from treatment studies, which have failed to establish evidence-based effective treatments for adults with anorexia nervosa (this topic will be explored further in the discussion of the literature on treatment). Further results of Clausen's study indicate that time to remission of behavioral and physical symptoms for both anorexia and

bulimia nervosa is shorter than time to remission of psychological symptoms. Keski-Rahkonen, Hoek, Linna et al. (2009) found similar results in a retrospective study of 59 individuals with bulimia nervosa. Investigators defined remission as one year without any incidences of bingeing or purging and maintenance of normal body weight. Results at 5-year follow-up showed 55% remission rates. Additionally, psychological symptoms were measured, though they were not included as criteria in the definition of remission. The findings suggest that psychological symptoms decrease over time among those in remission; however, a proportion of those individuals continue to experience body image problems.

In a 15-year follow-up study of adolescents with anorexia, Strober et al. (1997) found full recovery rates of 76% and rates of those who achieved only partial recovery of 14%. Like Herzog et al., Strober et al. defined full recovery as absence of diagnostic criteria, including behavioral, physical and psychological symptoms, for eight consecutive weeks. Partial recovery was defined as absence of behavioral and physical symptoms for eight consecutive weeks. The high recovery rate may be related to the relative youth of the population studied. Younger age at detection and first treatment has been associated with positive outcomes (Fichter, Quadlieg, & Hedlund, 2006; Hjern, Lindberg, & Lindblad, 2006; van Son et al., 2010; Wentz, Gillberg, Anckarsater, Gillber, & Rastam, 2009). In addition, in the study by Strober et al., partial recovery tended to be a transitional state leading to full recovery. This is in contrast to the studies described above in which results suggest that a significant proportion of those in partial recovery do not progress to full recovery.

Overall, studies tend to show higher rates of partial than full recovery. Findings indicate that a significant proportion of subjects remain in partial recovery without ever reaching full recovery during long-term follow-up periods. Studies tend to use presence of psychological

symptoms as the factor distinguishing between partial from full recovery. Several studies included specific behavioral or physical measures that distinguished the two types of recovery as well. These trends suggest that a significant number of individuals with eating disorders maintain a level of behavioral and physical recovery, while never experiencing significant relief from psychological symptoms. Other findings suggest that remission of behavioral and physical symptoms precedes remission from psychological symptoms among those who achieve psychological recovery. Generally, recovery rates are higher for bulimia nervosa than for anorexia nervosa in the adult population.

2. Studies on Components of Recovery

Another approach to understanding recovery involves considering recovery as a sum of its component parts. In this section, I review investigations of specific aspects of the recovery process. Several of these studies illuminate the contrast between partial and full recoveries. Others offer insight into the aspects of the process that individuals in recovery find most challenging and most important.

Returning to the notion of behavioral, including physical, recovery as separate from psychological recovery, researchers have attempted to understand the relative significance of these two components in the recovery process. Bardone-Cone et al. (2010a) compared four groups: a fully recovered group, as defined by the absence of behavioral and psychological symptoms; a partially recovered group, as defined by the presence of some behavioral and psychological symptoms; an active eating disorders group, as defined by DSM-IV criteria; and, a healthy control group. Investigators measured body image disturbance and psychosocial functioning among study participants. Results showed no difference in body image disturbance

scores between the full recovery group and the healthy control group. In contrast, scores in the partially recovered group were indistinguishable from those in the active eating disorders group. In terms of psychosocial functioning, the fully recovered group and the partially recovered group scored similarly to healthy controls, although the partially recovered group reported greater interference in functioning due to aspects of eating disorders. The authors propose to operationalize full recovery definition in which criteria for full recovery are met when individuals with a history of an eating disorder and healthy controls (those without a history of an eating disorder) are indistinguishable on behavioral and psychological measures of eating disorder symptomatology.

In a study evaluating whether remission of undue influence of weight and shape on self-evaluation, one of the criteria of DSM-IV diagnosis, should be included in defining recovery, Cogley and Keel (2003) found results similar to those in the study by Bardone-Cone et al. (2010a). The authors compared three groups: a group of fully recovered individuals with histories of bulimia nervosa, a group of partially recovered individuals, and a group of healthy controls. They defined full recovery as absence of behavioral and psychological symptoms for a period of three months. Partial recovery was defined as absence of behavioral symptoms for a period of three months. Those in the healthy control group did not have eating disorder histories. Study participants completed assessments for depression, anxiety, body dissatisfaction and social functioning. The authors found no difference in scores between the fully recovered group and the healthy control group. The partially recovered group had scores suggesting more pathology in all realms. The authors concluded that remission of undue influence of weight and shape in self-evaluation could be a useful criterion to incorporate in a standard definition of recovery. In a similar study of recovery from anorexia nervosa, Bachner-Melman, Zohar, and Ebstein (2006)

compared a group of fully recovered individuals, partially recovered individuals, and healthy controls (no eating disorder history). The authors defined full recovery as behavioral, including physical recovery, and cognitive recovery for eight consecutive weeks. Cognitive recovery was defined as absence of DSM-IV criteria of fear of gaining weight and body image distortion. Partial recovery was defined as behavioral, including physical recovery, with continued presence of fear of weight gain and/or body image distortion for eight consecutive weeks. Study participants completed assessments of general symptoms, eating attitudes, eating disorder symptoms and body image distortion. As in Cogley and Keel's study, the authors found no difference in scores between the fully recovered group and healthy controls. The partially recovered group had scores that were closer to the scores of individuals with active anorexia nervosa than those of the fully recovered group. The authors recommended the development of a standard definition of recovery from anorexia nervosa that includes absence of cognitive symptoms, as well as behavioral symptoms.

Windauer, Lennerts, Talbot, Touyz, and Beumont (1993) followed a group of women for one year following completion of inpatient treatment. Participants completed measures of eating disorder status, as well as overall functioning. In addition, participants kept a log documenting food and beverage intake. The findings indicated that the majority of patients maintained improvement on psychosocial measures and weight status. However, examination of food records revealed marked patterns of restrictive eating among the majority of the participants. This study highlights the risks involved in relying solely on standardized measures in defining recovery. The study, however, was small and all participants were under the care of the same treatment provider who was one of the contributing authors. Consequently, the results are not generalizable and risk of bias is high.

Though the Windauer et al. study had significant methodological weaknesses, it highlights the importance of exploring aspects of the recovery process that might be overlooked based on standardized measures alone. Rorty, Yaeger, and Rossotto (1993) conducted semi-structured interviews of women recovered at least one year from bulimia nervosa. Recovery from bulimia nervosa was based on self-report, though participants were screened to establish history of DSM-III diagnosed bulimia nervosa. The authors compiled responses to questions and calculated the percentage of participants who answered similarly. While the semi-structured interviews offered insight into the subjective experiences of individuals in recovery, the study is included in this section, rather than in the qualitative studies section, both because it offers a view of the components of recovery and because the data are presented as ranked percentages of nominal responses to individual questions. Eighty percent of the participants indicated that body image problems and desire to be thinner were the most difficult aspects of the disorder to change. Sixty-eight percent indicated the body image problems and desire to be thinner remained something they would like to change. These results suggest that not only does behavioral recovery tend to precede psychological and cognitive recovery, but also that psychological and cognitive symptoms are the most difficult to overcome. In a follow-up study by Jager, Liedtke, Lamprecht, & Freyberger (2004) of 92 individuals assessed at the beginning of treatment bulimia nervosa, the authors found that psychosocial adjustment was greatly improved at the 8-year follow-up mark. Participants reported that restrictive eating tendencies and feelings of ineffectiveness were the most difficult elements to change. These findings offer important information about the experience in the recovery process from the perspective of the individual in recovery.

In a study comparing patient and therapist perspectives on the recovery process, Noordenbos and Seubring (2006) compiled a list of 52 factors associated with recovery. The authors asked individuals in recovery from an eating disorder and therapists to rate which factors were most important in the recovery process. The authors recruited individuals who self-identified as "in recovery" or as having improved substantially. The authors found high levels of agreement between ratings of the individuals in recovery and therapists. Factors that received the highest rankings spanned the realms of eating behaviors, body image, somatic factors, emotional factors, psychological wellbeing, and social factors. These results further support the importance of developing a multi-dimensional definition of recovery.

In summary, studies exploring factors related to recovery suggest that those in full recovery have levels of psychological and social functioning comparable to those of individuals without histories of eating disorders. Those in partial recovery tend to have more in common with those with active eating disorders. These results are based on definitions of partial recovery that include remission of behavioral eating disorder symptoms, but not of psychological eating disorder symptoms. Additionally, these studies suggest that behavioral changes precede psychological changes in recovery and that psychological changes are more difficult to make than behavioral ones.

3. Qualitative Studies

In 1999, Jarman and Walsh published a review of the recovery literature. The authors observed that the voices of those in recovery were generally absent from the literature. While several early qualitative studies exist (Hsu, Crisp, & Callender, 1992; Noordenboos, 1992; Rorty et al., 1993), it is primarily in the past decade that researchers have begun exploring the

subjective experiences of those in recovery (D'Abundo & Chally, 2004; Federici and Kaplan, 2008; Granek, 2007; Lamoureux & Bottorff, 2005; Nilsson & Hagglof , 2006; Patching and Lawlor, 2009; Petterson & Rosenvinge, 2002; Reindl, 2001; Ronel & Libman, 2003; Shohet, 2007; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Though qualitative studies are highly limited in terms of generalizability, they offer the opportunity to explore individual experiences, while identifying commonalities (Charmaz, 1995). Recent qualitative studies highlight the diversity of experiences among those who recover. At the same time, challenging eating disorder-related thinking, self-attunement, and intimacy in relationships have emerged as common themes, as well as issues of ongoing struggle.

The literature includes qualitative interview-based studies that offer perspectives on recovery from individuals in recovery. Patching and Lawlor (2009) interviewed 20 women about the development of their eating disorders and their recoveries. Participants ranged from reports of 3 to 25 years in recovery. The definition of recovery for purposes of the study was self-identification as an individual in recovery. While a number of qualitative studies rely on subjective reports of recovery for inclusion in the study, many studies include a basic screening for eating disorder history and/or recovery in order to increase the likelihood that the phenomena being studied are similar among participants. Based on their interviews, Patching and Lawlor discovered common recovery processes: first, realizing that the eating disorder is creating chaos and, then, gaining control over symptoms. These findings support a developmental view of recovery. Federici and Kaplan (2008) interviewed weight-restored and weight-relapsed individuals with histories of anorexia nervosa approximately one year after discharge from intensive treatment. Similar to Patching and Lawlor study, the authors found weight-restored participants viewed weight restoration as one step in an ongoing process of recovery. On the

other hand, many in the weight-relapsed group reported not realizing that recovery required continued effort even after discharge from intensive treatment. In addition, several in the weight-relapsed group denied relapse. They described themselves as "in the process of recovery," (p. 5) similarly to those in the weight-restored group. This finding supports the importance of applying explicit operational definitions in screening for eligibility in recovery studies due to the potential inaccuracies of self-report. Tozzi et al. (2003) interviewed women approximately twelve years after discharge from inpatient treatment for anorexia. Among those who were assessed as recovered, as defined by absence of any type of eating disorder at the time of interview, supportive relationships and maturity were the most frequently cited contributing factors. Those who named maturity as a contributing factor identified significant life events, such as pregnancy or deciding to start a family, as turning points. These findings suggest that for some women a maturational process spurs the developmental process of recovery.

Nilsson and Hagglof (2006) interviewed individuals 15 years after discharge from inpatient treatment for anorexia nervosa. The authors classified participants as recovered or un-recovered, but did not present operational definitions for these categories. As in the study by Tozzi et al., the authors found individuals in the recovered group could identify specific turning points that represented their entries into recovery. Many respondents attributed their launch into recovery to realizations about the medical consequences of their illness. While some of the respondents described their turning points as sudden, others described gradual processes of reaching their turning points.

D'Abundo and Chally (2004) interviewed 17 women who self-identified as having recovered or being in the process of recovery from an eating disorder. Additionally, the authors gathered data by conducting a focus group with five respondents, and observing respondent

participation in a weekly support group. Based on these three sources of data, the authors developed the "circle of acceptance" model in which severity of symptoms increases until individuals reach a point of acceptance related to their disease, the other people in their lives and/or their spirituality. In the model, these acceptances foster feelings of self-worth and symptoms decrease. Respondents who reached points of acceptance in all three dimensions tended to have fuller recoveries. Respondents who reached only one or two points of acceptance tended to continue to struggle with symptoms. Results indicated that many of the respondents continued to struggle. Many whose behavioral and psychological symptoms had abated continued to struggle with mood and social adjustment. Others repeated a pattern of increasing and decreasing severity of symptoms without ever establishing normal eating patterns. Like D'Abundo and Chally, Shohet (2007) compared the experiences of women who self-identified as in full recovery and those who self-identified as continuing to struggle. Though Shohet's sample was small, one woman in full recovery and one woman "struggling to recover," (p. 244) themes of coherence and clarity versus confusion and ambivalence emerged in comparing the narrative of the respondent in recovery to the narrative of the "struggling to recover" respondent.

Hsu et al. (1992) interviewed six women in recovery from anorexia twenty years after onset of illness. The authors indicated that all respondents had stable weight and return of menses for at least one year prior to interview. Scores on psychometric measures, including the Eating Disorders Inventory, were predominantly in the normal range. The authors found that three of the six women had many years of behavioral and psychological recovery. Another woman reported that behavioral symptoms had been in remission for just over one year and that she felt comfortable with weight and body. Interviews revealed that the other two women, though they had maintained behavioral and physical recovery for over a year, continued to

restrict caloric intake and one complained of body dissatisfaction. Several women identified specific turning points that marked their entries into recovery. Turning points included becoming pregnant and gaining a sense of spirituality. The woman who described restrictive and unusual eating patterns, but denied bodily dissatisfaction, reported that she began to recover after receiving a leucotomy, a surgical procedure, that is no longer done, aimed at reducing psychiatric symptoms. Results highlight the wide range of experiences that can occur among individuals who meet the same basic definition of recovery.

Wasson and Jackson (2004) conducted focus groups with twenty-six women who regularly attended Overeaters Anonymous (OA) meetings, had a history of bulimia nervosa, and endorsed at least six months without symptoms. In addition to conducting focus groups, the authors interviewed six respondents individually. Respondents described maintaining recovery as a challenge that required regular use of OA strategies in order not to engage in symptoms. They described regular attendance of meetings, interactions with an OA mentor, journaling, practicing spirituality, and following a meal plan as the skills that were essential to preventing binge/purge episodes. Respondents indicated that while their meal plans tended to be highly structured initially, they adopted more flexible plans over time. These results illuminate the process of employing specific skills in order to stop engaging in symptoms and maintain recovery.

While many of the studies discussed describe internal processes of recovery, the study by Wasson and Jackson describes the concrete steps that facilitate the goal of abstaining from engaging in symptoms. This disparity raises the question of whether these guidelines, which serve as essential tools in early symptom management, become internalized and grow into a more organic way of being in recovery or if they remain rules to be followed. In another study of OA, Ronel and Libman (2003) found that individuals described recoveries that guided and

transformed their worldviews. The authors interviewed 88 individuals who attended OA meetings regularly and endorsed lengths of recovery, as defined by abstaining from eating disorder symptoms, from several months to several years. Respondents described shifts in the way they experienced themselves, their spirituality, their relationships with others, and the nature of their eating problems. Specifically, they described developing an understanding that their eating problems were not about food or weight, but about deeper psychological and spiritual issues. As opposed to the changes in practice described in the study by Wasson and Jackson, Ronel and Libman's study described profound internal shifts. It is important to note that Ronel and Libman described their respondents as individuals with eating disorders, but did not provide further detail. As a result, the nature and severity of eating disorder symptoms in the population is unknown. Furthermore, due to the wide range of recovery lengths and absence of data from OA members who continued to engage in symptoms, the relationship of these internal shifts with recovery is unclear.

The concept of self has been explored in a number of studies on recovery from eating disorders. Hesse-Biber, Marino, and Watts-Roy (1999) interviewed 21 women six years after they were identified in a college freshman population as having subclinical eating disorders. This is in contrast to previously discussed studies that focus on patient or community samples of individuals with histories of clinical eating disorders. At the time of interview, 10 women continued to struggle with symptoms, while 11 were classified as recovered based on standardized measures of eating disorder symptomatology. The authors found differences between the two groups in self-concept, which the authors defined as the individual's ability to achieve balance between autonomy and intimacy. While relationships were described as generally lacking in conflict in the recovered group, relationships in the unrecovered group were

described as fraught with difficulties navigating boundaries. Both groups struggled with self-directedness during their college years, although the recovered group developed positive coping skills by their senior years. Though it is impossible to determine whether positive relationships contribute to recovery or result from recovery (or both), the study highlights the importance of the concept of self, individually and in relationship, in understanding recovery. In their study of women's subjective experiences of recovery, Petterson and Rosenvinge (2002) found similar results. The authors interviewed 48 women with anorexia nervosa, bulimia nervosa and binge eating disorder. Participants described the components of recovery as increased self-acceptance, improved interpersonal relationships, decreased body dissatisfaction, and improved problem solving. Inclusion in the study was based on having sought treatment for the eating disorder. As a result, participants reported a wide range of current levels of symptoms, as well as differing levels of recovery.

In her interviews with five women who self-identified as in recovery from anorexia nervosa, Granek (2007) found that the respondents focused on recovery as a process of finding self-worth and connecting in relationships, as opposed to focusing on the behavioral/physical aspects of recovery. Lamoureux and Bottorff (2005) interviewed nine women who self-identified as in recovery from anorexia nervosa. Major themes in the interviews included self-rediscovery and what the authors called "becoming the real me." (p. 174). In describing the recovery process, participants described five components: realizing the dangers of the disease, taking small steps away from the disease, tolerating revealing their thoughts and feelings, challenging anorexic thinking, and reclaiming one's own self-worth. While the authors do not present these components as a developmental progression, the components of realizing dangers of the disease, taking small steps, and challenging anorexic thinking may be tasks of early recovery, while

reclaiming one's own self-worth may be connected with more advanced recovery. Garrett (1997) interviewed 32 women who self-identified as in recovery from anorexia nervosa. A distinction in this study is that the author disclosed her own story of recovery from anorexia story in her study recruitment letter. In discussing their recovery processes, participants described five essential elements: relinquishing obsession with weight and food, gaining a sense of meaning in their lives, developing self-worth, believing that they would not return to self-starvation, and finding meaning in spirituality. The respondents also talked about turning points and described recovery as a process, not an endpoint.

In her interviews with 13 women who self-identified as in recovery from bulimia nervosa for the previous 2-4 years, Reindl (2001) found themes of connection with one's internal sense of self. While several studies explore the concept of relationship to oneself and to others, Reindl broadened the scope of exploration to include processes of connecting with one's own emotions and body, two integral components in recovery that have rarely been discussed in the literature. Bjork and Ahlstrom (2008) interviewed 14 respondents self-identified as in recovery from an eating disorder. Normalizing eating patterns, acceptance of self and body, and connection in relationships emerged as central themes in their recovery processes. These results further support the findings from the studies by Lamoureux and Bortoff, by Garrett, and by Reindl.

In summary, qualitative research offers insight into the recovery process from the perspective of the individual in recovery. Studies reveal that experiences of recovery vary widely. Descriptions of recovery involved gaining a sense of self, including attuning to one's emotions, desires, needs and bodily experiences, as well as engaging in ongoing struggles. Overall, the findings suggest a progressive process of recovery with specific turning points.

Themes that emerged as central to the process were relinquishing eating disordered thinking, increased self-attunement, knowledge and clarity, and intimacy in relationships.

4. Stages of Change Models

A number of authors have developed models of motivational interviewing (Miller & Rollnick, 1991), a clinical technique developed to enhance motivation to change, adapted to the treatment of eating disorders (Killick & Allen, 1997; Lask, Geller, & Srikameswaran, 2007; Treasure & Schmidt, 2008). Motivational interviewing is often associated with Diclemente and Prochaska's transtheoretical stages of change model that considers a spectrum of levels of motivation to change from addictive behaviors (Prochaska & DiClemente, 1982; Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992). The spectrum is divided into five stages: pre-contemplation, contemplation, preparation, action and maintenance. The model includes a "relapse" stage, which can occur after the action stage in individuals who do not progress to maintenance. The goal of motivational interviewing is to help the individual advance along the spectrum of motivation levels.

Several studies have explored the use of the stages of change measures in assessing recovery from eating disorders (Ash, 1997; Jordan & Nigg, 2002; Jordan, Redding, Troop, Treasure, & Serpell, 2003). By integrating quantitative and qualitative findings, Ash developed a stage model of recovery (1997). Stages, or what she labeled "islands" to represent the non-linearity of the process, were defined based on her quantitative comparison across models of recovery. The author used narrative responses to categorize participants and illustrate "islands" of change. This study will be discussed further in comparison to the findings of the current study (see Findings section).

Other studies have explored the role of motivational stage and the use of motivational enhancement in the early stages treatment (Casanovas et al., 2007; Dean, Touyz, Rieger, & Thornton, 2008; Hasler, Delsignore, Milos, Budderberg & Schnyder, 2004; Touyz, Thornton, Rieger, George, & Beumont, 2003; Wade, Frayne, Edwards, Robertson, & Gilchrist, 2009). There have been relatively few other studies exploring stages of change during the recovery process. However, results from those that have suggest that stages of change and level of motivation are linked to outcome. Jones, Bamford, Ford, & Schreiber-Kounine (2007) investigated the impact of initial Body Mass Index (BMI) and self-rated levels of motivation on outcomes in 34 individuals enrolled in 3-month day treatment program for eating disorders. Outcome was based on measures of change in eating disorder symptoms, mood and self-esteem. The authors found that higher levels of self-reported stage of change were positively associated with decreases in eating disorder symptoms. The authors divided participants into three groups: anorexia with initial BMI<15, anorexia with initial BMI>15, and bulimia (no mention of BMI). The results indicated that BMI was not associated directly with outcome. However, there was evidence that BMI was associated with program completion, which was directly associated with changes in symptoms. Because low BMI was not a problem for those with bulimia nervosa, it is difficult to interpret these results. Stages of change reported in the study included pre-contemplation, contemplation and action. Further exploration is needed to determine the impact of the later stages of change, action and maintenance, on levels of recovery. Geller, Drab-Hudson, Whisenhunt, and Srikameswaran (2004) examined the relationship between stage of change and outcome among 64 women during residential treatment for eating disorders and six months following discharge. The authors gathered data on readiness to change in the following areas: restrictive eating, cognitive symptoms, bingeing and compensatory strategies. The authors

classified those who at baseline did not want to change restrictive eating patterns as in the pre-contemplative stage, which was highly associated with negative outcome at end of treatment. Positive outcome at 6-month follow-up was predicted by the extent to which participants reported changing restrictive eating patterns was something they wanted and had chosen versus something they were doing for others. Geller, Zaitsoff, & Srikameswaran (2005) assessed readiness to change over the course of treatment in 42 individuals enrolled in a 12 to 15-week intensive program for eating disorders. Readiness to change was measured at baseline, at week seven of treatment, and at the end of treatment. The authors found that readiness to change behavioral symptoms improved earlier in treatment than readiness to change cognitive symptoms. This finding supports results from previously discussed studies of partial and full recovery that suggest that behavioral change precedes psychological change. The authors also found that readiness scores changed less over time among those diagnosed with anorexia nervosa than among those with bulimia nervosa and eating disorder, not otherwise specified.

Rodriguez-Cano, Beato, & Escobar (2006) assessed motivation levels in 102 patients who sought treatment at a hospital eating disorders treatment unit. Based on the Attitudes Towards Eating Disorders scale, an instrument that measures stages of change categories and relapse, the authors found that low relapse scores predicted greater weight gain among participants with anorexia nervosa and a lower number of weekly binges among participants with bulimic nervosa. While there is some evidence suggesting that stage of change is associated with short-term outcome, this study suggests that stage of change, with the exception of relapse, is unrelated to long-term outcome.

A few studies have explored the relationship between change processes and stages of change. Hasler et al., (2004) assessed readiness to change among 88 individuals in treatment at

an outpatient eating disorders clinic. During a series of four sessions, research therapists introduced a set of eight recovery-oriented behavioral and psychological change processes. Therapists monitored the extent to which participants seemed to be engaging in these processes. The authors found that participants engaged in most of the behavioral processes throughout the different stages of change. Emotional involvement in treatment, one of the identified psychological change processes, was evident predominantly in the later stages of change. These results suggest that individuals practice behavioral skills throughout the range of stages of change, but emotional involvement is associated with the later stages.

Levy (1997) explored stages of change among women with current diagnoses of bulimia nervosa, as well as those with prior histories of the disorder. As opposed to the majority of stages of change studies, Levy's study included five groups, one for each stage of change, of participants. The author assessed participants for readiness to change, as well as use of change skills or processes. Her results showed that women in the pre-contemplation stage used the fewest number of change processes. The primary change process used by those in contemplation was raising consciousness about the eating disorder. For those in the preparation stage, beginning to focus on making the decision to change was the primary change process. Use of coping skills was primary among those in the action stage. Reliance on supportive others was primarily used in the maintenance stage. While the author expected that reliance on supportive others would be highest in the action stage, she posited that the high score in this realm in the maintenance group might have been a result of improvements in social functioning with advancing recovery. These results suggest that the action stage in the stages of change model may be the equivalent of partial recovery, while the maintenance stage may be the equivalent of full recovery.

Overall, the research on stages of change offers more insight into short-term than long-term recovery processes. There is, however, some evidence that stage of change is related to positive outcomes on behavioral measures. There is limited evidence that suggests separate pathways for behavioral and psychological change processes, with behavioral symptoms progressing more quickly on the change spectrum than psychological symptoms. Because few studies have explored the stages of change model through the maintenance stage, further research is needed in order to understand the relationship between stages of change and the recovery process.

5. Recovery Memoirs

Though not typically discussed in academic writing, memoirs by individuals who have recovered from eating disorders have the potential to offer valuable contributions to understanding the recovery process. As opposed to qualitative studies, in which authors of a study explore first-person narratives in order to answer questions and inform theory, memoirs are first-person accounts that tell a specific story which, in turn, may serve to answer questions and/or inform theory. Memoirs offer a unique perspective in which first-person narratives are constructed with the intent of presenting a particular perspective or message about the recovery process.

Many memoirs and recovery stories have been published; in this section I focus on works by two authors, Aimee Liu and Jennie Schaefer. Both Liu and Schaefer have become public figures in the eating disorders community as a result of their best-selling memoirs, speaking engagements, and websites. Liu originally published a memoir of her recovery from anorexia nervosa, *Solitaire*, in 1979. *Solitaire* focused on Liu's descent into anorexia and her process of

recovery, as she defined recovery at that time. Years later, Liu published *Gaining: The truth about life after eating disorders*, a revised perspective on the recovery process. In sharing her own experience, the experiences of other individuals in recovery, and the perspectives of experts in the field, Liu presents a multi-faceted view of recovery. In integrating the voices of the academic community with those of personal experience, Liu's work served to bridge a long-standing divide in the field.

Liu developed the term "half-life" to describe early recovery experiences that were fraught with rigidity and struggle (Liu, 2009). Liu described this "half-life" as a way of being in recovery in which major behavioral symptoms of the disorder have remitted, but more subtle symptoms persist and chaos in other life areas remains. Through her interviews, Liu discovered that many people described a similar pattern. According to Liu, "half-life" includes ongoing unhealthy focus on weight, food and exercise, rigid or ritualistic eating habits, and excess or avoidance in other aspects of life (e.g., work, alcohol, relationships). Liu attributes her move toward full recovery to the fear ignited by a return to anorexic behaviors during a period of marital conflict and the empathic presence of her therapist at that time. Liu defines full recovery, not by objective measures, but as an internal state, "Someone who is fully recovered embraces genuine (as opposed to superficial) gains in confidence, trust, intimacy, personal power, perspective, insight, faith, joy, nourishment, health, peace, love, and pleasures of the body and mind. Crucially, she makes choices in life out of desire, passion, compassion, and love instead of fear. She does not confuse perfection with suffering, nor does she feel she must measure up to some external standard of perfection" (Liu, 2007b).

Schaefer's books differ from Liu's in that they combine personal experience with structured exercises and advice. Though stylistically very different, Liu and Schaefer's books

follow a strikingly similar pattern. Schaefer's first book *My Life Without Ed* (2004) combined a description of her process of recovery with concrete self-help exercises aimed at overcoming eating disorder symptoms. In 2009, Schaefer published her second memoir, *Goodbye Ed, Hello Me*. As in Liu's *Gaining*, in which she questions the quality of the recovery she described in her first memoir. Similar to Liu, Schaefer discloses in her second memoir ways in which her food-related behavior remained chaotic, and she remained focused on doing what she imagined other people wanted during her earlier recovery. She also describes the crisis that propelled her to full recovery, as well her experience of full recovery as a reconnection to her body, emotions, needs, and wants.

While Liu's and Schaefer's books differ in style, with Liu reporting the findings of her investigation to a general readership, and Schaefer providing self-help advice to those involved in the recovery process, the journeys of recovery that emerge are parallel. Neither author recognized her earlier recovery as deficient at the time they wrote their first memoirs. Both described a crisis/turning point that precipitated the movement to a recovery that involved abandoning living based on some notion of how they imagined they should be living, and reconnecting with themselves. Considering these memoirs within the context of the recovery literature, the works of Liu and Schaefer may represent autobiographical accounts of the developmental process and experiences of partial and full recoveries.

Relapse

Long-term outcome studies suggest that the risk of relapse from recovery among individuals with eating disorders persists during early recovery and decreases over time. The research on relapse, however, has been plagued by the lack of consensus in defining recovery, a

concept that is integral to the definition of relapse, and lack of consensus about the definition of relapse itself. In this section, I review the research on relapse, including operational definitions and relapse rates.

In a prospective study, Olmstead, Kaplan and Rockert (1994) followed 48 patients classified as in partial or full remission from bulimia nervosa. Partial recovery was defined as no more than one binge/purge episode per week during the final four weeks of a day treatment program for bulimia nervosa. Definition of full recovery was absence of binge/purge episodes during the final four weeks of the program. Survival analysis indicates that while the risk of return to symptoms was highest during the first six months post-treatment, relapses occurred throughout a 2-year follow-up period. Based on their definition of relapse as a return to DSM-III diagnosis of bulimia for a period of three months, results indicated that 31.3% of patients relapsed during the course of the study.

In a later study, Olmstead et al. (2005) followed 46 patients who had completed day treatment, group outpatient treatment, individual outpatient treatment or inpatient treatment for bulimia nervosa for a period of a 19-month period. They compared survival results using four different definitions of remission: 1) absence of binge/purge episodes during the four weeks prior to start of follow-up period; 2) one or fewer binge/purge episodes; two or fewer binge/purge episodes; and three or fewer binge/purge episodes. Additionally, investigators compared length of time criteria: relapse as return to symptoms for one, two, or three consecutive months. The investigators generated 12 survival curves by crossing the four remission definitions with the three relapse definitions. The survival curve based on definitions of remission as one or fewer binge/purge episodes (what the investigators termed as partial and full remission, respectively, in the 1994 study) and relapse as a return to symptoms for a period of 3 months generated similar

results (e.g., 31% relapse rate) to those in the 1994 study. Comparison of the 12 survival curves, however, showed relapse rates ranging from 21-55%. It is worth noting that the 55% result, which was based on the least stringent definitions of remission and relapse, is rarely used and that the result is higher than has commonly been found in research. The findings of this study highlight the problem of interpreting results across studies applying different definitions of concepts. In her review of the literature on outcome among individuals with anorexia nervosa, Pike (1998) discovered similar problems with varying definitions of relapse, remission and recovery. Pike observed that many of the long-term studies do not control for initial response to treatment. As a result, relapse from recovery, as defined by the particular study, is not distinguished from chronic cycling between periods of engaging in symptomatic and non-symptomatic behaviors. Pike proposed operationalizing definitions of relapse, remission and recovery based on the diagnostic criteria: weight status, weight and shape concerns, eating behavior, and medical status. Pike suggested that a length-of-time factor should be used to delineate remission (short-term) versus recovery (long-term).

Despite these differences in definitions of concepts, several important trends in rates of relapse and recovery emerge across studies. Where recovery levels are assessed as either partial or full, risk of relapse is consistently higher in the partial recovery groups than in the recovery groups (Carter, Blackmore, Sutandar-Pinnock, & Woodside, 2004; Herzog et al., 1999; Keller, Herzog, Lavori, & Bradburn, 1992; Kordy et al., 2002; Strober et al., 1997). While relapse rates tend to be highest during the first 8-9 months of follow-up, risk of relapse persists beyond the first year.

Several studies have monitored relapses throughout the entire period during which relapse presents more than a minimal risk. Herzog et al. (1999) found relapse from full recovery

rate of 30% at 2-year follow-up and 40% at four years in a population of individuals with anorexia and bulimia nervosa. In a 10-15 year longitudinal study, Strober et al. (1997) found a 30% relapse rate, with an additional 30% developing binge-eating behaviors, in a study of anorexic adolescents discharged from inpatient treatment. Risk of relapse to anorexia nervosa and development of binge-eating persisted during the first five years of follow-up post-discharge. It is important to note that the study distinguished between post-discharge relapse and post-recovery relapse. Individuals who relapsed post-discharge had not met partial or full recovery criteria. As a result, baseline symptoms and risk of relapse were high. Among those who reached partial or full criteria for recovery, relapse rates were significantly lower. This difference in rates depending on when and what population (e.g. those seeking treatment, a community sample, those who have completed treatment, those who have achieved partial or full recovery) was used to measure baseline symptom levels influenced results across studies as well.

In general, although study results differ depending on the definitions applied, the research consistently indicates that rates of relapse are high among individuals with eating disorders and that the risk of relapse persists beyond the 1-year follow-up mark. Additionally, numerous studies have found that relapse rates are higher among those in partial recovery than those in full recovery.

Overview of Treatment

The majority of treatment studies measure symptom levels at two or three points: pre-treatment, immediately post-treatment, and in some cases at the end of a designated follow-up period. Inclusion in these studies is most commonly based on DSM-IV eating disorders diagnosis. Evidence of effective treatments of anorexia nervosa in the adult population is weak

(Attia, Mayer & Killory, 2001; Attia & Schreoder, 2005; Ben-Tovim, 2003; Bulik, Berkman, Brownley, Sedway, & Lohr, 2005; Claudino et al., 2009; Hay, 2003). There is significant evidence that cognitive behavioral therapy is effective in the treatment of bulimia nervosa (Fairburn et al., 2009; Fairburn & Hay, 1992; Fairburn, Jones, Peveler, Hope, & O'Connor, 1993; Hay, Bacaltchuk, Stefano & Kashyup, 2009; Leitenberg, 1995; Lewandowski, Gebing, Anthony, & O'brien, 1997; Mitchell, Agras & Wonderlich, 2007; Murphy, Straebler, Cooper, & Fairburn, 2010; Phillips, Greydanus, Pratt & Patel, 2003; Shapiro, Berkman, Brownley et al., 2007), although the majority of studies do not include long-term follow-up assessments (Ben-Tovim, 2003; Hay et al., 2009, Leitenberg, 1995; Mitchell, Hoberman, Peterson & Mussell, 1996; Phillips et al, 2003; Shapiro et al., 2007). Additionally, distinguishing between partial, defined as behavioral symptom remission, and full recovery, defined as combined behavioral and psychological symptom remission, in treatment outcome data is challenging. In a meta-analysis of treatment studies, Phillips and colleagues found 40% recovery rates among individuals who completed treatment for bulimia nervosa. This result, however, was found using a definition of recovery based on behavioral symptoms only. In general, frequency of binge/purge episodes is frequently the primary outcome measure in studies of bulimia nervosa. Results are easily presented using a ratio scale in which absence of bulimic episodes is considered recovered and/or equal to the frequency in a normative sample. Psychological measures are more difficult to interpret. Most studies report change, pre- and post-treatment, in scores on psychological measures, but rarely compare these results to a normative sample. As a result, behavioral and psychological changes pre- and post-treatment, as well as between groups, can be used to indicate treatment effectiveness, but level of recovery at outcome remains obscure.

In a review of 79 outcome studies, Steinhausen and Weber (2009) found that recovery rates were highest 4-10 years after intervention. The authors used a definition of recovery that represented a composite of the definitions used in the studies reviewed. This finding suggests that additional factors, beyond the specified intervention, contribute to the recovery process.

From a lens of partial versus full recovery, results of studies of treatment for anorexia nervosa remain inconclusive. Specific treatments for bulimia nervosa have been shown to be effective in helping individuals achieve partial recovery; however, impact of treatment on full recovery remains unknown.

Summary and Topic of Inquiry

The majority of the literature defines partial recovery as purely behavioral recovery, while full recovery is defined as combined behavioral and psychological recovery. Based on these definitions, evidence suggests that rates of partial recovery are higher than rates of full recovery among individuals with eating disorders. Evidence further indicates that behavioral symptoms remit prior to psychological symptoms. This suggests a developmental course of recovery that proceeds from engaged in eating disorder symptoms to partial recovery to full recovery.

However, a significant number of individuals with eating disorders do not progress from partial to full recovery, but maintain long-term partial recovery. As a result, they appear recovered, but their eating disorder persists in their psychological lives and they remain at risk of relapse. While symptoms in partial recovery are be less visible, studies have found that those in partial recovery more closely resemble those with active eating disorders than those in full

recovery on multiple measures of functioning. Additionally, risk for relapse is substantially higher than for those in full recovery.

Rarely do studies investigate treatment for individuals in partial recovery. For one, the risks associated with partial recovery are minimal in comparison to the risks associated with active eating disorders. Additionally, while eating disorders can go undetected for a long time, problems related to partial recoveries may be entirely overlooked, even by the individual in partial recovery. Those in partial recovery may assume that behavioral recovery is the endpoint of the process. Schaefer described not realizing that full recovery was even possible, while she was "significantly recovered" (i.e., partially recovered) (2009, p. 2). Stages of change studies have focused predominantly on the early stages through the action stage in eating disorders. The progression from action to maintenance, the stages that parallel partial and full recovery, has been given little attention. Treatment outcome studies have shown increased rates of partial recovery, but limited information is available about the impact of treatment on achievement of full recovery in bulimia nervosa. Treatment studies in anorexia nervosa offer inconclusive evidence.

Qualitative studies and personal memoirs offer insight into the subjective experiences of those in the recovery process. Partial recoveries generally include elements of ongoing struggle and retraining, while full recoveries generally include elements of connection to self and to others.

Steinhausen and Weber's finding that recovery rates are highest between 4-10 years post-intervention suggests that factors beyond treatment contribute to the recovery process. Due to the scarcity of follow-up data extending beyond the 4-year mark, this time period starting four years after intervention, remains largely unexplored.

Research Question

From this exploration, a central question emerges. How does the process of moving from early recovery to stable long-term recovery occur? Reaching a better understanding about how, when and why this shift occurs creates the possibility of learning how to help those in partial recovery avoid relapse and move forward in their process of recovery.

Chapter 3: Methodology

General Approach

This research project is a qualitative study of the progression from initial symptom remission to full recovery in women with eating disorders. The study is based on narrative accounts, obtained by interview, of women in full recovery (see Inclusion Criteria for operational definition). The objectives of the study are to gain an understanding of how this process occurs, what the experience is like, and what factors promote or impede forward movement. Answering these questions becomes of primary importance when considered in the context of previous findings that suggest that the majority of individuals who recover achieve only partial recovery, and as a result, remain at significant risk of relapse and continue to experience significant psychological and social distress. Ultimately, the goals of my inquiry are to offer sign posts that could serve as guides for individuals in the recovery process, and to inform the development of treatment practices that are aligned with stages of recovery. On a very practical side, the findings could have an impact on insurance companies, prompting them to cover treatments aimed not only at reducing symptoms, but also increasing the rate of long-term positive outcomes.

In this chapter, I discuss my rationale for using qualitative methods and describe the specific components of my research project. Lincoln and Guba's (1985) outline of the steps involved in qualitative research practices provided the general structure of the study's design. At the same time, my overall approach was largely guided by Luker's (2008) roadmap for conducting qualitative research in the "age of info-glut." Luker advocates for allowing the shape of the research project to determine methodology rather than be determined by it. She emphasizes that processes and procedures should be derived based on logic and clearly

documented, but be flexible enough to accommodate the direction and pace of the project. Adopting Luker's philosophy prepared me to adjust to unexpected events and new information, while maintaining the structure with clearly established parameters within which to work. Luker's particular way of thinking influenced my recruitment strategies, sampling procedures, gathering of data, and analysis.

Luker (2008) posits that the goals of qualitative methodology are to create a study with the potential to offer findings that are unexpected from the perspective of the investigator, and persuasive from the perspective of others. From my own training and clinical experience,[1] I have developed notions about how the recovery process unfolds, and these notions feature prominently in the paradigms I have adopted for this study. They comprise a rich form of knowledge, ideas acquired not only in my own training, but also from discussions in my role as a supervisor, or from individuals I have treated, as well as colleagues and personal acquaintances. At the same time, I also hoped to create a design that would extend beyond my own experiences, allowing me to discover other angles and perspectives, precisely the "unexpected" referred to in Luker's account of qualitative research. Ultimately, the goals of my inquiry were to offer a guide for individuals in the recovery process, inform the development of treatment practices that are aligned with stage of recovery, and pressure insurance companies to cover treatments aimed not only at reducing symptoms, but also increasing the rate of long-term positive outcomes.

Padgett (2008) argues that qualitative methods are helpful in gathering information of a phenomenological nature and pursuing topics of emotional depth. According to Creswell (1998), qualitative methods are helpful in exploring *what* a process is and *how* it occurs. Qualitative

[1] As I psychotherapist, I have extensive training and twenty years of clinical experience working with patients with eating disorders.

inquiry is based on social constructivist presuppositions, which hold that individuals ascribe their own subjective meaning to their experiences and that the subjective meaning is influenced by the social context (Lincoln & Guba, 1985). As opposed to quantitative studies, which focus on measurement of phenomena to discern and quantify differences between populations, qualitative methods aim to discover and articulate processes or what Moutakas (1994) describes as the essence of the experience. Based on these presuppositions, qualitative inquiry most naturally suits the subjective and phenomenological nature of my questions.

Additionally, Padgett (2008) posited that qualitative methods are useful in exploring topics that remain relatively unexplored in the literature. As Luker (2008) describes, qualitative methods lend themselves to discovery, as opposed to testing a hypothesis based on from pre-existing theories or data. With regard to the literature on recovery, studies have generally focused on the process of moving from fully symptomatic to less symptomatic or symptom remission. The process of moving from early to stable long-term recovery represents a gap in the empirical literature.

1. The Phenomenological Approach

Phenomenological research focuses on understanding the meaning and essence of lived experience (Moustakas, 1994). According to Giorgi, phenomenological inquiry is based on the assumption that experiences possess an intrinsic subjectivity and an essence that typifies the phenomenon (2008). According to Karlsson (1993), the qualities that make a phenomenon what it is and contain its meaning comprise its essence.

The aim of the present study is to understand the lived experiences of women in early recovery, in stable long-term recovery, and the journey between the two. As phenomena,

differences among these stages are primarily psychological and may be imperceptible to observation. It is for this reason that listening to the experiences of those in the recovery process is critical in understanding the interior workings of the process.

2. The Feminist Approach

Study design was also influenced by aspects of what have been described in the literature as feminist approaches to research. For example, feminist approaches emphasize the collaborative relationship between researcher and participant (Striegel-Moore, 1994). The process of collaboration was crucial to conducting phenomenological interviews. While I used my own terminology in designing the study, the language of the interviewees presided during our conversations. In essence, learning the language of the participants was at the core of my project. Specifically, I was careful not to assume the terms, "partial recovery" and "full recovery" were meaningful to the women I interviewed. In order to construct research my question, I needed to operationalize the experience of remission of behavioral, physical and psychological symptoms. However, in recruitment and my initial conversations with potential interviewees I made reference to "long-term recovery or what some people call full recovery," both familiar phrases in discussions of recovery. In the interviews I used the terms "early recovery" and "later recovery" or "current recovery" in order to privilege the language and experiences of the study participants.

Additionally, the current study emphasizes context (Gilligan, Brown & Rodgers, 1990; Striegel-Moore, 1994). Taking a contextual approach involved exploring and explicitly naming my own preconceptions. In my role as investigator, I kept a reflexivity diary in which I recorded my impressions, judgments and reactions throughout the process. Reflexivity is a critical

component of grounded theory (Glaser & Strauss, 1967), which I used extensively to guide the study (see Grounded Theory section).

According to critical feminist theorists, phenomenological research enables the process of deconstructing the illusory divide between normative and pathological functioning (Malson & Burns, 2009). The process of constructing and deconstructing was an essential component of my research process. Most basically, my study was an exploration of phenomenological processes that served to challenge strict delineations between categories of illness and recovery. However, in order to explore the more subjective aspects of recovery and "full recovery," I had to designate a set of discrete categories that would allow me to isolate and pinpoint the precise phenomena I aimed to study.

A crucial final point in discussing feminist approaches is that while practices of collaboration, reflexivity, contextualization and deconstructionism have served feminist scholarship well, these practices do not belong exclusively to the world of feminist research. The expansion and elaboration of these practices based on narratives of human experience have served to advance forms of empirical research in a wide range of fields. The converse is also true, that have served to advance forms of empirical research based on narratives of human experience, feminist research practices encompass a wide range of approaches and no methodology can be universally described as inherently feminist.

3. Grounded Theory

Principles of grounded theory, a method of generating theory based on analysis of data (Denzin and Lincoln, 1994), guided data collection and analysis in the present study. Additionally, grounded theory includes a practice of shifting between data collection and data

analysis; it is fluid approach to collection and analysis that allows the researcher to incorporate the information gathered from data analysis to inform ongoing data collection procedures (Charmaz, 2006). In the current study, I contacted all participants personally and used an interview guide (see Appendix B), which I had developed, to organize the interview process. I began coding and identifying themes after I had completed three interviews. Moving forward, I repeated this process as I completed each subsequent interview. This approach allowed me to incorporate the experiences described by study participants into further iterations of the research process. As a result, the voices of the participants were incorporated into the design of the research. I describe this process in greater depth in the data analysis section.

According to Charmaz (2006), grounded theory involves a degree of reflexivity on the part of the researcher. Even as the researcher adheres strictly to the data presented, a degree of interpretation is inherent in working with phenomenological data. Reflexivity serves to mark the input from the researcher and reveal the researcher's orientation to the data. In the current study, I incorporated reflexivity by keeping an ongoing log of my feelings and reactions as the study proceeded. According to Hall and Callery (2000), incorporating reflexivity enhances the rigor of grounded theory (for more on rigor, see Assessment of Methodological Rigor).

4. Recruitment and Screening

I recruited participants through word of mouth in professional circles (see Appendix C for recruitment script) and circulated flyers (see Appendix D). In addition, I sent e-mail announcements to colleagues (see Appendix E). Letters to colleagues included information on the research topic, eligibility requirements, and compensation, as well as my contact telephone number and e-mail. Additionally, I noted that I was looking specifically for participants located

in the Greater New York area, Pennsylvania and New England so that I could meet with them in person.

I was fortunate that several popular authors, who have written on the topic of recovery form eating disorders, offered to post my announcement on their websites and/or Facebook pages. Once those announcements were posted, I noticed that additional authors and organizations had posted the information on their own websites. In an effort to obtain a sample that was diverse in terms of race, ethnicity and sexual orientation, I contacted a number of eating disorder-related and body image-related organizations and authors whose work has focused on specific populations. I used purposive criterion sampling techniques in order to obtain a sample with the requisite characteristics for participation in the study (see below).

Once potential participants had contacted me by telephone or e-mail, we scheduled an initial telephone call in which we discussed details of the project, research goals, confidentiality, and other rights of respondents. If the respondent indicated she was interested in participating at that point, I conducted a brief screening to determine eligibility.

Eligibility was based on the following inclusion criteria:

1) Female, over the age of 18

2) Eating disorder (in past) fulfilled DSM-IV (or DSM-III, depending on date of diagnosis) criteria for anorexia nervosa or bulimia nervosa for the period of at least one year

For individuals with histories of anorexia nervosa:

3) Maintenance of normal weight and return of normal menstruation (unless lack of menses or irregularities are due to medical conditions unrelated to the eating disorder) for past 3 years
4) No bingeing or purging, as defined by self-induced vomiting, ipecac use, laxative use, weight-loss or diet pills, and excessive exercise in past 3 years
5) “No extremes,” defined as no interference in functioning, in the realm of weight-related thoughts

For individuals with histories of bulimia nervosa:

3) No bingeing or purging, as defined by self-induced vomiting, ipecac use, laxative use, weight-loss or diet pills, fasting, and excessive exercise in past 3 years
4) "No extremes," defined as no interference in functioning, in the realm of weight-related thoughts

My decision to include individuals with histories of anorexia nervosa, bulimia nervosa or both disorders was based on evidence of the high rates of longitudinal diagnostic crossover from anorexia to bulimia, as well as between subtypes of anorexia (Eddy et al., 2008). Categorization of eating disorders is often complicated by the crossover effect and it is not uncommon for an individual to have suffered from both disorders.

Because there is limited longitudinal data on recovery from binge-eating disorder, which has only recently been formally recognized as a diagnostic category, I did not include individuals with histories of binge-eating disorder, if they had never been diagnosed with anorexia or bulimia. However, individuals with prior histories of binge-eating disorder and anorexia or bulimia (or both) were eligible to participate. Additionally, individuals with past or present co-morbid disorders were included as well. Among the participants, generalized anxiety disorder, past and present, was the most common co-morbid disorder reported.

I assessed prior history of anorexia and/or bulimia in one of two ways. Either the respondent reported that she had been given a past DSM-IV or III diagnosis from a licensed mental health professional trained in the treatment of eating disorders or the respondent endorsed the requisite items on the symptom checklist (see Appendix F for symptom checklist). Additionally, inclusion was based on self-report that symptoms were present for at least one year. As a component of the study, participants completed a written eating disorders symptom questionnaire. Responses to questionnaire items allowed me to confirm eating disorder diagnoses and lengths of time of illness.

Those who met criteria for prior eating disorder were screened to determine recovery status. Because there exists a wide range of definitions of full recovery in the literature, I chose conservative operational definitions in order to ensure that participants in my study would be considered fully recovered based on even the most stringent standards.

I defined full recovery based on two factors: assessment of symptom remission and length of time in remission. For respondents with histories of anorexia nervosa, inclusion was based on meeting the following behavioral and psychological criteria: a) maintenance of normal weight and return of normal menstruation (unless lack of menses or irregularities are due to medical conditions unrelated to the eating disorder), b) no bingeing or purging, as defined by self-induced vomiting, ipecac use, laxative use, weight-loss or diet pills, and excessive exercise and, c) "no extremes" in the realm of weight-related thoughts. Endorsement of all three items is a close equivalent to a score of 1 on the Psychiatric Status Rating (See Appendix A).

Adopting the length of time in remission criterion used by Von Holle et al., I based eligibility, regarding behavioral/physical symptoms, on a self-report of absence of symptoms for at least three continuous years prior to current assessment. I did not use that same time frame in assessing psychological symptoms because respondents tended to have more difficulty pinpointing when exactly those changes occurred.

The criterion, "no extremes," defined as no interference in functioning, in the realm of weight-related thoughts (see above), was adapted from a study conducted by Kordy et al. and colleagues. The researchers used the phrase "no extremes" in the realm of "fear to gain weight" (2002, p. 4) in defining full recovery. I substituted "weight-related thoughts" for "fear of weight gain" so that my definition would include both distorted body image and "fear to gain weight" in order to more closely match the criteria of DSM-IV diagnosis (APA, 2000).

The decision to define full recovery based on "no extremes," as opposed to remission of weight-related thoughts, was based on "normal discontent," the notion that women, including those without prior histories of psychiatric disorders, experience a degree of body dissatisfaction (Rodin, Silberstein, & Striegel-Moore, 1984). Striegel-Moore and Smolak (2001) suggest that a certain amount of weight-related thinking is normative. The authors emphasize that the difference between normative, or "no extremes," and what would be considered pathological depends on whether or not these thoughts interfere with general functioning. I explained this distinction to clarify the definition during initial conversations with potential respondents.

For respondents with histories of bulimia nervosa, inclusion was based on meeting the following criteria: no bingeing or purging, as defined by self-induced vomiting, ipecac use, laxative use, weight-loss or diet pills, fasting, and excessive exercise, and "no extremes" in the realm of weight-related thoughts. As in the screening for recovery from anorexia nervosa, the length of time for remission of behavioral and physical symptoms was defined as three consecutive years. Additionally, the same operational definition for "no extremes" was explained.

If the screening indicated that the respondent was eligible to participate, I provided additional details about the study. Specifically, I informed respondents that the study would involve 2-hour tape-recorded interviews (with breaks as needed), that participation was voluntary, that they would have the option to withdraw at any point in the process, that all information obtained would remain confidential, and that participants would receive a $20 gift card as a token of gratitude. Additional information given included that I would be the only person hearing and transcribing the audiotapes, that their names would be substituted with a pseudonym, that transcripts would be identified by a numeric code, that all identifying

information would be kept locked in a file and destroyed three years after completion of the study, and that they would be given the option of receiving a summary of findings once the study was completed.

Once screening was complete, I scheduled interviews with respondents who were deemed eligible and confirmed wanting to participate. I sent questionnaires (see Appendix G) and an Informed Consent Forms (see Appendix H) by mail (I provided stamped addressed return envelopes). I asked participants to complete and return forms prior to scheduled interviews. The purpose of the questionnaire was to gather demographic information, eating disorder histories, and treatment histories. I used the questionnaires to confirm that participants met inclusion criteria with regard to DSM-IV or III diagnoses.

5. Participants

Participants had a mean age of 39 (median age 39; range 25 to 56). The mean duration of time during which participants met behavioral and physical recovery criteria (Psychiatric Status Rating between 2-3, see Appendix A) was 12 (median duration 12 years; range 3 to 22). Eleven participants were Caucasian, one was Latina, one was African-American and one was Asian-American. Twelve identified as heterosexual and two identified as gay or preferring women. Nine were married or in serious committed relationships. Four participants had children and/or stepchildren. All had bachelor's degrees. Nine either had post-baccalaureate degrees or were enrolled in graduate programs.

Six carried past primary diagnoses of anorexia nervosa, five carried past primary diagnoses of bulimia nervosa, and three carried past diagnoses of both disorders. Additionally, two carried prior diagnoses of binge-eating disorders. The average age of onset of anorexia or

bulimia (defined as meeting full DSM-IV or III criteria) was 18 (median age 18; range 14 to 21). Type of diagnosis was not associated with age of onset in the sample. The average duration of disorder (defined as the during which the participant met full DSM-IV or III criteria) was 9 (median duration 6 years; range 2 to 26). At the worst point of their disorders, eight would have had a Psychiatric Status Rating of 6; six would have had a Psychiatric Status Rating of 5. Three participants reported histories of generalized anxiety disorder, two participants reported histories of Major Depressive Disorder, and two participants reported having histories of alcohol abuse. One of the two participants with an alcohol abuse history endorsed having a history of bipolar depressive disorder as well. Three participants reported current treatment with anti-depressants (two for primary depression, one for primary anxiety).

Name[2]	Age	Race/Ethnicity	Sexual Orientation	Religion	Marital Status	Education Status	Eating Disorder Diagnosis
Leah	44	Caucasian	Straight	Jewish	Engaged	Masters	Anorexia
Zoe	28	Caucasian	Lesbian	Jewish	Single	Masters	Anorexia
Kristen	56	Caucasian	Straight	Episcopalian	Divorced/ Remarried	Masters	Bulimia
Emily	32	Asian-American	Straight	Non-practicing Catholic	Single	Masters	Anorexia
Alice	34	Caucasian	Straight	Non-practicing Catholic	Married	Masters	BED/Bulimia
Julia	36	Caucasian	Straight	N/A	Married		Anorexia
Helena	39	Caucasian	Straight	Catholic	Single	Masters	Anorexia/Bulimia
Amanda	36	Caucasian	Straight	Spiritual	Married	Masters	Anorexia/Bulimia
Holly	38	Caucasian	Straight	Christian	Divorced/ Remarried	Masters	Bulimia
Cecelia	41	African-American	Straight	Spiritual	Married	Bachelors	Bulimia
Anna	49	Caucasian	Straight	Jewish	Single	Masters	Anorexia
Shannon	36	Caucasian	Straight	Catholic	Single	Bachelors	Anorexia/Bulimia
Corazon	42	Latina	Straight	Spiritual	Single	Bachelors	Anorexia

[2] All participant names are pseudonyms with the exception of Corazon (by permission) which is the participant's self-chosen name in recovery

Eva	41	Caucasian	Lesbian	Non-observant Jewish	Married	Masters	Bulimia

Participant Profiles

Leah, age 44, is a psychotherapist in private practice. She is engaged and lives with her fiancé. She developed anorexia at the age of 19 years old while she was traveling abroad. She started weekly therapy at the age of 22 and began her recovery process at that time. She has continued in psychotherapy since that time and has gone twice a week for the past ten years. From the ages of 22-30, she reports that she was still very obsessive about food and exercise, but that since her early 30s the obsession has eased.

Zoe, age 29, is a teacher. She is single and lives alone. She developed anorexia at the age of 18 years. From 19-21, Zoe went in and out of inpatient, residential and partial hospitalization treatment programs multiple times. After her last discharge from inpatient treatment, at the age of 23, she did not relapse into anorexia. She reports her food obsession eased when she was 26-years-old. Zoe has been in weekly individual psychotherapy since starting treatment for her eating disorder and in weekly group psychotherapy for the past five years. She is diagnosed with OCD and depression, both of which are managed by medication.

Kristen, age 56, is an administrative assistant and a landscape professional. Kristen was married briefly when she was younger. Kristen is currently remarried and has one daughter who is 19-years-old. Kristen reports that during her childhood, her mother was physically abusive to her father and emotionally abusive to the whole family. In high

school, Kristen was sexually assaulted by her boyfriend. Her father died in a car accident when she was 19 years. Shortly after that time, Kristen developed bulimia nervosa. At the age of 28, Kristen developed alcohol abuse. Kristen got sober at the age of 39 after Child Protective Services became involved due to a drunk driving incident. Kristen recovered from bulimia at the age of 45 years. She has maintained both her recovery from bulimia and from alcoholism.

Emily, age 32, is a human resources manager. Her family moved from Hong Kong to the United States when she was 13 years old. She described the adjustment to American middle school as difficult and started restricting her eating at the age of 14 years. She restricted her eating from the ages of 14-27. She sought treatment for the first time at the age of 27. She was diagnosed with anorexia nervosa, though she clearly met DSM-IV criteria for anorexia for a number of years prior to evaluation. Her symptoms continued to progress and later that same year, she spent 4.5 months in residential treatment where she received treatment for anorexia, as well as PTSD (related to childhood sexual abuse by a daycare provider). She has maintained her recovery since that time. She is diagnosed with depression, which is managed by medication.

Alice, age 34, is a clinical social worker. Alice developed bulimia at the age of 15 years. At 17 years-old, she went to day treatment for two weeks followed by two months of intensive outpatient treatment. At the age of 18, an adoption social worker informed her that her biological mother had become pregnant with her as the result of rape. When she was 19, she continued to binge, but did not purge for several months. She returned to

bingeing and purging after a car accident during that same year. Her behavioral symptoms remitted when she was 22 years-old. Preoccupation with food and weight remitted several months later when she went to spend a year abroad. She has a history of depression, anxiety and panic disorder. She is currently stable without medication.

Julia, age 25, is a graduate student. She is married and lives with her husband. She became anorexic at the age of 20, while spending a semester abroad in college. She recovered at the age of 22 when she started participating group and individual counseling with her current therapist.

Holly, age 38, works in eating disorders awareness and prevention. She is married and has a step-son who lives with her and her husband part-time. When she went to college, she became a competitive athlete. During that time, she developed bulimia. She excelled athletically and rose to become a nationally-ranked athlete, as her eating disorder progressed. For many years, she struggled—alternating between months of remission and new outbursts of symptoms. At the age 0f 34, her symptoms had largely diminished, but she still experienced intense struggle. At the age of 35, she joined OA which she credits for launching her into full recovery.

Helena, 39, is a product manager at a technology company. She is single and lives alone. She was born and raised in Canada. She moved to the United States after college. Helena developed anorexia at the age of 16 years after her family changed their approach to eating in response to her father's diagnosis of high cholesterol. She participated in weekly

outpatient psychotherapy for about one year, but her symptoms progressed. At age 17, she spent three months in an inpatient psychiatric unit for treatment of her anorexia. After discharge, she developed bulimia. She participated in weekly psychotherapy for year at the age of 18. From the ages of 19-21, she attended Overeaters Anonymous meetings once a week for 2 years. She met full DSM-III criteria for bulimia nervosa from the ages of 18-20. At the age of 20, she started meditating and experimenting with non-traditional healing (e.g., rebirthing, past life regression). From the age of 20, her symptoms decreased gradually and remitted at the age of 23. She attributes her recovery to yoga and non-traditional healing practices. She does not feel that any of the psychological treatments she received were helpful.

Amanda, age 36, is a registered nurse. She lives with her husband and their baby. At the age of 8, a family friend attempted to molest her, but she got away from him. When she told her mother, her mother told her not to tell anyone because the perpetrator was the son of a prominent man in the community. She started restricting at the age of 11 years-old. She first tried therapy at the age of 22 years-old. She went to an inpatient treatment program for two weeks, followed by three months at a residential treatment facility at the age of 23 years-old. She became bulimic at the age of 24. Throughout this time, she was hospitalized multiple times for depression, suicidal ideation and two overdoses. During her last two hospitalizations, she received ECT. Her eating disorder symptoms decreased and, by the age of 30, the behavioral symptoms of bulimia had largely remitted. At the age of 30, after a couple of incidences of purging and a recurrence of restricting fluids, Amanda became scared and put herself back into day treatment for 30 days. She has not

binged, purged or restricted since that time. She is currently stable on medication for depression and anxiety.

Cecelia, age 41, is a legal assistant. She is married and has three sons, ages, 3, 6 and 13-years-old. Her oldest son is from a prior relationship. She recalls going on her first diet at the age of 6-years-old. She developed bulimia at the age of 20. She recovered from bulimia at the age of 24 when she started attending OA meetings. At 25, she went to a day treatment program and got sober from alcohol abuse. At 26, she was diagnosed with bi-polar disorder. She stabilized on lithium at that time, but went off her medication when she became pregnant at the age of 28 years-old. She reports that her obsession with food and weight eased when she had her first child. She stopped attending OA at the age of 31 years-old and has remained in recovery from her eating disorder and alcohol since that time. She never went back on lithium and has been stable psychiatrically.

Anna, age 49, is a psychotherapist in private practice. She is single and lives alone. As a child and through her teenage years, Anna was physically and emotionally abused by her mother. She developed anorexia at the age of 17 years. Anna participated in inpatient and residential treatment several times, but reports that the programs did not help her. She marks the beginning of her recovery at the age of 40, when she began seeing her current therapist two times per week. For the first two years of therapy with her current therapist, she worked adjunctively with a cognitive-behavioral specialist twice a week in order to focus more intensively on gaining weight. She discontinued the adjunctive therapy once

her weight had stabilized. She reports that her preoccupation with weight eased at around that same time.

Shannon, age 36, is a Human Resources Director. She is single and lives alone. Shannon developed anorexia during her sophomore year at college. She took a medical leave from school after she was hospitalized due to her low-weight at the age of 19 years. She participated in a day treatment program for about six months before deciding it was not helpful and returning to school. When she returned to school, she started seeing her current therapist. In the process of recovering from anorexia, she developed bulimia, which she struggled with from ages 21-23 years. She reports that the bulimia stopped at the age of 23 and the weight preoccupation eased at the age of 25 years. Currently, she feels that food has become a "non-issue," just as it was before she developed her disorder.

Corazon, age 42, is a dancer, writer and body esteem healer. She is single and lives with roommates. She describes her family, particularly her mother, as weight obsessed. She started worrying about her weight at the age of 9 and by 15 she was chronically dieting. She developed anorexia when she went to college. Her recovery started at the age of 23 when she began working with a somatic movement healer. She saw a therapist weekly that year as well. She reports that her body obsession eased at the age of 27. She credits her recovery to somatic, psychological and spiritual healing process. She currently works as a somatic healer with the woman who led her through the healing process.

Eva, age 41, is a Reading Specialist in a public school district. She lives with her partner and their two children, ages 10 and 12 years. Eva reports that she struggled with depression growing up and saw a therapist when she was 10 years old. She developed bulimia at the age of 17 years. Her recovery started in college when she started individual and group therapy. She reports that her preoccupation with weight and her body eased in her early 30s after giving birth to her first child.

6. Data Collection Procedures

Study procedures were designed to follow established guidelines for systematic and emergent collection of data in qualitative research (Lincoln & Guba, 1985; Padgett, 2008). These guidelines included initiation of data collection through specified recruitment procedures, consistent and clear methods of screening for eligibility, and detailing, both written and verbally, the rights of a volunteer participating in a research study.

The interview guide consisted of a series of open-ended questions designed to explore the participants' experiences in early recovery, current recovery and the transition between the two. Additionally, the guide contained questions examining various factors that may have contributed to or impeded recovery. Interviews were conducted either in the homes of the respondents or at office locations nearby (several colleagues were generous to allow the use of their offices for interviewing purposes).

7. Nature of the Data

The primary sources of data were the tapes of the interviews and their transcripts. Questionnaires containing demographic information, eating disorders histories, and treatment histories provided background information. Additional sources of data included field notes,

which were comprised of detailed descriptions or "thick descriptions" of my observations related to participants and interviews, a log of all procedures, memos in which I recorded emerging thoughts and ideas, and a reflexivity journal of my own feelings, reactions and potential biases (Charmaz, 2006; Lincoln & Guba, 1985; Padgett, 2008; Strauss & Corbin, 1990). Interview transcripts included my own added descriptions of non-verbal communications and a summary my overall impressions. I was the sole interviewer on the project.

The constant comparative method with emerging data allowed me to incorporate initial analysis results into the design of the study as it progressed. My analyses of early interviews influenced focus and emphasis in the later interviews. The audit trail, or log of procedures, served to monitor and document consistency (Lincoln & Guba, 1985). For example, I had initially asked participants to begin the interview by drawing a timeline of the development of their eating disorder and the recovery process. After five interviews were completed, I noticed that beginning my interview in this way seemed to orient the discussion toward the movement from active eating disorder symptomatology to entry into recovery (not my focus), as opposed to the movement from early recovery to present recovery (my focus). A couple of participants spent so much time discussing their eating disorder histories, despite my gently nudging them toward the topic of the study, that our discussion of the transition from early to current recovery was somewhat rushed.

In subsequent interviews, I reframed the question, as "Just to begin, can you briefly summarize the course of your illness, though our focus today will really be on the progression from your early recovery to the present point." This rephrasing of the question resulted in interviews that were naturally focused on my primary topic.

8. Sample Size

I received over thirty emails from women expressing interest in participating in the study. Initially, many were screened out due to geographic location. I conducted a total of eighteen interviews. Two early participants were not included due to audiotape malfunctions. Two others were excluded because it became apparent during their interviews that they did not meet inclusion criteria, even though the results of their screenings and questionnaires suggested that they did.

According to Mertens (1998), sample size is determined by saturation of the data. Saturation is indicated when ongoing data analysis produces examples of previously identified themes, as opposed to generating new categories. After completing, transcribing and preliminarily coding interviews of fourteen participants who met inclusion criteria, I determined that additional themes were no longer emerging and that saturation had been achieved.

9. Assessment of Methodological Rigor

Lincoln and Guba (1985) described a set of criteria for assessing scientific rigor in qualitative studies. The specified criteria were credibility, confirmability, dependability, and transferability. These criteria parallel criteria used to assess scientific rigor in quantitative studies, but unlike validity and reliability, are not measurable.

Credibility, which serves a similar function to internal validity in quantitative methods, refers to the believability of the findings (Lincoln and Guba, 1985). I incorporated member checking, which involves asking selected participants to evaluate the plausibility of the findings, in order to enhance the credibility of my findings. Additionally, my reflexivity journal served to highlight the distinction between analyses based on the data and my own presuppositions.

Confirmability, which is parallel to objectivity in quantitative research, concerns the ability of the researcher to show that study findings were not fabricated by the researcher, but were based on the actual data (Schwandt, 2001). The methods I used to ensure confirmability included the audit trail of data collection and analysis procedures, presentation of raw data, and inclusion of "negative instances," or examples in which the data did not necessarily support my findings.

Dependability, which is parallel to reliability in quantitative studies, refers to the consistency of the findings across researchers, time, and data analysis techniques. Dependability is established through methods similar to those used to establish confirmability. Again, the audit trail served as the primary tool. According to Morrow (2005), documenting the stepwise chronology of events offers a clear map of the research process for other researchers to observe. As an additional measure to ensure dependability, I asked colleagues to review portions of transcripts in order to compare notes about emergent themes and ideas.

Transferability, which is parallel to external validity in quantitative methods, refers to the applicability of the findings to other settings or populations. According to Mertens (1998), it is the study's reader, not the researcher, who determines transferability. The researcher can facilitate the process by including "thick descriptions" of concepts that may pertain to other populations or settings. In keeping with the principles of grounded theory, concepts and phenomena that emerged during data analysis of the data were presented in this highly detailed manner.

Charmaz (2006) suggested additional criteria for evaluating qualitative methods. These categories include originality, resonance, and usefulness. The current study focused on a central question about recovery that is absent from the empirical literature (originality), conveyed the

findings using the language of those who have experienced the process (resonance), and offered valuable information about avoiding relapse and maintaining recovery (usefulness).

10. Protection of Human Subjects

In order to maintain confidentiality, names, places, and all other identifying information were deleted from tapes and transcripts. Actual names were coded and not used in any written or spoken report generated from the research. Participants were identified on each tape by pseudonym, with the exception of one participant who asked that her real be used, and actual tapes were numerically identified for the researcher's own use. All tapes and related interview documents are kept locked and secured in my office and will be destroyed three years from the date of the completed study. Only I have access to the stated documents and related research data.

I made every effort to ensure that no participant encountered harm or discomfort. Confidentiality of the information obtained was emphasized several times. Women participating in the study were completely free from coercion or pressure, and participation was voluntary. In instances in which the participants appeared to experience discomfort, I was prepared to discuss appropriate counseling options and referrals. I was clear about my role as a non-clinical interviewer for purposes of the study. Participants were told that they could refuse to answer any question. In addition, each participant was informed that she could withdraw from the study at any time. Besides monetary compensation, a direct benefit to participants is the opportunity for individual participants to receive a copy of the study findings upon request. The researcher offered participants an opportunity for individual debriefing to address any reactions to the interview or the study overall.

Data Analysis

Data analysis was a multi-step process involving listening to audiotapes, transcribing interviews, thematic coding, categorizing analyses, contextualizing or connecting analyses, and combining analyses. In this section, I describe each of these steps in detail.

1. Knowing the Data

Transcribing the interviews was the first step of data analysis. I derived the notion that transcription is part of the analytical process, and not merely preparation for analysis, from Reindl (1995) and her description of the "sensory method" of data analysis. Reindl described transcription as a process of sensory and emotional engagement. Reindl explains:

> That process was in large measure a sensory one, requiring and engaging my senses via my ears, hands and eyes. I listened to each part of the tape multiple times. I created transcripts. I read the transcripts multiple times both as I created them and afterward. The process of transcribing also engaged my soul; at times I found myself moved to tears as I listened to these women speaking. (P.21)

For me, the transcription process created a sense of closeness with the women's stories. As I read and reread the transcripts, I would experience moments of excited anticipation as I encountered familiar passages. It was almost as if I were watching a favorite movie with a loved one and saying, "OK, here comes a really good part." Coming to know the stories of these women, who had endured life-altering struggles and come through their journeys with dignity, poetry and humor, had a powerful effect on my own understanding of how transformations occur.

2. Coding

My approach to coding closely followed Charmaz' guidelines (2006). After reading the transcripts several times, I proceeded with line-by-line coding. Through this process, numerous

themes emerged, and I initially identified twenty-four provisional categories. I pared down that number by collapsing negative and positive instances of the same theme into one category. In order to maintain the distinction, I indicated negative examples by italicizing the text.

As I continued interviewing, transcribing and coding, I noted consistencies and inconsistencies across interviews. According to Luker (2008), development of clear categories depends on the researcher's ability to articulate what belongs in the category, as well as what does not. As I tracked patterns and noted pattern breaks, I refined, culled and collapsed the original categories into twelve distinct categories that appeared throughout the data. The categories that emerged were as follows:

1. Behavioral changes: Experiences of changing behavior
2. Embodiment: Visceral experiences, bodily sensations, experienced emotions (not tempered by cognitions)
3. Emergence/Voice: Experiences of speaking one's mind, experiences of showing oneself, presentation of authentic self
4. Evolution: Experiences of gradual change
5. Insulation: Creating safety in the environment, experiences of sheltering by self or others
6. Landing at Self: Experiences of self acceptance, experiences of "this is who I am," acceptance of one's own imperfection
7. Listening: Experiences of listening to self without judging
8. Making a choice: Experiences of making a choice between moving toward recovery and moving toward disorder
9. Reflection: Simultaneous being in and reflecting on moments
10. Inner Voice/Guidance/Knowing: Experiences of being inwardly guided

11. Peace: Experiences of well-being, experiences of peace, experiences of feeling what recovery is like
12. Purpose: Ways of making meaning, motivation for recovery

Throughout this process, I wrote numerous memos documenting my ideas, thoughts and emotional reactions.

3. Categorical Analysis

My next analytic strategy was to conduct categorical analyses based on the steps outlined by Reindl (1995) and Maxwell (2011). I prepared two categorical analyses: one analysis categorizing responses to interview questions and one analysis categorizing codes. For the categorical analysis by question, I identified 24 core questions that consistently elicited rich responses (see Appendix B). I created a 24 x 14 matrix with participant's name on the horizontal axis and question number on the vertical axis. I then broke the matrix down into 24 separate matrices, which allowed me to see the collection of answers from all of the participants for each question. Because I had already coded by theme, these codes were visible in the matrices, but not organized in any particular way.

It is important to note that many of my questions contained a temporal element (e.g., "Can you describe your experience of hunger in early recovery versus now?"). At this level of sorting, however, the temporal element was obfuscated by the treatment of each question as one category. The resulting matrices were an unwieldy jumble of codes, which did not appear to form any particular pattern. Themes and patterns in responses to questions seemed to be more of a by-product of the content of the question (e.g., the question, "Can you describe your experience

of hunger in early recovery versus now?" yielded responses about hunger). I eventually determined that organizing the data by question was not useful in my analysis.

I next created a 14 x 12 matrix with participant names on the horizontal axis and codes on the vertical axis. Additionally, I broke the larger matrix into 14 separate matrices in order to visualize how these themes were arising for each individual participant. Each code had an indicator of the question that the participant was responding to in the particular instance. I included these indicators in case I needed the information as I continued my analysis.

4. Contextualizing (connecting) analysis[3]

Whereas categorizing analysis involves dissecting narratives and compiling pieces of text with common thematic elements, contextualizing or connecting analysis involves investigating the relationships among different elements within the text (Maxwell, 2011). Reindl (1995) and Miller (1991) approached this process by writing summarizing narratives of the individual interviews in order to understand how various elements of the text were situated and related to the larger story. I found it challenging, however, constructing these narratives because the data contained such a multitude of themes and I wanted to make sure not to overlook any salient information for the sake of summarizing. In order to contextualize the elements while ensuring the narratives encompassed the relevant themes, I returned to the 14 matrices that presented the entire set of codes for each individual. I then composed a narrative for each category for each individual. The results were 14 focused mini-narratives for each participant. My last step was to construct a larger narrative for each participant by weaving together the 14 component pieces. Again, throughout this process, I wrote memos tracking my emerging ideas and reactions.

[3] Reindl (1995) referred to this type of analysis as contextualizing analysis, whereas Maxwell (2011) referred to the same process as connecting analysis.

5. Combining Analyses

The following step involved investigating the relationship between categorizing and contextualizing analyses. I used the memos I had already written to inform this exploration and continued to generate new memos as I proceeded. As I read and reread the narratives, relationships among the themes began to emerge. For example, the negative instances of "Inner Voice" appeared most frequently in descriptions of experiences from early recovery. On the other hand, positive themes of trusting one's instincts or being flexibly and inwardly guided featured most prominently in descriptions of full recovery. As I explored the context of these two iterations of a theme, a third subset emerged. This subset referred specifically to the process of moving away from relying on external guidance and/or moving toward relying on inner guidance. I identified this third subset as "Transition from External to Internal." I proceeded to construct a new matrix with "early recovery," "transition" and "full recovery[4]" on the horizontal axis and individual codes, identified by participant's name and question, on the vertical axis. I renamed the code "Guidance/Knowing" in order to encompass the three variations: flexibly following inner voice, guided by external sources, and blending inner knowing and external direction.

I proceeded to explore temporal relationships among the other categories. I revisited the transcripts with my original coding and began to mark each code "early," "transition" or "full," depending on how the particular theme was located chronologically in the overall recovery process. Finally, I created a new matrix with "early," "transition" and "full" along the horizontal axis and individual codes on the vertical axis. Additionally, I created 11 separate matrices (I had

[4] After analyzing the data, I renamed what I had been calling "full recovery" "full-enough recovery."

already constructed the one for "Guidance/Knowing") with the temporal categories on the horizontal axis for each individual code. The matrices revealed that each theme had a predominant temporal category. The other categories, while clearly inter-connected, did not follow the same sort of evolutionary process as the "Guidance/Knowing" theme, with the exception of "Embodiment" which was most frequently associated with full recovery, but appeared repeatedly in the transitional stage in variation characterized by the process of becoming embodied. I created one final matrix with the temporal categories on the horizontal axis and the themes that fell most frequently in that category on the vertical axis (see below):

Early	**Transition**	**Full**
Externally-Guided	Blend External and Internal	Internally-Guided
Behavioral Change	Embodiment (emerging)	Embodiment
Safety	Listening	Emergence
	Making a Choice	Landing at Self
	Evolution	Reflection
		Peace
		Purpose

6. Consultation

I consulted with colleagues throughout this entire process. I received valuable feedback at each phase of my project. As I analyzed the data and began interpreting the results, I discussed my findings with colleagues in my field, as well as professionals in other disciplines. Every conversation helped me in weaving the multiple individual ideas into an integrated whole.

Chapter 4: Findings

In this chapter, I present a developmental model of the progression from early to full-enough recovery from eating disorders. I developed the model based on the three major stages that emerged from my data, the individual elements of each stage, and the transformational processes that link the stages together.

The evolution of the concept of "Guidance/Knowing" suggests the developmental nature of the process. On the timeline of recovery, these codes consistently appear sequentially in three distinct iterations: relying on external guidance, blending external guidance with inner voice, and following inner voice with the flexibility to incorporate external input.

Belenky, McVicker, Goldberger, and Tarule (1986) developed a stage model to describe the evolution of how women know and relate to knowledge. The reliance on external guidance that appears in the early recovery stage of the current model parallels "Received Knowledge," Belenky et al.'s second stage in which women look outside of themselves in order to know about themselves. In terms of attachment theory, this state of dependence and disconnection from self may be reflective of insecure attachment (Ainsworth, 1978). The early stage of recovery form eating disorders includes the elements of seeking safety, and focus on behavioral change (I discuss components and the composite of each stage in the following sections).

Entry into the transitional stage is marked by the emergence of inner voice. Considering model of Belenky et al., the transitional stage may be viewed as an integration of "Received Knowledge" and "Subjective Knowledge," a stage in which inner voice and intuition are dominant. In the transitional stage of the current model, inner voice starts to influence

external messages. This occurred as the women began to internalize or reject what they received externally. Choosing recovery, listening to self, and emerging embodiment were instrumental to the transition and established the foundation for the next phase of recovery. While the word "transition" suggests movement, the changes that occur in this stage are gradual and only over time evolve into the phenomena that mark full recovery, or "full-enough recovery," a term I created to describe the final stage of the model.

In categorizing and analyzing my data, I used the term "full recovery" as a placeholder for the final stage of the model. However, while a few women in the study embraced the term "full recovery," the majority of the women, all of whom clearly described experiencing the phenomena associated with this final stage, did not resonate with the term. Their objections were based on the notion that the term "full recovery" implied the reaching a goal, as opposed to being in a process. For this reason, I developed, the concept of "full-enough recovery"[5] to signify recovery that offers an adequate platform for the emergence of the associated themes: flexibly trusting inner guidance, embodiment, capacity for reflection, landing at self, emergence, sense of peace, and having purpose (for full description, see section below on "Full-enough Recovery"). Flexibly trusting inner guidance recalls Belenky et al.'s notion of "Constructed Knowledge," the stage in which ways of knowing are integrated and a narrative sense of self has emerged. Integrating this iteration of the theme with the associated phenomena results in a composite picture of "full-enough recovery." Finally, though for the sake of description I have summarized each stage with a list of associated phenomena, the actual process of transformation is fluid and does not adhere strictly with the designated delineations.

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[5] The concept is based on the Winnicottian notion of the "good-enough mother." Winnicott theorirized that the "good-enough" mothering, as opposed an idealized model of parenting, is required to promote healthy child development (1953).

Stages of Recovery

In this section, I describe and illustrate the components of the three stages: early recovery, transitional recovery and full-enough recovery. When I use the phrases, "most of the women I interviewed," "the women I interviewed," or simply, "the women," I am describing a theme that appeared in the interviews of at least ten of the fourteen women interviewed.

Early Recovery

> *I think you said early recovery and that feels right, I mean I think if you were describing the difference between an infant and a newborn baby, if I were to think of the cusp of the earliest recovery from the eating disorder, I mean the crawling of recovery.* *(Leah)*

> *Feelings happened before that but they were very much controlled so to speak, it wasn't like I just felt, it was like, I almost gave myself permission to feel sometimes and other times to shut them off, and then once I decided that was part of the process of getting better, I felt like I was all over the place and that's when I didn't have an identity and I felt like I wandering around without a clue.* *(Amanda)*

> *I'd rather be safe than enjoy.* *(Zoe)*

In my preliminary discussion with participants, I defined early recovery in the simplest most basic terms, as the period following initial behavioral and physical remission of symptoms. While I used a clear operational definition of full recovery in recruiting participants, I did not need such a precise definition for early recovery. Because they were all in advanced recovery, I

assumed that each of the women had an early recovery phase, though I did not assume anything about the details. As I was interested in the perspectives of the participants on their journeys to "full-enough" recovery, I allowed them to respond to questions based on their sense of when precisely recovery started.

My own fuller conceptualization of early recovery is characterized by several intertwined elements: externally guided knowing, seeking safety, and focus on behavioral changes. On the timeline of recovery, "Guidance/Knowing" appears in its earliest incarnation as externally guided knowing.

I categorized the other identified themes based on their temporal relationship to the iterations of "Guidance/Knowing." As I studied the themes that clustered temporally around "externally guided knowing," seeking safety and focus on behavioral changes, I identified a way in which these themes integrate into a composite that captures the essence of early recovery. The picture that emerges is a stage of not knowing oneself, relying on external structure for direction and safety, and practicing a methodical way of not engaging in symptoms. From a top-down perspective, symptoms have abated, though maintenance of recovery and general coping are effortful. From a bottom-up perspective, the psychological issues underlying the disorder remain.

1. External Guidance

The theme of how one knows or "is led," emerged as a transformational process with specific iterations marking each stage of recovery. In early recovery, the women described the incapacity to know themselves, their wants and their needs. For several of the women, early recovery represented a time of wanting to be healthy, but not knowing how to get there. This stage was marked by a reliance on external guidance, in the forms of advice and structure, in

navigating the path to wellness. In contrast to the stage of "full-enough" recovery, during which knowing and trusting oneself predominated, being a "good patient" and following instructions were instrumental in early recovery. The process of seeking external guidance permeated the most basic levels of functioning, eating and engaging in daily activities, as well as more dynamic intangible levels of functioning, such as gaining awareness of and experiencing feelings.

a. Externally-Guided Eating

Many of the women described adhering to a meal plan, the advice of a nutritionist or some set guidelines around eating during the early stage of recovery. Leah, age 44, described her early process of recovering from anorexia and how being a "good patient" served her. In retrospect, this time evoked both humor and sadness:

> *I was laughing as I was recalling when I first went to a nutritionist and the astronomical amounts of food I was eating, like these eight-ounce servings of fish and I didn't even know what an ounce looked like, but I was eating these piles of food and it wasn't that I was so freaked out or anything, I just remember feeling so bloated and gassy, oh God, and I was totally just following directions, so some of that is just humor, like that was totally ridiculous, but it was also sad…I was so confused, I mean, I was a pretty good patient so once I started in treatment, I cooked pretty fast, so maybe it's just more the eating disorder that makes me feel so sad, just how checked out I was and how defended and blah.*

As Leah explained, her underlying striving toward health allowed her to her follow her nutritionist's advice, despite her displeasure in the process:

> *At that point, I was eating and I was eating enough so that I didn't look scary, but I wasn't eating well…I hadn't eaten any meat for seven years and when I went to the nutritionist, again, I followed directions and they told me to eat animal protein, I remember going to this nasty taco place and getting a taco salad with chicken and it was like "aaah" (pretends to scream) and I remember eating cut up chicken livers, but I did it, I guess I was always really motivated by health, I was really scared, it had nothing to do with whether I would be able to have kids, I just didn't like being identified with being sick, it didn't feel right to me.*

Similarly to Leah, Holly, age 38, explained how being "good" served her during her early recovery. For Holly, adhering to her meal plan offered containment during her initial recovery from bulimia:

> *At first I did the strict thing even though I hated it, but I did it just as a discipline, it's sort of like a fence for a horse…it's given me guidelines because for me lack of guidelines is usually a bad thing, I need some sort of parameters, and it's evolved, it's gotten more and more lenient as the years have gone, but I think at the beginning I needed something to grip onto and a way to be good and a way to be "I did it right today."*

In essence, Holly adopted her meal plan as a check to her eating disordered tendencies. Like Holly, Zoe, age 24, described using her meal plan as protection against her own tendencies. Zoe, in her recovery from anorexia, described depending on the structure of a meal plan because she could not trust herself. Zoe contrasted her current connection to her hunger with her practice of overriding her inclinations in early recovery:

> *For a long time, I really could not afford to do that (listen to her hunger) because whatever I thought I needed was always way less than I should be having and then that*

> *would, you know I couldn't really trust myself for a long time so I really did need to think a lot about "I need two grains and I need…" and so I had to do that for a long time.*

Amanda, age 34, reported a similar self-distrust and reliance on the guidance of others. She noted the novelty of trusting others during the early phase of her recovery from anorexia:

> *It started out minute by minute and then it got easier, but it was still very focused on meal plans, not allowing myself to exercise if I was going to be a nut, things like that, it was this is what it's going to take to get me better, but this is what everyone says I need to do, I need to trust them, I haven't trusted anyone ever, and I did and it was basically calling my therapist and talking to my husband and going to groups and doing the whole thing.*

For many women, entering recovery involved a shift from subscribing to a set of unhealthy rules around eating to a structured plan established in service of health. Eva, age 41, explained this distinction:

> *I felt like I was very rigid about it like I pretty much ate the same thing every day for probably it would have been a whole year that I had the same thing for breakfast and the same thing for lunch and then kind of a variation of a couple of different things for dinner and then with some snacks and some stuff in there. I felt like part of it was I didn't have any realistic idea of what I should be eating…I did not know how to feed myself well, I don't even remember if I worked it out with a nutritionist or with my therapist or maybe I just worked it out by eating with Jennifer (i.e., her partner) and seeing what she was eating, but I just kind of figured out a few kind of set healthy things, I would have a cookie after lunch and a cookie after dinner and I wasn't restricting, it was like re-patterning somehow what's an appropriate thing to eat.*

In general, the women described early recovery as a time in which they did not know how to feed themselves in a way that would move them toward health. Moving through this stage for most of the women involved placing their trust in someone or something outside of themselves.

b. Getting through the Day

In addition to the sense of not knowing how to eat healthfully, many of the women related a more global sense of not knowing how to take care of themselves. Emily, age 32, described having to establish external boundaries in order to contain her work life during her early recovery from anorexia:

> *I had never not been a workaholic before and I actually needed it a lot so after inpatient we (she and her treatment team) actually set the schedule full-time, but I was very conscious that I had to leave, first it was 37 hours a week, then it was 40, I had to be very conscious to do that and the strange thing is that those things that I said I could not have foreseen early on, like a good relationship, I don't even want to work that much anymore (laughing)!*

Many of the women discussed their awareness that their eating disorder symptoms were serving the function of regulating emotions. This topic has been discussed extensively in the literature (Barth, 2008; Bohon, Stice, & Burton, 2009; Clinton, 2006; Deaver et al., 2003). The women in my study conveyed their confusion about knowing how to deal with the space created as symptoms subsided. For Holly, participating in Overeaters Anonymous (OA) provided the structure and she felt she needed:

> *I felt like it (OA) would work, it gave me a specific plan and it wasn't vague, it was sort of like go home, do this, call me tomorrow morning, do this, and each thing was really hard to do but it was sort of manageable to do that at the time so it was get abstinent (from the behavioral symptoms of the eating disorder) and then I'm going to give you these thirty questions and I want you to answer them and I want you to read them to me tomorrow morning. I want you to go to x amount of meetings and showing up and oh my God, I belong here. I'm not the freaky weirdo that I thought I was that did need an eating disorder, other people get me, I get them.*

Holly discussed her feelings of belonging (see next section), as well as her relief in receiving direction. Cecelia, age 40, described a similar experience. She immersed herself in the OA community during her early recovery from bulimia:

> *Every suggestion that somebody said do, I did, we're all going to see Marianne Williamson, ok, I'm going to see Marianne Williamson, you know, she has a great tape on food, get her tape on food, I got her tape on food...*

For Holly and Cecelia, OA offered a structure that extended beyond their eating disorder symptoms.

c. Externally-Guided Emotional Life

Many of the women discussed difficulties in experiencing their emotions in early recovery. Some of the women described not experiencing them fully. Others described feeling completely overwhelmed by them. As discussed above, Zoe identified the emotional regulation function of her eating disorder symptoms. She talked about needing to develop strategies for coping with emotions as she relinquished symptoms:

> *I felt that people just didn't get it, they didn't get that this (her eating disorder symptoms) was all that was keeping me sane…I was like this is my management tool, if I don't have this, I am not going to survive and everybody else saw it for what it was, but I didn't get that, I thought it was all that was keeping me stable…I did feel so protected by them (her eating disorder symptoms)and comforted by them so I did need to develop other strategies that would work before I was able to let go of anything.*

Like Zoe, Eva described developing concrete strategies in an effort to maintain emotional equilibrium:

> *I remember kind of with the same rigidity as with my food, I felt like I was really proscribed about what I did and what time I did things, there was just a little bit of just if I can control this everything will stay ok.*

Leah described a lack of connection between her conscious awareness and her emotional life. Leah described her first therapist as a "translator" of her inner experience:

> *I think that it wasn't until I started working with her that I truly understood, I think that I'd been in a lot of pain and I think I had no idea why and I think she was an extraordinary translator of what was going on and I don't think anyone had ever paid that much attention to my internal life before.*

Shannon described emerging from years of anorexia and bulimia without a sense of what mattered to her, what she liked and, essentially, who she was. During her early recovery, Shannon used the memory of herself prior to developing her eating disorder as a guide:

> *The only thing—that's a good question—the memory that I had of myself—the only thing, it's almost like, if you got the flu really really badly but you had been healthy last Tuesday you'd be like ok I know this sucks right now but I remember how I felt last*

> *Tuesday and I know I'm going to feel that way again it's just a matter of time before I get there and that's a huge comforting thought for me because you can be in a really bad place in life but if you can remember having a really positive place in life you know you can get back there…you go if I want this thing, I remember how I used to eat then and I remember how I used to think about things then so if I just act more like I did then I'll be more like that person…It started very practical, very linear, OK, if I used to eat pasta for dinner, I should eat pasta for dinner now because I looked like that and I had that life, that's the life I want…I was lucky because I actually liked myself then, I used to think about that, if I didn't have a happy high school experience, if I didn't like, would that have been a powerful pull for me? And I don't know whether it would have been or not but I had an actual unbelievable high school experience, I loved my friends, I loved where I grew up, I loved sports, I loved school, I just, I really liked who I was at that point so it was the closest thing for me to go ok that is me, that was me, so it should be easier for me to get to that, it's almost kind of like, people who pick up a magazine and say I want to look like Jennifer Anniston so I'm going to do her work-out or I'm going to eat what she eats, for me this was like the next best thing because it was actually me.*

In the same way that the women described seeking structure around eating and activities, they sought external sources to help them navigate their internal lives.

2. Safety

As the women described receiving external guidance, themes of experiencing safety emerged. I noted the theme of safety when the women described feeling understood, heard, accepted, protected, supported and loved in a way that felt new to them. While some of the

women discussed mutuality in their relationships, in developing this theme I focused on stories in which receiving was an essential component. These themes arose in descriptions of particular relationships, therapeutic experiences and communal experiences. Many of the women emphasized their reliance on this kind of holding during the early stage of recovery and a diminishing need as their recoveries progressed.

a. Safety in Relationships

Leah talked about her "first best friend" whom she met during her early recovery. For Leah, the relationship created a space in which she felt seen and heard:

> *I think it was that I was just thinking about it all in my head and it was so exhausting that it felt really good to get it out of me, I think part of it was literally that, and part of it was just her listening because I don't remember her talking that much, I mean I'm sure she did to some extent because I know her now and she tends to be pretty vocal, but she didn't say, "you should do this" which is what I got so much in recovery. As a child it was "you should be thinner" and in recovery it was "you should be fatter or you should be changing or you're crazy"…she was my first really best friend, you know really being seen and talking about things that I had never talked about before and I don't think it was just about food, but you know maybe some guy she was with and the condom broke, things that were really real and naked and I don't think I had ever a friend like that before.*

Julia, age 26, attributed the support and acceptance in her friendship with a co-worker to her beginning to allow more flexibility in her life:

> *There was this girl that I worked with who had become a very dear friend and she's had all sorts of issues in her life and we would talk and things would come up and we became really great friends and she became a really great support for me and I think I felt not alone in my issues because of her life path too, so there was a lot of acceptance there that started to make me feel like I didn't have to cling so tightly to controlling everything.*

Both Leah and Julia conveyed gaining a sense of freedom in the context of being authentic in relationships.

For Helena, age 42, feeling her boyfriend's love for her was a stabilizing force during her early recovery from bulimia. Helena's emphasis was on the experience of receiving:

> *My first boyfriend after college helped me go through this healing because he was really loving and caring…*
>
> *I: What was it about that relationship that helped you do that?*
>
> *P: When somebody really loves you for you, if you're not nice to him, I was not really nice to him actually, but he was really caring, really nice, really present all the time so he didn't have school, he was a guy working and I'm going to college but he was very there, very present, very caring, listening…*

For all three women, their relationships offered a newfound feeling of safety that was instrumental in their early processes of recovery.

b. Therapy as Safe Space

For Amanda, her relationship with her therapist provided a protected space in which she could explore self-expression and receive acceptance. She described the evolution of learning to express herself:

It was early in treatment and I was like she wants me to draw a picture, this is cuckoo therapy and I look back on it today and one of my first pictures is like fire and I wasn't thinking when I did it, I just did it, so my pictures slowly became words and so first it was just like random pictures, then it became random words…and then the words started to make sense and then I started writing paragraphs and then I started writing and I still couldn't speak very freely in therapy so I would read my journal entries and then I would cry and then I would talk, it was like I was experimenting with my voice and then I found myself practicing out in the real world and sometimes I found myself saying things I shouldn't or I was too loud when I shouldn't have been, but like you're learning so it's like you're a child and you're practicing and so you make mistakes and you learn from them…I think I saw in her the way I wanted my mom to be (tearful).

I: In what way?

P: Just compassionate and it's OK to say whatever you want, it's OK to feel whatever you want because that's real and it wasn't growing up so it was nice to have that acceptance for whoever I turned out to be in recovery.

For Amanda, therapy was a forum for discovering her authentic self and feeling accepted.

c. Safety in Community

Several of the women described finding a community in which they experienced safety. In her early recovery from anorexia, Corazon met a woman who became her spiritual mentor and joined a non-traditional healing community. Corazon felt held in her process of shedding old messages from her family and culture:

My family was not an extremely dysfunctional family but it was dysfunctional in the normal sense, like I felt very, as I grew up I discovered I felt very constrained because of

> *the expectations of how I was supposed to be and all this and physical appearance was part of that and was very present in Hispanic culture, you had to look a certain way, your hair, all of that was so much present when I grew up that it became like this. The healing process it was that I continued in the laboratory (referring to the space where her mentor conducted healing workshops) with Lucia (her mentor) for many years so it became from twenty-three for four years until I was twenty-seven, it was really my main priority to heal myself, it was like my full time job that was what I did…the safe space is very important, also it's like you learn not to feel shameful when you are in a safe space so in those first years in my healing process, having that safe intimate supportive environment.*

When Corazon felt at risk of relapse after a significant relationship ended, she immersed herself in her community:

> *What happened is that I didn't feel my hunger so I knew that I had to feel my pain every day but then even though even after that after crying for an hour it was like I don't want to eat, so all my friends, I have a support system that was very important, very wise women, not only Lucia, we became really good friends, she was part of my support system, so I had some good friends and they were all very wise, many of them were psychologists or social workers, they knew about healing and they were my friends, they were not people who I had gone to their offices, they just happened to be my environment and they became my support system, I remember the second day that I was going through this, two of my friends show up, they were both social workers and said "Ok, we're going to brunch" and then I was able to eat because they were there and then I was "Ok, this is what I need, I need to eat with people who loved me."*

Holly found a place of safety in Overeaters Anonymous (OA). For Holly, the community in OA truly satisfied many of the needs that she previously tried to satisfy with eating disorder symptoms.

> *I: What would you say specifically, if we can unpack that, what did OA give you?*
>
> *P: So I feel like if I was turning to my eating disorder for all sorts of things, comfort, peace, ease, way to deal with my feelings, friendship, you know whatever it was, it was serving so many purposes, I needed something that big to replace it, so I think what OA gave me is a place to be honest and I think for me, the group part was really important, of being around a group of people that you could be open and honest around and to share it with and it gave me hope…to be in this room and share something that I thought made me crazy or would get me kicked out of the room and instead people would nod, be so loving, that helped me really have so much more compassion for myself.*

For Holly, OA served the function of "undoing aloneness," a process that lies at the center of the therapeutic process (Fosha, 2000). According to Fosha, this process occurs as the therapist offers empathy, validation, responsiveness and guidance. For Holly, sharing what she perceived was shameful and receiving the attuned responses of OA members served this function of "undoing aloneness." Cecelia described a similar process:

> *P: I could never have guessed that I would be in that much emotional pain, I remember it being stunning how raw and naked, I remember feeling like I was walking around and I had no skin and it was very clear to me that all the stuff I was doing with food and substances and what not was all about not being in pain…*
>
> *I: So what was it about the rooms? (earlier in the interview, Cecilia referred to OA as "the rooms," a term commonly used to describe 12-Step programs)*

> *P: That those women gave voice to an experience that I was having that I didn't have words for, like I'm having this experience and I don't know how to describe it, I don't know if anybody else can relate to it, I don't know if anyone else is having the same experience, I thought I'm going to say some of this shit and people are going to think I'm nuts and everything I was thinking was coming out of people's mouths and I was like, oh my God, how is that even possible that I'm having these feeling but I haven't told anybody and you're having this same experience and you've found a way to make it better when I'm just trying to make it stop..*

Whether in relationships with individuals or as members of a community, the women described having a safe space, one in which they felt they could be authentic and feel accepted, essential in early recovery.

d. Safe Space in Hindsight

The importance of having a safe haven was a predominant theme in early recovery. However, as the women progressed, their need for feeling this level of protection diminished. Several of the women articulated their current understanding that once they had progressed in recovery, they no longer needed what they did early on in the process.

Like Holly and Cecelia, Helena described feeling understood in OA during her early recovery. As she progressed in recovery, she began to feel like the environment was not healthy for her:

> *It (OA) was really beneficial in the beginning and I was there for a year, I think it was beneficial because you see that others are worse than you and it was good too, affection, people understand, you cry, they cry so it was beneficial… I think it's that maybe people*

> *are so worse (sic) that it's just a lot of people emotionally in really bad shape so when you're recovering and you're suddenly in really good shape, you have to get out.*

Leah expressed similar feelings about the therapist she began seeing during her early recovery:

> *I think the person that I saw all through grad school until my early 30s was a very kind and accepting kind of person, I think in retrospect there were some things that she missed, she was kind of like my mom so I think I steamrolled her a little bit…she tracked me, she was with me, she held a safe space for me, but I think relationally she was not as sophisticated as I wanted her to be, but it was really good at the time.*

From the vantage point of "full-enough" recovery, many of the women reported that the level of externally-provided safety that they needed early on was not what they needed as their recoveries progressed.

3. Focus on Behavioral Change

During the early stage, in which the women relied predominantly on external guidance and acceptance, behavioral change was the primary focus in recovery. I coded the theme of behavioral change in instances when the women described experiences of behavioral change preceding psychological change. This theme arose as women discussed prioritizing behavioral changes, experiencing continued emotional distress in spite of behavioral changes, and living with the assumption that their recoveries would never be more than behavioral symptom management.

a. Prioritizing Behavioral Change

Several of the women described wanting recovery in an abstract sense early on in their processes, but feeling hesitant about making the necessary behavioral changes. Shannon recalled her therapist's clear instructions that their initial focus needed to be on behavioral change:

> *For me when I made the decision that I wanted my life to look differently, I also understood that there was all this stuff that I needed to go through to understand why I had an eating disorder because I didn't want, I remember consciously thinking about this, I didn't want to replace my eating disorder with another behavior. I just want to understand it, do the work and be done with it and so when I made that switch I was all about that and my therapist like that's lovely, but I've got to tell you that until you eat again, because I was like, ok I can kind of go on with my disordered eating and we'll just spend more time talking about this stuff and she was like, it doesn't really work that way, until you're feeding yourself so that your brain can function and process again so that you can deal with the emotional issues you're going to be like a gerbil on a ferris wheel that was helpful for her was to be like, I know you don't want to hear this right now, I'm really not going to entertain the notion of doing a whole lot of deep soul searching with you until you're committed to actually giving yourself the nutrition to be able to even process the emotions and for whatever reason that resonated with me and that was super helpful and so at that stage of my recovery I needed that dual, the good cop, bad cop, I needed someone to both hold me accountable to what I needed to be doing from a nutrition perspective, but also someone to acknowledge that I needed to understand the emotional side.*

For Shannon, progressing in recovery depended on her focusing initially on physical rehabilitation.

b. Behavioral Recovery in the Absence of Psychological Recovery

The women consistently described early recovery as fraught with difficulty. This iteration of the theme of behavioral change was consistent with previous study findings that suggested that remission of behavioral symptoms generally preceded remission of psychological symptoms (Jager, Liedtke, Lamprecht, & Freyberger, 2004; Rorty et al., 1993) and that individuals in partial recovery experienced levels of distress comparable to those active in their disorders (Bachner-Melman, Zohar, & Ebstein, 2006; Bardone-Cone et al., 2010a; Cogley and Keel, 2003).

Alice recalled her intense discomfort during this stage:

> *I think that when I was in the moment of early recovery, you know fists clenched, it felt like I was very uncomfortable in my own skin and it felt like I almost wanted to jump out of it, but I wasn't doing the behaviors, I didn't have the symptom and it was just this uncomfortable ugh feeling.*

Eva, who came out as a lesbian during her early recovery, viewed the remission of her eating disorder symptoms as one component of larger process of self-discovery. She recalled how unsettled she felt at that time:

> *I think I was very fragile, it felt like this see saw that I was trying to balance in the center of and sometimes that would go tipping off into one side or the other…it just felt all very tenuous and scary and trying redefine myself as a recovering bulimic, not just a bulimic*

> *and also defining myself as a lesbian… It just feels like it was a time of discovery and that was scary for me.*

Amanda portrayed this stage as one marked by confusion and disconnection:

> *Being in the stage where you're so focused on what you're doing and what you're not doing and what you should do and what you shouldn't do is a really hard place to be and I don't know if that's a better, it's healthier because you're not participating in eating disorder behaviors, but it feels really bad…I couldn't relate to anyone, I wasn't sick, I wasn't better, but people would say I was better…I was doing the behavior-free thing but I also feel that at that point I didn't have a clear identity and that was what was really hard for me, I didn't have my eating disorder, I wasn't recovered, I didn't know who I was and I hadn't really figured out who I was without an eating disorder because I was still thinking like an eating disorder, I was just doing the behaviors that weren't.*

For Amanda, the incongruity of appearing recovered, while not feeling recovered, evoked considerable distress. Zoe described a similar feeling. At that time, Zoe recalled asking herself whether she would always experience recovery in that same way:

> *There was definitely a very frustrating or confused period when physically I was fine, but mentally I felt no different from when I was really struggling and that was very confusing to me because I was like, I'm healthy and I still feel like this and what does that mean, am I going to be like this forever? There was a lot of anxiety around looking healthy, but not feeling healthy.*

3. As Good as it Gets?

In line with the theme of seeking external structure, Emily reflected on early recovery as a time in which she employed specific strategies to fill the space where her eating disorder symptoms had been. Like Zoe, Emily had difficulty imagining that she would ever feel free from her structured way of living:

> *I think for me, it was hard to even imagine what was possible in the next step until you really get there, because I think a lot of it, especially in the earlier stages, it's really more about ok, replacing this with something else and later you get to the point where I'm like, I am actually freed up and I have time to do other things, but it was very difficult even to imagine because I hadn't had it for a really long time so it's almost you know, it's unrealistic, people could tell me but I don't think I could relate to it at all, I would have been, it sounds nice, but I don't think it's even possible so…*

Julia recalled her sense of resignation during that stage:

> *For a long time, I was like, well, this is how my life is going to be and I'm always going to have these thoughts and I'm just not going to act on it and that's going to be where I go.*

From the vantage point of "full-enough" recovery, the women described early recovery as a time of distress. Some of the women explained that during that time they never imagined that recovery could offer more for them. These themes are reminiscent of Schaefer (2009) and Liu's (2007) memoirs of recovery. Both authors described coming to the understanding that what they had previously defined as recovery was, in actuality, a partial form of recovery. Schaefer and Liu, like many of the women in the current study, could not have imagined during early recovery that full recovery was possible.

Transition

The idea that this problem can be solved, even if I don't see how it's going to be solved, like I don't have to sit and come up intellectually with the exact plan, I just have the awareness that there is the possibility that this problem can be solved, it exists in the universe that there is a answer to this question so that if I can be calm and plug in to the level of whatever where answers lie, it's like electricity in a house, it's always there, you just have to plug into it, I can just calm down and get myself plugged in, then the next right action just sort of flows, I experience it as if it rises up from my toes, it's like I feel like something's coming, it's almost at my knees, so something hits my head and it's like oh yeah, I never would have thought of that and then it's just there and it's not like God, am I doing it right? God, am I doing it right? This felt like the next right thing and to really really grasp the idea that there's not a wrong answer, there's no like if you do it wrong then you're going to go to hell, whatever comes from this action, you'll be able to deal with whatever comes from it, not there's one path, you have to figure it out and if you don't figure it out you're screwed, it's like just stay on the path, you'll get to where you're going. *(Cecelia)*

I: You said that you were more aware of your body at the gym, but not at the grocery store or the rest of your life, so what was your experience of your body in the rest of your life? How did that start to change?

P: I think I was pretty checked out, that's a really great question, when did I start to get embodied? I think my first real boyfriend when I moved here for grad school, I went to grad school and I didn't date anyone for a long time, but I met this great guy and he was

> *a nightmare, I was his first girlfriend after his wife left him in the previous months, it was the first adult sexual relationship I had, and we just did crazy shit like eat watermelon for breakfast in bed, and once when we were driving in his car and I was giving him a hard time about his sunglasses and he just threw them out the sun roof, there was this way that it was just great, he was just free and goofy, and that was part of what he was coming out of too and it was very, not just about body, I mean like sex, it was just very human and I just think that relationship really shifted things for me, he was really into food and art and he was really just very aesthetic and that got me really to be more aware of my visual self and touch and taste, and it was pretty much the first time I had had sex in that next stage of recovery, like until then the last time I had had sex was with my long-term college boyfriend and I was still really sick and I don't remember, but there was one guy in between, but it was just really different to have sex in a kind of more recovered body and to be 29 and 30 and it was really just different.* *(Leah)*

I marked entry into the transitional stage by the introduction of internal voice into conversation with the external guiding voice or structure. Factors that coincided temporally with the appearance of this new voice were: making a choice, listening, emerging embodiment and evolution. The three agents of change at this stage, making a choice, listening and emerging embodiment align with treatment methods that have been investigated as possible adjuncts to eating disorders treatment. Specifically, making a choice is a central component in Acceptance and Commitment Therapy (ACT); listening is a central component of mindfulness; and emerging embodiment is central to body-based therapies. Brief reviews of the studies on these approaches are in included in the sections on the associated themes.

The hallmark of this stage was increased self-agency with the women making their own choices about recovery and either incorporating or rejecting the direction they had previously followed. The key agents of change were listening non-judgmentally to one's internal voice and reconnecting to bodily experience. From a top-down perspective this stage is about maintaining recovery and internalizing coping strategies. From bottom-up perspective, this stage is about beginning to understand and heal, to borrow Leah's phrase, "the formative that belies the manifest." While early recovery was focused on changing behaviors, the work of the transitional stage occurred at an internal and less visible level. As a result, narrating the process of change was challenging and the women tended to convey their experiences through analogy.

1. Blending External and Internal

The question of how one is led, or how one knows, drew consistent responses about taking in external guidance in early recovery and trusting oneself in "full enough" recovery. When asked how this change occurred, the women described a process of beginning to compare or integrate the guidance they had received externally with an emerging sense of instinct and knowing oneself. I noted this theme when the women described experiencing a dual awareness of external feedback and internal knowing. While the concepts of "Received Knowledge" and "Constructed Knowledge" were closely aligned with early and "full enough" recoveries, respectively, the transitional stage did not align neatly with one of the stages of knowing, but included aspects of "Received" and "Subjective Knowledge" (Belenky et al., 1986).

Glimmers of emerging inner voice marked entry into the transitional stage. The theme appeared, specifically, in relation to recovery from eating disorders and generally, in relation to knowing themselves. This blending of inner and outer propelled the women toward "full

enough" recovery in two distinct ways: things got better or things got worse. For some of the women, a transformational process ensued as they continued in the practices that had been prescribed for them. They started finding pleasure in them and began to make them their own. On the other hand, some women described realizing that their current practices were not working for them and that they needed to make a change in order to remain in recovery. Several of the women described recognizing that aspects of their recoveries were stagnating or deteriorating. In response, these women actively practiced approaching situations more flexibly (i.e., as opposed to the all-or-nothing thinking that is associated with eating disorders).

a. Integrating External Feedback with Internal Knowing (eating disorders recovery specific)

Some of the women described gaining a new perspective on eating once they had adjusted to their new practices. Eva, whose familial approach to eating had been shaped by her grandmother's experience as a Jew during the Holocaust, developed trust by following her partner's lead in making choices related to food (she described her partner as a "normal" eater), as well as the advice of her therapist:

> *I: What allowed you to trust them (her partner and her therapist) in that way?*
>
> *P: I guess it was just over time that the things that they did didn't hurt me…I think seeing people who were just so not dramatic about food was a huge help, like it's ok to sometimes eat more and sometimes eat less and it doesn't have to be, it's not always life and death, but I feel like with my grandmother everything was life and death.*

For Eva, the internal shift occurred as she experienced the benefits of her new practices. Zoe described experimenting with making the changes in her eating patterns and monitoring the results. For Zoe, this process included consciously connecting to her likes and wants:

> *I think I've had some experiences where I see that if I don't do it exactly right, nothing happens and so I am sort of gathering evidence slowly where I see that I don't have to do it exactly and so I'll have a day where I don't do what I usually do and that will be fine, I was very resistant to experimenting so it took me a while to see that that would be OK, but now I sort hear my nutritionist's voice in the background saying, (in a very soothing tone of voice), eating is not a science, it does not have to be the same every day and your body can handle it, and I didn't believe her for a long time and now I think I see that I can be more flexible and so if I start thinking about it from a very analytical perspective, I to just would say "OK, what do I need? What do I want? What would be good?" and think of it more that way and try and trust that that will be fine.*

Recalling Fosha's (2000) concept of "undoing aloneness," Eva and Zoe's reflections highlight the role of attachment and safety. For Eva, her relationship with her partner was the safe container in which she could begin to relinquish her rigidity around food. For Zoe, the internalized voice of her nutritionist served to calm the anxiety that arose as she lessened her grip on the rules that guided her eating.

While Cecilia described her initial total immersion in the OA program, as she progressed she realized that she needed to create her own path of recovery as an African-American woman in a predominantly Caucasian community:

> *In terms of my body, I sat in OA meetings AB (Anorexia/Bulimia) focus in a room full of skinny white girls and a handful of skinny girls from other ethnicities, but mostly a room full of skinny white girls …I felt like everybody was skinny so there was a lot of acceptance that I had to come to and that my body might end up looking different than theirs because initially I was absolutely willing to get abstinent (from bingeing and*

> *purging) as long as I didn't gain any weight, but at rock bottom starving, puking, barely taking in a morsel of anything I got down to a size 4 and I had women who those were their big jeans the size 4s, they were shopping at gap kids, I might as well have been at Lane Bryant, which now is my favorite store, but I was like oh my God, I have to power on and create an experience that I'm not seeing around me.*

For Cecelia, progress in recovery depended on her finding a way to be in OA that felt right for her.

b. Integrating External Feedback with Internal Knowing (general)

Many of the women related a shift from consciously practicing coping skills to approaching emotional situations more naturally. Alice contrasted her early practices with the ease with which she experienced emotions in "full enough" recovery:

> *I think the emotions are still there, but I think my ability to cope with them have changed drastically, so in my early days I would have my list of coping skills and look at the list and say what am I going to use now and sort of go down the list and it was not easy whereas now I can do breathing exercises or I can go for a walk or call a friend and just sort of take a couple of breaths, but I think, and the emotions have lessened over the years, but I think in that early stage, the emotions were still very intense, and I would sort of clench my fists and sort of figure ok what do I need to do?*

Alice initially needed concrete strategies for dealing with emotions however, as her recovery progressed her ability to cope improved and her experience of her emotions softened. Zoe described moving from using coping skills to manage emotions to learning to just "be in it" when feelings arose:

> *I: What about feelings and experiencing feeling in early recovery versus now?*

> *I think early on I got a lot of concrete strategies like DBT or whatever, like I did all that, and that was very helpful for a period of time, I think my group has been really helpful because my group therapist loves feelings and she loves to say, if I'm telling a story, she'll be like, "What's the feeling?" and I'd be like, "I don't want to talk about feelings," but she's very persistent about feelings so she's really made me more aware of it and also we talk a lot in group about how do you just be in it, how do you just be in a feeling and I never wanted to be in a feeling, like my whole M.O. was to escape from feelings and so I've had to work a lot on how do you just be in a feeling, but not let it consume you completely and so I feel like my work in group has been really helpful with that because the therapist is all into being with your feelings which I hated for a long time, but I really think it has worked.*

For many of the women, the need for "skills" lessened and the attention to inner resources increased in the transitional stage of recovery. Corazon described being guided by her mentor through a process of connecting to inner emotional resources and overcoming self-defeating tendencies:

> *I remember in the process, inner dynamics technique that's she (Lucia) developed because what she told me was to identify healthy energies within myself that could take care of me and one of those healthy energies was the inner mother and also to identify the shadows so the one who wants to be anorexic was the shadow so I became detached from my shadows.*

For Anna, her therapist's encouragement of exploring and creating meaning was instrumental in her movement toward "full enough" recovery:

P: One of the things my therapist said to me, we can't wait for you to be totally recovered before you start a life, she said you've got to start living your life and more of your recovery, and that will help you to keep on recovering, everybody else was always like you have to be fully recovered before you can do anything else so I was always waiting and waiting and waiting, but in some ways it almost made it more scary to recover because if I recovered there was nothing to fill in so by helping me to find things that were meaningful to me, I could see, I don't need this because I have other things already (becoming tearful).

I: It looks like that still brings up a lot of feelings.

P: It does because, that was key and I think that's important because sometimes in eating disorders especially for me because it had been my whole life for so long if you say to a person I'm going to take this away and then you can start filling in, there's an empty hole almost and it's kind of scary to have that empty hole where if you say let's at least fill in part of that hole a little bit.

As discussed in the section on early recovery, many of the women described experiencing a hole or space where the eating disorder symptoms used to be, as well as a reliance on coping strategies. In the transitional stage, the women described coping more organically and experiencing the need for coping less acutely.

c. Things Got Better

This intermingling of external resources with an emerging inner sense of knowing led the women in two different ways through the transitional stage toward "full enough" recovery

described. One of these ways involved internalizing the external guidance and building upon it or making it their own.

Leah described her shift from experimenting with ways of nurturing herself to embracing the process:

> *I started getting used to it and I like it and I think I, if we go back to the clothes thing or any of these things, I remember taking myself to the movies, I remember feeling like it was such a treat, it was like when I was buying my car, I was thinking "I don't need a sun roof and electric windows" and then you're like "this is awesome," I mean, I can't go back, I mean I never would, but allowing myself to experience pleasure more and more and really enjoying it.*

Alice described awakening to pleasure as she engaged in life without her eating disorder:

> *At times, I was feeling good, when I didn't overanalyze it, and other times when I would look at pictures, I'd be "I'm not where I want to be, but I'm also not having the eating disorder so let's just go with it" and just try not to obsess about it or be so preoccupied with it because I found that the freedom was a lot more enjoyable.*

For Leah and Alice, the behavioral practices they had learned and incorporated in their lives in early recovery became the foundation of a fuller recovery.

d. Things Got Worse

Some of the women described reaching a juncture in which they realized that their recovery was in jeopardy. The women conveyed experiences of coming to an awareness that they needed to deviate from the externally guided plan or risk returning to their eating disorders. These examples demonstrate the advent of attending to one's own internal knowledge.

Emily discussed beginning to feel a fatigue in practicing her new behaviors. In response, she realized that she needed to bolster her recovery efforts:

P: I think keeping it up, it started to become, OK, I've been doing it for a while, this is getting kind of tired and that's what I hear from a lot of my friends too…

I: What do you mean—you had been doing it for a while and it felt like work?

P: Yeah, it felt like work, it's really difficult, it definitely feels like you're treading in water type of thing and I am guessing that for me if I didn't have the intensive and the extra things to kind of push through the issues it would probably be a slip or relapse or something.

In early recovery, Shannon participated in a treatment program that approached eating disorders as a chronic condition. She realized that she needed to reject her treatment program's philosophy in order to progress in recovery. Shannon discussed her decision to leave her treatment program and return to college:

I felt like I had a better shot of recovering in that environment (the college community), it sounds ridiculous, versus an environment where having an eating disorder (the treatment program) became the normal thing, I didn't want that to feel like my normal, I wanted my old life to feel like my normal…Doctors, even the therapists I had said it's something you'll have to learn to live with and manage, they used to equate it to back problems, I don't know if you've ever had any back issues before. I actually have, you hear people say once you injure your back you can never bring it back to what it was before, but you can prevent it from getting worse and that's how they used to talk about eating disorders but for me that was not inspirational.

For Shannon, moving forward depended on her finding what worked for her in recovery. Amanda had a similar experience in early recovery when she realized that following a meal plan was no longer helpful and that she needed to start eating intuitively. For Amanda, intensifying eating disorder thinking served as her signal that she needed to make a change:

> *It was not so much the behavior, but the thinking was there again, and I knew it was just a matter of time because when you have that sort of thinking for me it's hard not to act on it…what wasn't helpful was that everyone was scared that I wasn't going to be OK so they wanted me to take my meds, stick to my meal plan, all these rigid things, and I was like I've been rigid, I need to be non-rigid …I went to see the therapist and she was very much into you need a meal plan, you need this, you need that, and I was like no, I don't and we didn't get along and I left and whatever and saw someone else, I said I'm not at that point, I need to learn…*
>
> *I: So you had a sense of what you needed…*
>
> *P: I said, I need to learn to do this intuitively… I was always calculating in my head what I ate, what I ate, what I ate, and now if I don't remember what I had for breakfast I'm ok with it, I don't have to be like, what did I have, how much did I have, how many calories are in that kind of thing, it's I'm not obsessed with it, I just sort of live and eat because I'm hungry, it's a part of life.*

Amanda realized that what she was being advised to do felt too rigid and was no longer helpful. She made the decision to honor her own inclinations about how to proceed. Cecelia, too, came to a point in which she needed to separate what she believed from what she was being told by her therapist. Throughout their relationship, Cecelia had consistently deferred to him in making decisions, however, as she progressed in recovery she noticed rising feelings of distrust and

anger toward him. It is worth noting that at this point Cecelia had progressed dramatically in her eating disorders recovery. She was no longer engaging in symptoms and her obsession with weight, shape and food had largely diminished. At the same, she continued to struggle with self-trust. Cecelia described her confusion at that time:

> *P: I went back to the therapist and I didn't trust him but I felt like I needed him and so I went back to him and I was stable, I was stable again…he moved me forward in a lot of ways, he was very directive, some therapists are not so directive, they'll spend years going how do you feel or how does that make you feel, he'll just tell you straight out…*
>
> *I: And you felt you needed that…*
>
> *P: Until I got to the point where I felt I gave too much power to him…I felt like I was getting back to that uncomfortable place where I'm doing all these things that other people are telling me to do but it's fucked me, historically it fucked me so when do you trust and when do you go I'll get to the answer sooner or others, when do you lean on others, when do you lean on yourself and all this back and forth.*

The shifts described by these participants are similar to the turning points that launched the process of full recovery for Liu (2009) and Schaefer (2009). The presence of turning points during the transitional stage appears associated with changing a current practice or belief that is not helping recovery. The women who had the experience of "things getting worse" described turning points that marked that prevented relapse and initiated the process of progressing in recovery. Those who had the experience of "things getting better" described a more fluid process. Nevertheless, both groups described the change process as gradual (see Evolution).

2. Making a Choice

As the women began connecting with an inner guiding voice, themes around taking responsibility and choosing recovery emerged. I coded this theme in instances where the women articulated consciously choosing recovery over disorder.

This moment of making a choice recalls the women's articulations of the process of intially entering recovery and matches the descriptions offered by Liu (2011) and Reindl (2003), as well as how the women. In the transitional stage, the theme marked a refueling once the recovery journey had begun. Some of the women described reaffirming the concrete choice not to engage in symptoms in their daily lives. Others described making a psychological shift during early recovery that powered their movement forward toward "full enough" recovery. For some of the women who described "things getting worse," making a choice was associated with the recognition that what they were doing was not helpful and choosing a new direction as in Shannon's decision to leave a treatment program that she did not feel was helping her (see "Things Got Worse.")

Making a choice is a central component of acceptance and commitment, a model that has been applied to the treatment of eating disorders. The model is premised on committing to the process of recovery (Berman, Boutelle, & Crow, 2009; Heffner, Sperry, Eifert, & Detweiler, 2002; Wilson & Roberts, 2002). I mention the relevant literature as a way to highlight that researchers are currently exploring treatment approaches that map onto the transformational processes that appear in the transitional stage.

a. Concrete Choice

Several women noted the impact of deciding not to engage in symptoms. For Cecelia, her decision not to purge triggered a positive chain reaction in terms of not engaging in other symptoms of the disorder:

> *It was just no purging, eat what you want, don't eat what you don't want, if you feel like starving, starve, you'll get hungry again, it was like just don't throw up but that meant that everything I put in my body I had to take responsibility for so if I starved then I was going to be starving and I would binge and that binge would make me want to purge so if the bottom line is no purging, then fuck I can't binge, fuck I can't starve, fuck I have to eat regular meals so I backed into it.*

Holly recognized the potential negative consequences of re-engaging in her old behaviors:

> *I mean do I think I'm perfect, but I feel like the work it would take me to get perfect or look better isn't worth my losing my peace so be it and then I also realize it's not going to get me anything that I really want other than some old distraction.*

b. Psychological Shift

Some of the women described undergoing an important psychological shift. Corazon described a moment of epiphany during her early recovery:

> *It's like I made a decision, like there is a moment where I made it, I really made a deep decision from my soul, it was like, OK I am living this life that is not me and I wanted to be me and somehow I realized that there was a possibility of being me, like being free so I'm going to put all my attention in doing that.*

For Zoe, the choice involved committing to something that was more important to her than her eating disorder. Zoe described coming to the realization that she not achieve her professional goals while engaged in her eating disorder:

> *I think for me becoming a teacher was very important to my process and I think what I realized in trying to be both eating disordered and a teacher is that you can't do both, well, you can do both but it will seriously compromise your teaching and so I had to say, "which is more important to me, or ultimately what do I want" and what I wanted was to feel like I was a really good teacher and I didn't feel like that, if I don't eat breakfast you don't want to know me, I was cranky and edgy and emotionally unstable and you can't be good at your job if that's how you feel and so I think there had to be something that I wanted more, but I also had to experience that you can't do both, but I thought, ok, I'll just do both and people would say you can't have both, and I'd say, "just watch me try," you know and I couldn't and I think that was important for me to see first-hand, you do have to make a choice if you want to do either of those things well, you can't so both of them.*

3. Listening

The act of inward listening undergirded the process of blending external and internal information. Actively listening to one's inner voice emerged as a central theme during the transitional stage. This theme emphasizes the process of listening without judgment and is not necessarily linked to the act of following one's inner voice. I noted this theme in instances in which the women described listening specifically to hunger, listening to themselves in general,

and engaging in the process of listening. The theme of conscious listening heralds the emergence of instinctive knowing in "full enough" recovery.

a. Listening to Hunger and Appetite

Many of the women described their approaches to listening to hunger and appetite. Helena's method involved first deconstructing her internalized food rules then, consciously listening to her cravings. Helena designed her particular approach based on what she believed would work for her (coincidentally, Helena's created approach was actually a previously established method)[6]:

> *That was a part of my recovery so I experiment with my own self for a while so I said I'm going to eat chips for a while …it could be weeks but your body just asks for vegetables at one point when you really listen to it when you're not sick anymore your body is just going to balance itself.*

Similar to Eva and Zoe's descriptions of the process of integrating external feedback and internal knowing, Helena reported that she gathered evidence that her new system worked. Corazon conveyed a similar process:

> *I learned how to go to the supermarket to do food shopping, it was a whole process like ok, I'm going to make a list, it's what I'm going to do for myself, I'm going to learn what I like to eat, it was a discovery process, what do I really like to eat, I had to listen to my body to see what I like to eat so I discovered what I liked to eat and I became very good with food and the whole process of creating food as a whole nurturing ceremony instead of just eating anything, cooking with consciousness, serving food with consciousness and*

[6] The approach described by Helena is a method that was established and popularized by Geneen Roth (1995).

love so that was part of my whole eating process, eating became part of the healing itself, it was not just I have to eat, I make my soul eat.

Like Helena, Corazon's evolution toward eating healthfully started with conscious listening.

b. Listening to Self (general)

The women recounted stories of listening to self in a multitude of dimensions, including emotional awareness, sexuality, relationships and vocation. Cecelia recalled writing in her journal:

The first page, in the beginning was always like I feel fine…I'm going to have a bagel for breakfast, I remember it was all like fluff and then by page three I would be like, but yesterday this happened that hurt my feelings and this person said that and I disagreed with it, but I went along with it or somebody really wants me to do xyz and I don't really want to do xyz, but I'm going to do it anyway, it allowed me just to slow down and be still enough to identify what the issues were because I would feel like I'm going along, I'm fine, I'm fine, I'm fine and then boom, I'm body slammed with this big wave of feelings and I came to understand that the wave came from all those little times that things didn't work for me and I said nothing.

Cecelia became aware of her pattern of self-constriction by attending to her thoughts and emotions. For Cecelia, the listening process unearthed feelings, as well as an internal sense about how to proceed. Cecelia described discovering clarity through meditation:

I would sit there and after I was able to clear my mind from what subway was I going to take home and where was my token, I was like I could change plans and not go to that event I don't want to do, I could say that doesn't work for me but how about this, meditation let me be quiet enough to hear that the answers were already there previously.

For Emily, the process of listening unearthed joy, a feeling she barely recognized after her eating disordered years:

> *I was journaling about the clouds, I was noticing things and I was writing oh, this is really girly because everything was nice, and then we (she and her therapist) talked for a while and I was like wait a minute, is this what people feel like when they're happy? I guess I hadn't felt that for a long time, I didn't recognize what it was, it actually felt like it was strange, this is weird, that's what I kept saying, this is kind of weird, it's kind of like ok, I was feeling like oh the clouds are nice so yeah I think I really just even kind of feeling maybe it comes more naturally to some other people (laughing), but I didn't know what I was feeling.*

Like Emily, Shannon described relearning to recognize her emotions. For Shannon, a painful relationship spurred her awareness:

> *It was probably my first serious emotional relationship after recovery and I think back on it now, some of the stuff I put up with that I wouldn't put up with now, part of it was that pull, I wanted so badly for him to love me that I was like of course, I understand if you can't come down for my birthday and it was during that relationship that I learned to listen to my gut again, and I think I had the confidence and the trust coming out of recovery, but I didn't necessarily have the self-esteem built yet, I know it's a weird distinction to make, it was during that relationship, it was like an elementary school for emotions, it was like I know that I really don't like how he's making me feel right now.*

Shannon explained that learning to listen to how she was feeling preceded having the confidence to take action. Similarly, Zoe described awakening to her feelings about her own sexuality that had been obscured by her eating disorder.

> *And it slowly started to dawn on me that I don't think I'm ever going to be interested in being with guys that way, I just don't think that's ever going to happen and then I started to look back and realized that I had been drawn to women that way, but I hadn't known what that was and I had always assumed that I'll get interested in guys when I get interested in guys or I'll just have to wait so it was then very confusing to have to think, wait, what? And I think it's always been true that I'm more drawn to women but I didn't connect with that until last year, so that's been a whole other piece of this which I think probably does link into the eating disorder in some way because I think a big piece of what that did for me was that it totally took me out of the game altogether.*

For Kristen, age 52, the process of writing reflective papers for school offered her insight about the importance of vocation. Kristen's transformation from being "someone who never finished anything" to a responsible adult was central to her story of recovery from bulimia and alcoholism:

> *I learned because every class you take you have to write a reflective paper and you have to put your story in a different angle and I learned about all my job choices and why I like what I do, it was the perfect class to take as a first class and I realized how important it is, and satisfaction with work can build your self-esteem and make you move forward, make you stand still or make you fall backwards, and so things were just starting to tie together.*

In general, the emergence of clarity resulted from this process of conscious non-judgmental listening.

c. Engaging in Listening

The women approached the process of listening from different angles. As previously mentioned, several women described listening through writing. For some of the women, listening resulted from an act of asking questions of themselves and being open to what arose naturally. Anna described her process:

> *Part of it is I say to myself what is my heart telling me? What is my heart telling me? And there are times when I just say to myself, forgetting everything, forgetting the voices of what I think my parents want me to do or whatever, I say what does my heart want me to do and my therapist, I love her, we've, she's more than just a therapist in some ways, she's a friend, a colleague so I think also when I'm really doubtful about something I feel like I can talk about it with her and she helps me figure out what do I really want, she helps me, she's also helped me to trust myself.*

Anna's description highlighted the importance of flexibility in listening. For Anna, the act of listening to self included choosing to allow input from a trusted other.

Discerning whom she could trust was central to Cecelia's exploration:

> *I don't know what point it showed up (feelings of distrust toward her therapist), but in my life I just kept going, how do I feel about this, put it in my pocket, how do I feel about that, put it in my pocket, with everything, not just him (her therapist), with everything, I drink a glass of soda, put it in my pocket, so I kept doing and writing, and things would come out in writing, I had no idea I felt that way about that, and I didn't judge, I didn't stop it, I didn't try to change my mind, I didn't force myself to change my mind about it, I just went huh, OK and once I just let it sit and marinate I started seeing him differently, I didn't have to force myself to see things differently, I just started to see things differently*

For Cecelia, "put(ting it min my pocket" meant noticing and noting what she was feeling. Cecelia described this conscious practice as an integral part of the transitional stage of recovery (as opposed to her more instinctual current practice):

> *I mean there are still plenty of things that I'm like hmm, how do I feel about this, but I have a lot of years at this point of asking myself every step of the way "how do I feel? What do I think about this? What do I think about that? Does this work for me? Does this not?" Before I would find myself knee deep into a situation and then ask myself, oh, my God, "how do I feel?" Because now I automatically check in myself as we go along so that at each part I'm like this works for me, this works for me, this works for me, when we hit a part that doesn't work for me, I'm like yeah, no, that doesn't really work for me.*

Some of the women located their practice of listening within a spiritual context. Through yoga, Leah adopted a practice of non-judgmental observation.

> *P: I think the words that come to mind about that community (yoga community), one was permission and one was allow, like the way that there's just this like invitation, it's similar to what I was saying about being tracked, it's inviting you to track yourself all the time, but not in a judgmental way…*
>
> *I: And what was that like for you in early recovery?*
>
> *P: I had a lot of the judging, I had a father who was extremely rigid and obsessive and structured and had a lot ideas about what was good and bad, including my size, you know when we were talking about recovery in terms of that spiral*[7]*, I come back to that question all the time, early on it was "Am I a good enough?" whatever it is or am I doing*

[7] Earlier in her interview, Leah described recovery as spiral that allows you to visit and revisit the same place in a way.

it in a right enough way rather than "is it enough for me?" it was "is it the right thing?" so yoga for me feels like the anti-dad.

For Leah, adopting a spiritual practice of non-judgment served to repair the patterns she had learned as a child.

Similarly, Corazon described learning to listen to herself as spiritual process:

P: I trust myself, I do a lot f meditation and it's like I have a relationship with my spiritual guides or gods and that's very central in my life, in my personal life, like without that I lose direction.

I: And your relationship to your guides is connected to meditation?

P: Exactly so that's why spirituality is very important, I think that without that, I wouldn't be in full recovery, that's very important.

I: And early on, your level of your connection…

P: Early on, I had a teacher to help me to get connected and because I trusted her, I would say I opened my soul to that, many miracles happened in my life so that was a way to start trusting life.

Like Alice, Corazon described being guided by a trusted mentor to connect with her own inner sense of knowing.

Holly linked her practice of deep listening to her relationship with her higher power. For Holly, her evolution centered on her practice of slowing down and being with a question rather than moving immediately toward action:

One of things that program (OA) has evolved to is more meditation and writing, the tools are more connected to your higher power, whatever you want to call it, the idea that I might have an immediate idea of this is what I think I should do, now I might sit and ask

> *my higher power what I should do or talk to people I really trust about this, so for me making decisions has a lot less to do with doing what I think is right, but a process of arriving at what's right versus yes, no, yes, no, because I didn't always know and sometimes I am right, but you know it's the discipline again of being quiet and sitting which is the opposite of the eating disorder.*

As a theme that emerged in the transitional stage of recovery, conscious flexible listening was a hallmark of the shift to being in full recovery.

Enhancing an individual's ability to observe the present moment has been another area of interest in eating disorders treatment. Similar to current research exploring the process of making a choice in the treatment of eating disorders, current research on mindfulness training maps onto the transformational process of listening in the transitional stage. Though the majority of studies have been exploratory, preliminary results suggested that incorporating mindfulness training was effective in the treatment of eating disorders (Bruha, 2010; Calogero & Pedrotty-Stump, 2010; Courbasson, Nishikawa, & Shapira, 2011; Duprey, 2011; Hepworth, 2011; Kristeller, Baer, & Quillian-Wolever, 2006; Kristeller & Wolever, 2011; McCallum, 2010; Proulx, 2008; Wanden-Berghe, Sanz-Valero, & Wanden-Berghe, 2011; Wolever & Best, 2009). The women's ability to notice and observe their inner processes in a non-judgmental fashion reflected an emerging capacity for mindfulness.

4. Emerging Embodiment

Along with the process of listening, this transitional stage was marked by the emergence of themes of visceral and bodily experience. I noted the theme of embodiment when the women made reference to actual bodily experiences, as well as when they described feeling an emotion

fully or viscerally. While embodiment themes arose as the women described this in-between stage, the theme is most prominent in discussions of "full enough" recovery. Themes that appear in the transitional stage focus on the experiences of coming fully into the body or of emerging embodied experience. The process of becoming or emerging distinguishes the transitional iteration of the embodiment theme from examples of full embodiment that appear as the women talked about "full enough recovery" (see Embodiment).

There has been increasing interest in the role of body awareness and connection in recovery from eating disorders. Recent research has focused on incorporating yoga and body-awareness practices in the treatment of eating disorders. Though much of the research has been exploratory, preliminary findings suggest that these practices may be effective in reducing eating disorder symptoms (Carei, 2008; Carei, Fyfe-Johnson, Breuner, Brown, 2010; Catalan-Matamoros, Helvik-Skjaerven, Labajos-Manzanares, Martínez-de-Salazar-Arboleas, & Sánchez-Guerrero, 2011; Dale, Mattison, Greening, Galen, Neace, & Matacin, 2009; Douglass, 2009; Douglass, 2011; Wallin, & Kronovall, Majewski, 2000). While some of the women in the study were engaged in body-awareness practices, many described attuning to their bodies and experiencing emotions viscerally as a natural outgrowth of the recovery process.

a. Coming into Bodily Experience

Many of the women related experiences of coming to be in their bodies in a new way. Anna described her process of entering her body more fully as she began her Pilates practice:

I: What was your awareness of being in your body in early recovery?

P: It was totally disconnected, again, this is really kind of visceral, but I felt like there was a split, I didn't feel connected, my body, my mind, my heart, I always felt like there

> *was split and I think Pilates just helped me because it's a very flowing kind of movement and I love the stretching part and all of that and I was very disconnected and I think the Pilates helped me to feel more one, more unified, and even now when I'm feeling something, I'm feeling sad or anxious, I automatically think of that in terms of where I'm feeling it in my body, it's become very much part of my life, oh my God, I'm really anxious, my heart is pounding, I have knots in my stomach so I don't only think about it on an intellectual level, I really do think about it in terms of where I feel it in my body,*

For Anna, the mind-body connection that she discovered through Pilates blossomed into an experience in her daily life.

Corazon described discovering a connection between how she felt in her body to how she was seeing herself in her daily life. Like Anna, Corazon began connecting what was happening in her mind to what was happening in her body:

> *I felt fat for a long time when I looked in the mirror and that lasted maybe a year but because I was beginning to do the yoga and the movement, I began to feel my body and I and I began to feel the energy in my body and I realized that I felt very heavy in many parts of my body so that heaviness translated into the image that I saw in the mirror, that's what I realized years later thinking about it so the process of movement and allowing the energy to flow in my body that was my work.*

For Eva, giving birth and becoming a mother offered a new way of being in and seeing her body:

> *I did natural childbirth with both of the kids, it was more than I had bargained for in terms of the pain and the out of control of it…if I can get through that I can get through anything…having children was a huge turning point for everything, I think in my recovery and seeing my body in a different way.*

For these women, bodily-based experiences fostered the mind-body connection.

b. Emerging Embodied Feelings

Some of the women described the dawning of viscerally experienced feelings. Gendlin (2007) used the term "felt sense" to describe knowledge or awareness experienced at a bodily level. This iteration of the theme is similar to Gendlin's "felt sense."

Kristen recalled noticing moments of wellbeing that were not a part of her early recovery:

P: I remember even telling my husband about the sense of wellbeing for the first time ever since I was a kid, there would be moments that you felt good, just right.

I: What was that like for you?

P: It was really wonderful because you knew this is how it could be although you didn't really think about, it's just for a second you lived in that moment and you felt good.

For Kristen, these glimmers of wellbeing marked the transitional stage of recovery. Julia experienced an emerging sense of wellbeing in starting a job where she felt competent. For Julia, her internal critical voice subsided as she became connected and engaged at work. Julia linked her positive feelings to her connection with her work, as well as with her co-workers:

I ended up working at a residential treatment center for troubled adolescent girls, I started working for them at the end of that summer and it just really, I loved it and I felt really connected to the work and I was so busy with other things that I didn't have room in my head for caring about those other things and I felt active and strong, I just felt good in the stuff that I was doing and so that voice started, got a lot quieter, it was still there during, and I think it still pops up when I'm really stressed out…I feel like that the relationships I started to form and that environment where I really felt competent and

> *enjoyed it, it was such a deviation from everything that had been previous for an entire year and so I felt very alive and I started, I felt like there was just a time when I was anorexic when I was just numb and dead to anything and that just faded away, I started to feel engaged, and strong and competent and like I had a place because in residential there is so much team work that you have to do, I think I thrived on that, being part of a team and feeling like I fit in.*

For many of the women, introduction of the experience of a "felt sense" represented a break from what they had experienced in early recovery (and in their disorders) and an opening to a fuller embodied way of being in recovery.

5. Evolution

While listening and becoming embodied emerged as salient processes during the transitional stage, the women had difficulty articulating what had actually occurred. For most of the women, recovery was a gradual accumulation of minute changes that amounted to significant transformation over time. Sheila Reindl (personal communication, November 3, 2011) observed at numerous presentations in which speakers tell their stories of recovery that the question, "How did that change happen?" arose frequently from audience members. Reindl noted that the specific actions of the internal process were often difficult to articulate. In describing an overall pattern of a gradual accumulation of imperceptible changes amounting to significant change, many of the women in my study conveyed the nature of the experience by analogy.

Shannon portrayed her forward movement like that of an infant beginning to crawl:

> *When I think of things that were easy I associate that with a cartoon light bulb moment going off and as soon as I realized it and saw the light everything changed and there*

> *were very few moments that happened that way whether it was my academics or my relationship with my family or my eating habits or my exercise habits, I really felt like a lot of it was gradual, I always thought it would be, and hoped it would be more spontaneous and more black and white than that but for me everything was gradual… it was definitely progressive, meaning when I first started, you slipped up more than you stood up and then eventually for me I got my legs underneath me and I was ok, now I can crawl, and now I can walk and now I can run.*

Helena likened her way of pushing forward during a ten-year span in which her symptoms ultimately remitted to dealing with "stepping in a poop."

> *P: For ten years it (binge and purge episodes) happened less and less, it's just an oh shit moment and I don't make a big deal about it, I think that's why, I'm like oh shit, damn, what's going on? And like ok, whatever, instead of saying what's going on, how did this happen, did that happen, did something happen at work, am I stressed, what's going on.*
>
> *I: So not analyzing it…*
>
> *P: Yeah, I just accept it, I don't even try to think about why it happened, that's the only way for me that that would work for me, if it's oh shit, alright, like stepping in a poop, you're like oh fuck, I'm not going to do it again next time, but I don't say why did I step there and not across the street (laughs)?*

For Helena, the perspective that occasional symptoms were part of an overall recovery trajectory was instrumental to her continued forward movement.

Leah represented her movement as an upwardly moving spiral, more specifically, a slinky. As in Shannon's description, Leah referred to changes in the realm of eating disorder symptoms, as well related dynamics:

Definitely and I feel like and the way I describe it to my patients is the idea of a big slinky that you stretch, so you're cycling and spiraling and so you're visiting the same place but it's different and each time you have more information, so you go on a trip and it goes a certain way and x, y and z happen and you handle it one way and the next time you do it, you handle it another way and hopefully there is more of a softness and there is more of an ease or there is less anxiety and again, it could be eating disorder-centric or it could what is at the basis of it, like anxiety or how you execute it, you know, being more real with someone or something like that.

Kristen compared her recovery process to working on a jigsaw puzzle:

When you do a jigsaw puzzle, you don't just start and do the whole thing, you have the red barn, you do it, you have blue sky in the corner, you do it, you have a patch of sand, you do it, you do what's easiest and you put all those pieces in and then things become clearer, it makes it easier and in eating disorders recovery, you have a therapist, you have a dietitian, if you're lucky, you have a primary care, you have work, you have a home life, not all are going to work well together so you do what's easiest and then when you get stuck you find what's easiest in one of those other places and you keep putting pieces in until that picture fills in and you don't even realize that you've recovered more until you look back because it doesn't feel like recovery.

I: What do you mean?

P: A lot of people think that once you get rid of your symptoms, you stop bingeing or you start eating, that's recovery—recovery is the process, I'm still in recovery to a certain extent because I'm recovering my life and I'm recreating my life, recovery is not a state of being, you're not going to wake up one morning and the binge purge, I always thought

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> *that the minute I woke up today's the day no bingeing and purging and that would be recovery, recovery is not tangible like that, recovery is looking back and seeing how much of your puzzle is done, when you're in early recovery, you see all the puzzle that needs to be done and you don't feel that each piece is recovery, a month after I quit my symptoms, I didn't see that I was any, I was just surviving day to day, I didn't realize at that time that I'd put pieces together.*

Zoe noted that in early recovery she viewed recovery as a finite goal:

> *I used to always say "OK, eating disorder is here, in Maine in the winter, and recovery is California and I'm here in Iowa, Iowa sucks, there's nothing to do, nothing to see, no one wants to go there and so I hated being in neither here nor there.*

This perspective evolved as she progressed in recovery:

> *I think recovery isn't a destination, it's how you go and I don't feel like you have to really wait at its doorstep, like you sort of do it, it's the process, it's not like California is recovery, I don't really think like that anymore, the whole trip is recovery so you can be doing it even if you're not ultimately where you hope you'll end up.*

As discussed previously, the view of recovery from the vantage point of early recovery was often stunted. Only in retrospect were the women able to reflect on the enormity of their transformations. Through the current study, I detected discernable processes of change however, day-to-day shifts were intangible and often best conveyed by analogy.

Full-enough Recovery

Hunger now, I feel like it's impossible to ignore my hunger now, I don't know how I ever did and I feel like when I'm hungry now, I just listen to my body and I eat what I want or what comes into my head. *(Julia)*

I was like it's going to be whatever it's going to be, so yeah I don't have a size 4 ass, but I have a size 65 life, this amazing abundant life. *(Cecelia)*

I like who I am, I like me, I like being me, being in my head is much better, being in my body, sometimes I'm still like is this really me, have I really gained this much weight? Oh my God. But then, I look at it as, I think for me the scale and comparing myself to other people has been the hardest thing, the last thing to let go of, and I still struggle, not so much that it permeates my being and I'm overtaken by it, but I'm more, I'm almost more rational about it, I almost can't believe that I'm almost OK with being me, I never would have thought, I would be this size, I would have called myself fat, and now I'm like, you know, it's just who I am and I'm so much happier than I was , my thinnest I was the most miserable. *(Amanda)*

I think the other thing that I feel now that I didn't feel before is my own vulnerability, I was so busy not feeling and being miserable in the process, but I didn't have to really contend with being vulnerable and my family loved me and I loved my friends but I didn't have that intimate relationship where the prospect of having children where you're really vulnerable where you really matter and someone really loves you and you really love and

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> *it makes the world incredibly different, it's just a different experience of life whereas the ED is sort of like I'm kind of here, but I'm kind of not, don't quite count on me 'cause I'm not, and that's sort of what I feel like again, full recovery is really growing up. (Holly)*

Though I had defined what I called "long-term" recovery in recruiting for my study, I did not return to this definition during the interviews. While the screening process ensured that the women met specific criteria for recovery, my aim was to hear their perspectives and the terms they used to describe it. Currently, there is a great deal of debate in the field about "full recovery." Considering this debate, I did not assume that this term was relevant or applicable to the study participants. As previously discussed, the interviews revealed that many of the women did not resonate with the term "full recovery." Though they experienced freedom from a life dominated by behaviors and obsessions, they objected to any implication that full recovery was, to borrow Zoe's word, a destination. In response to these objections, I developed the term "full-enough recovery."

I delineated the shift into "full enough" based on the emergence of "Constructed Knowledge" or flexible internal guidance. Themes that cluster temporally around this iteration of the theme are embodiment, reflection, landing at self, emergence, peace and purpose. In "full enough" recovery, these elements are integrated in such a way that seemingly conflicting elements co-exist. This stage involves knowing oneself and trusting one's instincts, while remaining open to external input. The women experienced ease in relationships with trusted others, as well as a level of comfort in being with oneself. Themes emerged of feeling fully, while maintaining the capacity to reflect; it involved striving for authenticity and accepting imperfection; the women described knowing peace and having purpose.

In considering the "full-enough" stage in the realm of attachment theory, this final stage is closely aligned with "secure attachment." As discussed earlier, attachment theory is the notion that early interactional experiences with a primary caretaker influence the individual's capacity to connect with others (Bowlby, 1977). More recent research connects the capacity to regulate affect with the capacity for attachment (Fonagy & Target, 2009; Sroufe, 1996; Schore & Schore, 2008). In the current study, the women's descriptions of dependent relationships and difficulties with emotion regulation in early recovery suggest insecurity in attachment style. Though the women did not elucidate the process of change specifically in terms of attachment, undergoing the processes of progressing to "full-enough" recovery did result in a shift in attachment style. The internalized capacity to regulate emotions and maintain authentic connection in relationships, which are the hallmarks of "secure attachment," were repeatedly demonstrated in the women's narratives during this stage.

Many of the women reflected that healing and growth were not processes that ended as they reached recovery; these processes were parts of their lifelong journeys. At the same time, they described experiencing joy at a level that they never had before. When asked if recovery was what she had imagined it would be, Leah replied emphatically, "In terms of the quality of my life, absolutely, it is more than I ever could have hoped for in terms of contentment, and pleasure and aliveness."

1. Internal Guidance

As the women talked about their current recoveries, themes of following their instincts and being guided internally predominated. The glimmers of self-guidance that emerged during the transitional stage were fully present in this stage of recovery. I noted the theme of internal

guidance when the women talked about experiences of being internally led, specifically, in terms of eating and generally, in terms of navigating their daily lives. Additionally, I identified instances in which the women described relating in a more flexible way to what or who had previously guided them. The earlier pattern of seeking protection was transformed as self-trust increased. Included in this theme were revelations that continuing to grow emotionally was the ongoing work of recovery.

a. Eating Intuitively

During the stage of full-enough recovery, the women described experiencing a sense of ease around eating. What had been a conscious process in early recovery and an experimental ground in the transitional stage was now experienced as organic and intuitive. Shannon portrayed the evolution of her relationship with food throughout the recovery process:

> *I do consciously remember at certain points in my life, thinking about food in different ways, like I vividly remember when I first left school thinking about it as medicine, I remember when I went back to college thinking about it as something that was going to help me be healthy so it was less medicine at that point, it was more me making a positive choice and that kind of evolved into it wasn't really a medicine or something I had to do to something I was choosing to do and then it became less and less a focus and part of that is just your life starts again, you're back and you're spending time with friends and you're working and you're socializing and it's good, your eating disorder comes down, your life comes up and at some point you just don't have time to think about it.*

Eva described being attuned and guided by her own needs:

Listening to what it is that I need, I feel like I do have a pretty good sense now of what my body needs and I eat pretty healthfully.

In general, the women described more organic relationships with hunger and appetite.

b. Living Intuitively

For Alice, "full enough" recovery was marked by a shift from consciously using coping skills to manage the anxiety that emerged once she had stopped engaging in her eating disorder symptoms to a dissipation of the anxiety itself. For Alice, her entry into "full enough" recovery coincided with her year abroad in London during college:

I: What was it like initially when you stopped engaging in symptoms?

P: They came out in road rage (both laughing), just yelling at people on the road, that was the only time I would yell, it came out in journaling, it came out exercising in a normal way, it came out by working really hard in my classes, it sort of switched to anxiety sometimes so that was interesting…

I: So without your symptoms, your anxiety increased?

P: Right, then it would come out in almost panic attacks and I think exercise really helped, just walks, not even…I think in those early, it was really more the journaling, the walking, trying to breathe it out a little bit, using breathing exercises…

I: So that's interesting, you stopped your symptoms, then you had the anxiety and you used other coping skills to deal with the anxiety and then in London…

P: The anxiety went away too.

Cecelia, who was diagnosed with bipolar disorder, bulimia and alcohol abuse, experienced her first moments of stability in recovery once she was prescribed lithium. When

she learned she was pregnant shortly after this time and was taken off the lithium, she vigilantly focused on self-care in order to maintain her stability. In "full enough" recovery, Cecilia described a shift from conscious effortful self-care to automatic instinctual self-care:

> *P: They brought me off lithium and I was terrified but I stayed stable but it was a lot of jumping through hoops to get and stay stable because I had to figure out a whole new way…I had to go to bed earlier, I had to eat square meals on time every day, I could not wear high heel shoes, I could not exhaust myself, like the list of crap that I had to do was very long it took a long time to sort out but anything that made me feel overtired or overemotional I had to avoid…*
>
> *I: What's it like now?*
>
> *P: It's what I do, it's what I've done for, my son just turned thirteen so I've been off lithium for almost fourteen years and have remained stable through, the stuff that did then is the stuff that I do now…*

c. Diminishing Need for Protection from Others

Whereas in early recovery the need for protection emerged as a prominent theme, in full recovery many of the women described a new way of relating to their support systems. Julia described the transformation in her relationship with her therapist:

> *I think in the beginning I viewed her (my therapist) very much as the authority or the person who will fix this or help me fix this, now there's more of, I don't want to say that she's my friend, but it feels more friendly and sort of, more easy, certainly the intensity of things that we discuss has gone down a little bit over the years, from time to time I'll*

show up in tears because of x, y, or z thing, but there's an ease or comfort there that has grown over three years.

As Cecilia progressed in recovery, her reliance on OA diminished:

I: So has your relationship with OA changed since early recovery?

P: I held onto OA like a life preserver in the beginning, I was there five to seven times a week, I made it my business to know everybody and the rules so that I could take what I wanted and leave the rest and now I go to an OA meetings every couple of years and now if I go to a meeting it's more likely to be AA because they're easier to find and I relate more to the people and I feel like I hear more recovery in AA meetings than in OA…

I: So OA has changed or have you changed?

P: The way I experience them has changed. In the beginning, it was like oxygen, I needed them to breathe and now I don't hear so much recovery, but that's the reason that I left OA and started going to AA because I wanted to hear experience, strength and hope and not what you had for lunch.

d. The Deeper Work

The women described a shift in focus from behavior issues during early recovery to emotional or underlying issues in later recovery. Many of the women embraced the view that the "work" of "full enough" recovery was the ongoing life-long process of growth and healing.

Holly contrasted her first year of recovery, in which she focused on managing behaviors, to her current work on emotional issues:

Just like I've had a lot of medical stuff going on lately and I think I have more fear than normal, than a friend or my husband would have, you know, I've had, it's sort of like, it's

> *just something I have to walk through my day with, feeling anxious at times and that is getting better, I used to, in the first year of abstinence I struggled on a daily basis with food and the impulses and this year I struggle with fear and I have to work with it the same way, kind of diving into it.*

Leah distinguished between the "manifest," the behaviors of the eating disorder, and the "formative" or "underbelly" of the disorder:

> *I'd say it's like 2% food, 5% exercise and 93% the work, like telling my fiancé when I'm mad and being more direct with my parents, it's all that stuff, you know, the underbelly of how this all came to be and obviously at a very different place and it's always evolving, but I guess it's about the formative that belies that manifest in the eating disorders that I'm still working on, those further down the line because in some ways they are really core, like really believing that I'm not crazy or weird or too girly or emotional and that negotiating needs is a normal thing to do or anything that just feels more authentic about who I am in the world, I guess, so it feels more focused on that than behavioral stuff, like maybe 2% and 3% and 95% or something, I mean that behavioral part just seems so small…I think absolutely that people recover from the behavioral structures or the practices of it or the external manifestations of it, and you heal, but I don't think of it as you get sick and then you get better, I think of it as a manifestation of some really important information that needed to be brought to the surface and that information is what you're going to live your life with, it's not just like, "My dad's mean," it's like everything that we are gets turned inside out and now you have to deal with it.*

2. Embodiment

As discussed earlier, I noted the theme of embodiment in instances in which the women made reference to actual bodily experiences, as well as when they described experiencing feelings fully or viscerally. While the embodiment themes that arose for the women during the transitional stage focused on the process of becoming embodied, experiences of feeling and being embodied predominated in full recovery. These themes emerged as the women discussed awareness of bodily experiences, embodied sensations and emotions and full presence in relationships with others and with self.

a. Experiencing the Body

During "full enough" recovery, several women related a new way of inhabiting their bodies. Shannon described her attunement to her body in full recovery:

> *I'm much more in tune to how my body feels, I'm very much in a way that I was not when I first had an eating disorder and even early on in recovery where I would go and work out even if my body was hurting, I don't do that anymore, I'm like this is my body's way of telling me I don't need to work out today or if I have the flu or all of these things, I'm like I don't really need to do that, I don't need to push myself that hard, so I feel very much in my body now in a way that I don't really think I did when I had an eating disorder and even initial stages, it definitely evolved over time.*

Similarly, Helena described her practice of beginning her day by tuning into her senses:

> *I wake up and in the morning, I feel my body, I feel my heart, I feel my stomach, I feel movement, that's the feeling, the feeling of the touch, like swimming was good for me, the*

> *feel of touch and when you're anorexic and bulimic you feel nothing, you don't feel touch you don't feel taste, you don't feel smell.*

Kristen described experiencing her body's capabilities, as opposed to focusing on her weight or size:

> *When you're digging in the garden and you're lifting things and your muscles are working, you feel powerful, you feel your body at work, your muscles at work, it's an incredible sensation of power, and it had nothing to do with what your body looks like.*

b. Embodied Emotions and Sensations

"Full enough" recovery was marked by instances and experiences of being in the moment in an unfiltered and visceral way. Corazon conveyed her process of reconnecting with her hunger and appetite:

> *In the process of asking myself what I really like, I began to remember the good parts of growing up and the healthy part of food, I remember I like fruit because I grew up on a farm and I had all these fruits that were delicious and fresh, I like fruits a lot, I like vegetables a lot, I never like meat a lot, I love fish I grew up by the sea, this is what I'm going to make, I'm going to make fish with mango sauce or something like that, I'm going to make something different because I like fruit so much and fruits were very important to me, I put fruits in everything I eat…*
>
> *I: So connecting to a way of eating that was…*
>
> *P: organic, it was organic.*

For Corazon, reconnecting with her appetite, what she hungered for rather than what she was told she was supposed to eat, was an essential element in full recovery. Kristen described

experiencing satiety and satisfaction in allowing herself to eat what she wanted. She contrasted her current sense of freedom to the fear of losing control that haunted her in early recovery:

> *On Fridays, at work, they have the best chowder in the world, so every Friday, I can't wait to go to lunch and I have this sense of well being because I'm going to eat that fattening chowder, I don't even think of it as fattening, I just love the chowder…I can't wait to eat those things and spend all the rest of the day Friday feeling good because I had this wonderful meal.*
>
> *I: And what would that have been like early on for you?*
>
> *P: I wouldn't eat it, chowder. I wouldn't even touch the stuff. Yeah, I wouldn't be able to control portion size.*

Leah described embracing pleasure in a whole new way:

> *P: I thought about my wedding and the two pairs of shoes and they are not super-expensive shoes, but I just thought it might be nice at the wedding to have a pair for when I walk down the aisle and a pair for when I'm dancing, it feels more luxurious, whereas then (early recovery) the number one goal was getting the job done so if you can find the black shoes for 19.99 that cover your feet and do what they do, then that's fine, it takes out the pleasure of it, I have so much more pleasure in my life now whereas before it was much more about purpose like I said it was much more utilitarian.*
>
> *I: Were you aware of, and I know I'm asking about shoes, but I mean in general, were you aware when you were buying those 19.99 dollar shoes whether you liked them or not?*
>
> *P: Probably not. I mean I let in a little, I mean I don't think I went to super crappy shoe stores, but there's a way in which now I have shoes in my closet that I love and I mean*

> *not that many, I'm not like Sarah Jessica Parker, but I have these heels in my closet that are purple and really slutty and have all these different colors of purple leather and someday I'll wear them, I don't know when and I think that that's just cool, I mean I think that's just part of being female, I mean the pleasure of it, that's something I've just been really aware of lately is the pleasure of aesthetics so I think back then I just didn't think about it as much, I mean I don't think I would have bought shoes that I hated. Food, I would buy the store-brand of whatever it was, say balsamic vinegar and it was fine, but I'm sure there was a much better brand of vinegar out there, that kind of thing and so it was much more about a job getting done than it was about the pleasure…*

Like Kristen, Leah described reveling in experiences that she would not even have allowed herself in early recovery. For Helena, allowing herself to feel anger was a new experience in full recovery. Helena explained, "Like feeling anger, but truly feeling, not feeling because those are the thoughts you're having, so feeling you're connected to the mind and the body." As opposed to a cognitive realization of anger, Helena experienced feeling her anger in her body. Similarly, Alice described knowing in her body that she felt ready to start trying to get pregnant. Alice, who had been adopted as a baby, had spent years struggling with this decision after having been informed by a social worker that she was the product of rape. Alice described experiencing her readiness, "It's just sort of a groundedness, and it's something with my core and my stomach and feeling OK."

c. Connection to Self and in Relationships

In early recovery, the women described not trusting and feeling disconnected from themselves. This self-disconnection translated into a disconnection from others. In "full enough"

recovery, the women described experiencing being deeply connected to significant others, as well as experiencing being fully present to themselves.

Though the processing of developing secure attachments is not described in depth by the women in the study, evidence of having established the capacity is prominent in the "full-enough recovery" stage.

Leah described feeling less focused on what she needed to do for herself and more present in the moment in her relationship with her fiancé:

> *I find myself, I am just so much softer with him, like if we wake up in the morning and I find that we're caught up in whether it's a sexual moment or a talking moment, I'll not go to yoga. There's a way that it's so much easier for me, it's the same thing as when you asked me about how I make decisions, it's just a no-brainer and part of that is that I just like him, part of it is just that there are so many needs that get met by the relationship that I don't need to use these other parts of my life as much, I feel like I love that, I think that we're alike enough that I don't feel so weird, whether it's just that we share food, our lifestyles make me feel like I can be more flexible.*

Like Leah, Amanda experienced a new sense of openness in full-enough recovery. Amanda conveyed her sense of vulnerability as she expressed her feelings about her daughter:

> *P: You have to be very vulnerable as a parent and I don't think I could have done that years ago, I wouldn't have been a very good parent, you really have to open up your heart up and bleed basically because you have to be real, I keep using that word, like they have so much hope and everything is new and fun and exciting, I want the world to be a special place for her, not like it was for me, I don't want it to be scary for her and if it ever is I hope I can be there for her in a way that my parents weren't and get her the*

help she needs if she needs it, it's life-altering having a child and I knew it would be, but you don't know how much.

I: And your relationship with your daughter…

P: (tearful) And they are a part of you and you've created them, what an awesome thing, I still look at her when I'm rocking her at night and I'm giving her bottle and she's amazing, and I've taken care of so many people's kids, when it's you and your body has done that and it's just, yeah.

Zoe recalled a profound moment of awareness that she had returned to her essential self, after years of being encumbered by everything she needed to do to maintain her eating disorder, followed by years of doing what she needed to do just to maintain early recovery:

P: I'm sort of kind of interesting because I've always been sort of routine-oriented and I like what's familiar, I mean even from when I was very small, I'm not spontaneous, I don't like to just do things, you know, I'm not impulsive, but I did have an adventurous streak and so I was like, I would go and do these trips in the summer where I didn't know anyone and it was in a new place and it was like hiking and people were like, "Oh my God, you're doing that?" and I was like, "Yeah" and I loved it and then I would go back home and go back to my regular routine, but I had those moments where I would sort of break out and when I was really sick I didn't do that…

I: So that was before your eating disorder?

P: Yeah, that was before my eating disorder and I remember thinking, "I miss that. I miss that part of me" because I couldn't go on vacation because I had so many things that I needed to anchor me so I didn't have that flexibility and I think my first big trip, I went to Israel three summers ago and that was huge for me because I didn't know anyone again

and I had never been to Israel and that was like, I remember the first hike we went on and I was like, (closes eyes and gestures toward herself/her body), "Oh my God, I'm back."

3. Reflection

While experiencing their emotions and bodies more fully, the women described a heightened capacity for reflection in "full enough" recovery. I noted the theme of reflection when the women described being present to an experience, while simultaneously contemplating its meaning as it pertained to recovery. I coded, specifically, for instances of non-judgmental reflection.

Anna articulated her ability to feel sadness and joy simultaneously:

P: I was always able to feel sadness and sometimes the sadness it would just color everything though, it was an overwhelming feeling of sadness.

I: Is it still…

P: Not overwhelming, but there's still sadness and I think I mentioned the mourning, the sadness for what I've missed out on, and what I've learned is that this is a process for me, learning that the sadness can co-exist with other things, there can be sadness over what I've lost, but I can still feel happy and excited about what I have now.

Corazon reflected on the impact that her mother's food obsession had on her. Returning to her old environment with a new perspective allowed Corazon to understand the underpinnings of her eating disorder:

It doesn't trigger my eating disorder because I'm not there, but it's disharmonious, I relate to food in a different way, I eat when I'm hungry and when I'm not hungry, I'm not thinking about food, but she's constantly thinking about food and cooking and giving you

> *food, but if you gain one pound, it's just so it's kind of crazy-making and then I also, this is how I grew up, no wonder, it's not normal, I realized that this is not normal, the behavior that was normal as I was growing up and I thought it was normal is not normal, it's unhealthy.*

Emily offered her interpretation about the connection between emotions and body image:

> *P: I definitely have more positive moments, like there are days when I wake up and it's like "Oh my God, I'm really hot"…*
>
> *I: So what are those moments like?*
>
> *P: I mean it's great, I just feel really comfortable, and again it's really emotional, right? So if I run into traffic, I don't think I'm hot anymore ((laughing*).

Similarly, Leah described her understanding of the emotional meaning underlying thoughts about body and food. For Leah, the momentary recurrence of an old eating disorder voice offered insight into the function of her symptoms:

> *I remember going to my grandparents' and there was a weird meal like hot dogs and I remember thinking, "the solution to this is not to eat" and it was later, like I was in my early 30s and I remember thinking, "Oh my God," it was such an old belief, it was sort of like trying on an old sweater to see if it fits, and it was sort of appealing to me, and then I was like, "You're just pissed because you don't want to be here, they only have hot dogs, your boyfriend is bothering you, you feel stressed with your grandparents" it was like someone slid an old slide into a new slideshow and I was like "Oh, that's how it served me all that time."*

Most of the women described experiencing occasional eruptions of old beliefs about food or weight. However, paired with the old thoughts was a confidence that they would not engage in

old behaviors and an awareness of underlying emotional content. Zoe described approaching those stray thoughts with curiosity:

> *I woke up and I was like, "What am I going to eat?" That was my first thought and so I just had to say to myself, "OK, I'm nervous, I have a lot of things going on, I'm not going to get into that" and sometimes I'm like, "I had that thought, what does that mean?" …I can view it with a little more, like if that happens, I can view it more objectively, like looking at it rather than just being in it and for me it is sort of an indicator.*

For Zoe, a moment of food-related anxiety was a signal to look inward.

4. Landing at Self/Self-Acceptance

The theme of self-acceptance was closely related to the theme of non-judgmental reflection. I noted the theme in instances in which the women discussed self-acceptance. The phrase "Landing at Self" was derived from Leah's declaration of body acceptance, "I have landed in this body." Central to this theme is the notion that places of imperfection and doubt are encompassed within a larger sense of accepting oneself. These themes arose as the women described their senses of body image, relationships to occurrences of "old beliefs," as described above, and accepting their actual lives, as opposed to the lives they had planned.

The connotation of acceptance is not that of resignation, but of embrace. The phrase, "Love is acceptance," which is often associated with Buddhist philosophy, is evocative of the acceptance of full-recovery. The rigid thinking that permeates eating disorders engenders dichotomous thinking about self and body. Dictates to "love your body" and "love yourself" abound in popular cultural messages aimed at repairing self-image. For women with histories of

eating disorders, the command to "love" opens up a chasm between the given goal and the years spent submerged in bodily and self-hatred.

The concept of love as acceptance offers a way of embracing one's experience of body and self without imposing perfectionistic standards. This way of being with love and acceptance flows seamlessly into the concept of full-enough recovery.

a. Body Image

Leah conveyed a level of comfort with her body's shape and size, as well as a level of acceptance about her current related concerns:

> *I spend generally a lot less time worrying about my body, well at least, I spend less time worrying about how it looks, I probably spend more time worrying about how it feels because getting older and stuff, I have more aches and pains…actually my hang-ups now are much less about the shape of my body and they are much more about aging, they are much more about my skin, they are much about the quality of my shape than my actually shape, sort of like gravity, I feel much more focused on that, if my neuroses has transferred, it has transferred more to, not necessarily wrinkles, but it feels like it has manifested more that way and I don't obsess about it and there's no way to weigh your face, thank God… I feel like I have landed in this body, whereas before there was this constant attempt to change it, now, it's like, "OK I'll try another fucking cream," (laughing) but I don't have any real belief that it's going to change anything, I mean I like the process and I like getting facials, you know, it's much more about working with what is than it is about changing something.*

Similarly, Eva conveyed her appreciation of her body and her awareness of aging:

I feel like I'm more accepting of the imperfections and also I feel like I look pretty good for 41 (laughs), you know, my body has not changed that much in these past 20 years and I didn't gain all the weight that I did in my pregnancy and I was surprised and I feel like I'm never going to get to perfection, but at least I can be healthy, and especially now that there's a family history of heart disease, exercise just for my health.

For Cecelia, a constant sense about the functionality and health of her body overrode her, at times, vacillation with ideas about her body's appearance:

I feel like it's (referring to her body) fine, it is what it is, you know, it's my body, it does what it's supposed to do, I probably don't shave my legs enough and I feel like things like that and I feel like "Eh, it works what more could I ask for," sometimes I'll see a picture and I'll be like "Really??!" but other times I'll see a picture and "Oh, how cute am I? I am adorable, I had no idea," but living inside this house I feel good, I feel good.

b. Old Beliefs

As discussed in the section above on reflection, the women at times experienced occurrences of "old beliefs," usually in the form of rigid ideas about food or weight. In discussing her retired "as good as it gets" notion (see Behavioral Change section) about her recovery, Julia described her current experience of freedom from obsession, combined with her acceptance that occasional eruptions of "old beliefs" might just be part of her recovery (see Behavioral Change section):

I definitely had that experience of it (referring to her belief that her early recovery was "as good as it gets") and that belief the year that I started therapy and then I feel like, I don't have that same belief, I don't think and it's not always here for me and it's just like

> *"Oh, this person gets stomach aches when she's anxious or this person gets a headache, I get fucked up with my body image," so I guess in a way, it is the same thing, it is a thing that maybe I'll have for the rest of my life, but it's not ever going to be intense that way so it's more just a marker for me to be curious about other things.*

For Julia, there was a level of acceptance that her "old beliefs" might always crop up occasionally, but not necessarily have a significant impact on her life. As discussed in the section above (see Reflection section), Julia did not experience these old beliefs as triggers to engage in behaviors, but as "markers" for underlying emotional content.

Though Leah struggled with the question, she came to view her relationship to exercise as emblematic of her personality and way of being in the world, as opposed to being a relic of her eating disorder:

> *I pretty much eat anything that I want, but I'm not that way with exercise and something I've been thinking I need to work on for myself is maybe accepting that, I think I am such an embodied person and a lot of the way I experience life is through my body, I'm sort of giving myself, I mean my systems with food, they feel sort of softer and I feel there is more of a systemic quality to my exercise, and I wonder if my rigidity, and there's still some of that around the food, but with my exercise I wonder "Is that ok?" and that maybe that it's just more a part of me and serving me, I mean if I were someone without a history of an eating disorder, would I be someone who would still work out regularly and really I don't think it would be that different than the way that I am, I really don't think so, I mean there might be more times when I woke and felt tired and felt like I didn't want to go so I didn't go, and that doesn't happen, so those are things that I wonder about*

> *now, that those things are just a part of who I really am , but that the eating disorder allowed to get obviously really out of whack.*

Helena distinguished between "using" food to self-regulate and "using" food in a self-destructive manner. For Helena, the difference rested in the meaning of the behavior:

> *I still use food, I think it's wrong to say you can not, you don't use food for emotions and I do, I mean sometimes when I'm stressed I'm like I'm going to go buy myself something like this or to her and eat the whole thing but I don't make a big deal about it because my friends who have never had an eating disorder will do the same thing, so I'm now normal I'm now normal because I don't make a big deal out of eating a big bag of chips whereas before I was like oh my God I have an eating disorder and I look at my friends and they do the same so that's normal and I'm like oh so that's normal.*

c. Life As It Is

Some of the women discussed how they came to accept a life that was not as they had envisioned it would be. Anna talked about her process of healing from trauma of abuse by her mother and moving forward in her recovery:

> *I think there's a part of me, there will always be a hurt there I guess, like a scar, I guess, but I knew that I couldn't, part of my recovery has been knowing that I can't undo what happened I can't change my childhood, but I don't want it to prevent it from living, from making changes in my life, that's part of the recovery process.*

Alice, who was adopted at birth, discussed healing from the trauma of being informed when she turned eighteen that she had been put up for adoption because her biological mother's pregnancy had been the result of rape:

> *In this writing group in 2009, I've let that identity, something has shifted with the idea, maybe I'm a product of rape maybe I'm not, but it is what it is and I'm never going to know so I have to figure out what's going to make me feel good about myself moving forward so that sort of shattered about ten to twelve, yeah, twelve years of thinking that.*

For both Anna and Alice, arriving at a place of acceptance was central to creating joy in their present lives. Anna accepted that she could not change what had happened and Alice accepted that she would never know what had happened.

For Shannon, recovering from her eating disorder offered a profound acceptance about her life in the past and her plans for the future:

> *It's really after that you kind of look back at the car wreck and you go "Wow, it's actually pretty amazing what I survived" and you start feeling and for me that's when I started feeling this like this is unbelievable, "I have the rest of my life to look forward to, it was like OK I'm back to square one, I get to go play now" and since that point, pleasure and joy for me is a totally, at a totally different level and even at a different level than before I had the eating disorder because before that I was so focused on, you know I wanted a life that looked like everyone else's that I was so worried about what if I erred on the other side and now I have erred by very wide margins on both sides and I 'm here to tell about it, it's like, "OK, that doesn't freak me out anymore."*

5. Emergence

The theme of emergence of voice was closely linked to embodiment and self-acceptance. As the women came to embody and embrace themselves more fully, the desire for authentic self-expression emerged. I coded this theme in instances in which the women described expressing

themselves in an uncensored way, proclaiming their truths in relationships, and relinquishing old patterns of people-pleasing.

a. Uncensored Self-Expression

Corazon's early recovery was a time of going inward in the sheltered care of her mentor and friends. In "full enough" recovery, her instincts pulled her in the opposite direction. Corazon talked about her evolution:

> *P: In my early recovery, maybe I was going into myself, like "OK, I'm going to look inside" and I wasn't connecting so much with my spiritual ways, I was with my energies, but not with so many people, I'm here in this safe environment with a few people that I know that I trust they love me and I'm going to look inside and I was very determined to do that because I wanted to be free but the image is going within, now it's like OK, let me just touch the world and let me be touched by the world.*
>
> *I: So a time of going inward before you could be in the world…*
>
> *P: And it was a gradual process of coming out, literally coming out… so I was very much myself in my safe environment and then I have to bring this message to the world as my life's purpose.*

For Corazon, her work with others she trusted in early recovery prepared her to present her self and her message about body image health publically. Helena associated her transformation with becoming independent from her family. She described her transformation from insecurity to self-confidence:

> *I: And your emotional life early on in your recovery?*

P: Insecurity or not being affirmative or complying to your parents what they want or complying to what others want in the workplace, that's how I felt, not quite there so inside I always felt not sure, not sure and so it was not related to food, it's how I felt inside just being different, I don't fit, I don't want to talk too much or people will blame me, over time, you know, I moved and was working for this Israeli company that were really tough and I didn't want to speak because I was too afraid because they yell at each other all the time, that's who they are, but the founder taught me you got to speak up, just speak up so as soon as I started yelling, everybody loved me, this is weird, this is totally weird, so I learned a little bit at that time of how to behave and that brings confidence so in the workplace and then it applies to your personal life, saying I'm in a relationship, it doesn't seem to work, see you later, not afraid of moving on or doing things like that, but yeah, it was a feeling of insecurity, I don't want to speak up too much, I have to do what my parents tell me.

I: And when you say the affirmative, you said before that you're really connected through the affirmative, can you say more?

P: The yoga helped a little bit, but the only way I learned it really was going through life on my own, not really being close to my family.

I: And what does the affirmative mean?

P: The affirmative in the sense I'm making my decision and I'm sticking to it, if you're not in agreement with me, we'll discuss, but I stand for myself.

b. Real Self in Relationships

Many of the women described a desire to show their true selves in relationship. For Shannon, it was important to dispel any false beliefs those with whom she was close held about her:

> *With the people that I trust emotionally and I'm closest to I'm probably overly vocal with them about when they say things that even sort of flippantly that I feel set an unrealistic expectation or perception of me, I'm really quick to be like, so not the case, and part of that is to alleviate any pressure on me.*

As Shannon came to realize that how she presented often belied her feelings, she focused on communicating what she was feeling directly:

> *I realized that is probably one of the biggest things that I had my entire life is that I was able to project this calm confidence and I don't even know that I'm doing it part of the time and on the inside I'm like really uncertain or unsure and so it's been interesting bringing those into balance so I've had to get better at saying to people, actually a perfect example so the guy that I'm dating now who is not the most emotionally aware guy, (laughing) we're working on that, but it was so funny because he's like, he is all about being together all the time which is lovely, I'm not, I'm very like I need my own space and my own head time and everything else, and he's like why don't I drop you off at your thing this morning then I'll pick you up and we'll go and watch the Patriots game and we'll do this and I'm like, and he knew, I told him what the interview was about and everything and I was like, instead of getting pissed off I'm actually going to need to explain this to him so I'm like I need you to understand that going back through some of*

> *this stuff, as much of a command as I have on it, is a pretty emotional thing, I may need a couple minutes to myself afterwards just in order to regroup.*

For Alice, a moment in which she asserted herself to her parents about a painful memory signified how far she had come in her recovery:

> *I think he (her father) was so adamant about not understanding how these two things are connected, "Well, let me show you, how can you not know that these two things are connected and this was such a difficult time in my life and neither of you understood what your role was in it that I'm going to tell you now because I have the strength to do that," so that was sort of an eye-opening.*

What Alice was describing was the emergence of her authentic voice in her relationships with her parents. Anna conveyed a general comfort in allowing others to see her and know her in her "full enough" recovery:

> *I definitely have more friends in my life now, people I feel I really be my whole self with, I don't feel like I have to hide anything, I can tell them about that I had, my long history with eating disorder, I feel like I can be my full self and I don't have to hide anything, obviously it's not the first thing I tell somebody, but as we get to know each other and talk about ourselves, I don't feel like I have to hide or anything like that and that makes a huge difference.*

c. Relinquishing People-Pleasing

For many of the women, relinquishing people-pleasing was a central component of emergence. Julia described her decision to defy family rules about speaking by telephone on Sundays:

I used to have this relationship with my family and sister where I was very dutiful, and she lives in Poland and talking to her is supposed to be a once a week hour-long activity and sometimes I'm not up to it.

I: What do you mean you're supposed…

P: It's just in my family, because she's so far away and she's six hours in the future so we're supposed to connect and have a meaningful catch-up about the week, and it's always been that way and she's always lived abroad…

I: And that expectation comes from…

P: Well, she calls and expects it. My mom talks to her for an hour or two on a Sunday, the only people who don't participate are me and my dad, and me is only recently, my dad it's sort of understood, he's really busy and he's not a big phone guy so he'll say hello and that's it and I've just found recently, I just won't take the phone call and I'll be annoyed and say to my husband it's just so fucking annoying that I have to talk to my sister for an hour, she and I are really different, there's nothing to report this week, so I guess developing a sense of likes and dislikes about these norms or these rules that I have and being able to even act them out from time to time is a big difference of who am now versus who I was.

I: Because then?

P: Because then I would just do it and I would guilt myself, I should just talk to her because this is what we do, I should just pick up the phone and fit into this role of being a good sister whereas now, I still have those nagging feelings but I'm like whatever, I don't want to talk to her, that's stupid and it's done.

Julia described a sequential process of first recognizing her feelings, then being able to act on them. Anna described freeing herself from her mother's rules about what she should wear.

> *I know there are certain things that she probably will hate that I wear and I'm like tough shit and I'll wear it in front of her just because I'll know she hates it and it'll almost give me pleasure because I like it and I know she won't like it and I'm like "I'm wearing it anyway, Mom," and maybe it sounds childish but it just gives me pleasure because it took me so long to get to that point, it's like I never rebelled as a teenager so I'm going to show her now, I don't care so much, I mean sure, if she likes something it's great, but if she doesn't it doesn't mean I'm not gong to wear it anyway.*

For Anna, whose mother physically and emotionally abused her into her adolescence, doing what she wanted and defying her mother were both powerful incentives.

In freeing herself from people-pleasing, Shannon landed in a place of unwillingness to compromise. Shannon recognized that she needed a period of over-correction in order to find a healthy middle ground:

> *I just spent six years trying to make someone else happy and someone hasn't been trying to make me happy, someone else has been trying to make someone else happy and making me really unhappy during that time (laughing) and all of a sudden I was like "Huh, this doesn't work, I need to take best care of me."… I definitely swung to the opposite side of the pendulum, I just didn't have a desire to have, I wasn't ready to compromise, I wasn't ready to build a life with someone, I wanted my own life because I didn't feel like I really had that and now I'm coming back somewhere in the middle.*

6. Peace

As described above, feeling, understanding, accepting and expressing were the essential processes that constituted the experience of "full enough" recovery. Throughout the descriptions of these processes were reflections on wellbeing. I coded the theme peace as the women described conscious moments of recognizing recovery and conscious moments of recognizing the gifts of recovery. These revelatory moments often arose in the midst of ordinary dialy activities.

a. Noticing Recovery

Helena reflected on her experience of recovery in daily life:

I think it's just the day to day thing, my fridge is full and my freezer is full, I have chocolate and chips and all the trigger food that used to go crazy for me, they're here and I'm not eating them all on the same day (both laugh) so that's where I feel complete recovery because it's, somebody who is alcoholic and has booze around the house, for me it's there and it's no big deal.

Eva expressed her amazement about the "normalcy" of her relationship with food:

I: Do you consider yourself fully recovered?

P: I really do. I haven't thought about a lot of this in so many years and now I really only think of it in terms of what do I want to do to try to keep my kids healthy and not do stupid things like I did like. I just don't think about food and my body in that way anymore.

I: in terms on your recovery now, what did you imagine recovery would be like?

P: I don't know that I thought it could ever be like this, that I could know what I needed to eat and make that food for myself and feel fine about it just feels so normal (laughs).

Leah reflected on a moment of feeling "normal" in recounting a recent evening in which she and her cousin missed dinner because they were in the ER with their grandmother. In these contexts, Eva and Leah used the word "normal," not to imply anything about how they appeared, but as the opposite of eating disordered. Leah contrasted how she would have experienced this same episode in early recovery with what this recent experience was like for her:

P: I would have been more scared before, whereas now it was almost as if I realized we were going to be in the ER and I forgot my coat and it was cold, it was just kind of an is as opposed to this much more monumental experience.

I: What was that like?

P: it was cool, it was freeing, I felt like a normal person and that felt really…it was like my cousin was more worried about getting dinner…and I was also just aware of like, "Wow" I was just so much more focused on how the night went and sitting with my grandma while she was crying and what that was like and I kept trying to teach her about Lamaze breathing and I was just really present and I was really aware of that and that felt really cool.

For Leah, the dual capacity to be present in the moment and reflect on the experience served to deepen the process. In this example, it is Leah's process of reflection, as discussed earlier, that fostered this sense of peace.

b. Moments of Peace and Wellbeing

Many of the women described allowing and experiencing moments of peace in a way that would not have been possible in early recovery. Julia contrasted her most recent 4th of July with prior holidays in which her expectations about what the day should look like dominated:

> *One of the huge things that my eating disorder and therapy taught me is the importance of slowing down or attempting to be in the moment more and more mindful and I think I'm still, and this is probably the big thing I'm working on is how to be present and not freak out about next year, whatever, so I'm by no means Zen, but even being able to, like July 4th we spent the whole day on a picnic, just my husband and I and our dog, and it was really liberating to spend the day reading my book and not do anything else, in previous years I'd be like it's 4th of July we should all just get together and eat some patriotic food and watch some fireworks, so it was like yeah…*

For Julia, full recovery was marked by these newly discovered moments of peace. Kristen, who lives in a rural setting, described moments of peace experienced in just being present to her surroundings on the way home from work:

> *I'm driving home from work at midnight, my headlights seem to illuminate the trees in front of me and it's peaceful, any stress just dissipates and I feel connected, grateful that I don't see the trees on the side of the road as just trees, but you know, the spiritual connection …when I drive home at night and I look at the world around me, I just feel that things are right.*

Holly reflected on the power of recovery in engaging in the routine household activity of making the bed:

> *Last night we were putting sheets on my stepson's bed and they were my sheets that I bought two years ago and I'm like "Gosh, I never would have expected that I'd be putting these sheets on an 11-year-old's bed," but I have moments of incredible awe at all the wonderful things that have happened since I've gotten deeper recovery that I didn't feel I had to do, I mean obviously I worked my butt off dating and all those things, but all these cool things have just happened, I have a lot of respect for how hard I've worked to get it and then I have a lot of awe about what happened.*

For Holly, this ordinary moment evoked awe about the evolution of her life and recovery in the two years since she purchased those sheets. Cecelia experienced a moment of awe in recognizing that the good things in her life have nothing to do with food or eating:

> *I was like I'm going to eat and let my body do what it does and instead of focusing all of this energy on the size of my ass, I'm going to switch all of that and focus on making my life better, it never occurred to me that I would have a really good life, I just thought I would have a life better than what it used to be…the fact that I have a really good life that has nothing to do with how much I ate or didn't eat is a revelation to me, it's like who knew? Who knew? That is amazing to me.*

Cecelia's description captured the essence of "core state," an experience of self that lies at the end of profound transformational processes (Fosha, 2000, 2011). In the frame of attachment theory, Cecelia's ability to generate a "coherent and cohesive autobiographical narrative" is indicative of secure attachment (Main, 1995).

7. Making Meaning

For the women in the study, these moments of peace marked how profoundly the way they experienced themselves and their lives had changed. The theme of making meaning arose as another integral component of this change. I coded the theme of making meaning when the women discussed specifically wanting to "give back" for all that they had received in recovery and, more generally, being guided spiritually or religiously in a new way.

a. Giving Back

Many of the women expressed gratitude for their recovery and wanting to "give back" to others. For some of the women, helping others represented a spiritual mission. Kristen, who was bulimic and abusing alcohol during her pregnancy, related feeling like God had given her a healthy child as a call for her to help those who were suffering from eating disorders in her community:

> *I think God listened, how did I not have a child that wasn't fetal alcohol and totally screwed up? I mean, we never even really fight and she was always a good child and I felt like God made her a good child because I would not have been a great parent if she had been a difficult child and I believe that because I feel God helped me raise her because he has other things for me to do, all the eating disorders advocacy is what he wanted me to do because I have a way of doing it.*

Corazon described experiencing a similar calling:

> *P: As I recovered, I learned to discover who I am as a spiritual priestess and that has to do with your life's purpose, I became connected to feminine energy, the goddess, so that's why that's very important because through that connection I began to be more in*

> *touch with my feminine body, my curves, to understand more about this feminine energy, I think that the eating disorder in my anorexia there was a total repudiation of my feminine energy, it was not only eliminating curves it was not being expressive of my gentleness or things like that a rejection of feminine energy so in that sense it became very central in healing my eating disorder.*
>
> *I: When you say your life's purpose, can you say more about that?*
>
> *P: Because the shamanic principle is your medicine is where your wound is and your medicine is your life's purpose, your medicine is the medicine that you are to the world so my life's purpose has to do with helping people to feel happy in their bodies and to understand that the body is much more than pounds, the body is really a bridge to your soul and to the sacred energy of the world because when we get connected and we flow then there are many magical things happening and that's what I do through dance and my work.*

For Anna, connecting with what felt meaningful to her led her to wanting to educate others about eating disorders:

> *I think part of it is having more in my life, not just having more, but having more meaningful things in my life, I think that's been the key, finding things that are really meaningful…feeling the sense that I'm making a difference in somebody's life is really meaningful to me so that's also helped a lot and when I go into the schools and I do a workshop and having the kids, we run out of time and they still want to go on and go on and go on, that's so meaningful to me, I spoke at a college and I spoke at one of the medical centers and just getting the feedback and just knowing that I am helping people understand this better really means a lot to me.*

For Emily, her sense of gratitude for her recovery led her to want to help others, though she specifically chose to not do eating disorders-related work:

> *It definitely feels along the lines of second chance, there's definitely gratitude, especially for me I was going to kill myself, I was very conscious of doing that and was on my way to do that, so there is a gratitude for being alive and what I have, so that definitely is there, overall I am grateful and appreciative and I do think it is important to give back or make a difference, not necessarily with eating disorders, because I think that's probably too close to home, but maybe mental health in general, but it does make me more clear and make me want to be more clear about the type of person I want to be, you know what I want, things like, because the process really forced me to think through these things, I definitely wasn't clear or didn't really know or care to know.*

b. Adopting a New Spiritual Perspective

Several women described journeys of linking their spiritual lives to their processes of recovery. Zoe described seeking to understand how her religion connected to her recovery:

> *You know, there's all these rules for eating and I was like, "This is not helpful," but I was reading that there are actually three parts, first you eat, then you have to be satisfied and then you make a blessing and you're only supposed to make a blessing if you eat enough to be satisfied and so for me, I was like, "You're kidding me," this idea that you're supposed to be satisfied and it's supposed to be a pleasurable and gratifying experience and that you're not supposed to be afraid of your body's signals, that's God telling you that you need something and you're supposed to listen to that so I was like, "This is amazing," so I'm sure that is not something that everyone would relate to, but I*

who have had this ridiculous relationship with being satisfied was like, (emphatically) "Oh, this is fantastic, I love this."

Cecelia described developing an image of God that gave her what she needed in her recovery:

P: I've made myself comfortable with the idea that I don't have to know, that I don't have to have a concrete answer of this is what God is, this is what God says, this is what God wants or does not want you to do.

I: And early on, did you have an image of God?

P: There was a God who was a white man with a beard in the clouds and he hated me for all the wrong that I had done.

I: And do you have an image now?

P: Whoopi Goldberg, a black woman, not ironically, a black woman with dreadlocks, a God that looks like me, who is just sort of, I disagree with a lot of the personal or political stances that Whoopi takes, but what I love about her and why identify her as God is that she's look, "look, relax, don't go so crazy with it, you're taking this way too seriously, chill out" you know, the spirit of oh God, you are making this so much harder than you have to, in my mind, that's what God does, I don't think that people don't take their religion or spirituality seriously enough, I think people take it way too seriously, like I have to, I should only, I must, I should never…after the every-day all-day pain left I needed to find something that made sense.

Previous studies have explored the roles of meaning-making and spirituality in the recovery process (Garrett, 1998; Mulvihill, 2009; Tramontana, 2009; Way, 1993). In the current study, the themes of purpose and meaning in the recovery process were powerful and highly individualized factors.

Conclusion

The course of recovery followed a developmental process from early recovery, through transitional recovery, to full-enough recovery. Each stage in the process was comprised of themes that integrated to create a composite whole. The final chapter summarizes and explores the implications of these findings.

A Developmental Model of Recovery: Two Narratives

The following narratives are Amanda's and Cecilia's the stage-wise journeys through the recovery process:

Amanda

Amanda recalls her obsessions starting at the age of eight, the same year that the family's minister's son tried to molest and her mother told her never to tell anyone. At the age of 11, her general obsessions became focused on weight. By the time she was in high school, she was always either dieting or fasting and walking eight miles per day. During college, the restriction became even more severe. At the age of 22, she began abusing laxatives. This was the year she was first hospitalized for depression. The following year, she was admitted to an inpatient facility, then to a residential facility, for treatment of her eating disorder. At the age of 24, Amanda became bulimic.

At the age of 22, Amanda started psychotherapy, once to twice a week, with the woman who would become her therapist fro the next nine years. It was during this time that Amanda became a registered nurse and started dating the man who would later become her husband.

It was also during this time that Amanda gained control of her symptoms and entered the early recovery stage of recovery. Amanda recalls that initial recovery started "minute by minute." During this time, she was very focused on following the rules and the guidance of her treatment team. For Amanda, the experience of trusting others was novel, yet she did it because she did not know what to do on her own. At that time, she participated in individual therapy, group psychotherapy and nutrition counseling. She describes this as a time in which she worked

to manage her emotional life--allowing herself to experience feelings little by little. The safety within which this exploration was possible was in her relationship with her therapist, who was a nurturing and empathetic presence for her. She also recalls feeling miserable as her behavioral and physical symptoms subsided. She describes feeling like she did not have an identity. Being sick had been her identity for so long and though she no longer appeared sick, she did not feel well.

At the age of 30, during the early stage of recovery, Amanda became alarmed by a reemergence of symptoms. After having one or two incidences of purging and some restriction of fluids, Amanda decided to go back into treatment. She ended up being hospitalized for depression at that time and treated with ECT. After discharge from hospitalization, she made the decision to participate in an eating disorders day treatment program. She did not meet level of care requirements by her insurance company's standards, but knew she was in trouble and made the decision to pay out of pocket.

Several coinciding events marked Amanda's entry into the transitional stage of recovery during this time. For one, Amanda made the choice never to engage in her eating disorder symptoms again. Her early recovery was initiated by her decision to try to recover; the shift to her transitional stage was initiated by her commitment never to engage in eating disorder behaviors. Another hallmark of transitional recovery occurred when Amanda decided she needed to learn to eat intuitively. Though her treatment team recommended that Amanda follow her meal plan after completing her day treatment program, Amanda knew in her core that that would not work for her, "I think what wasn't helpful was that everyone was scared that I wasn't going to be ok, so they wanted me to take my meds, stick to my meal plan, all these rigid things, and I was like I've been rigid, I need to be non-rigid." Amanda ended up finding a therapist who

would work with her in a non-rigid way. During this time, she experienced an easing with the obsessions with food and connecting with the bodily feelings of hunger. When asked to describe how this change occurred, Amanda, who has a gift for putting words to internal experience, replied, "I don't know." Amanda's response exemplifies the evolutionary experience of the transitional stage. She described a gradual process of transformation, but did not have the words to convey exactly how the change occurred.

Though it is difficult to pinpoint the shift from the transitional stage to full-enough recovery, Amanda's description of her current life captures the essence of the full-enough stage. At four months post-partum, Amanda sees a body she would have scorned in the past but experiences the beauty of what her body was able to do and the awe of having a healthy baby. She also is present to her vulnerability in loving her daughter and the importance of being her authentic self. In contrast to the numbness she experienced in her disorder, Amanda describes the profound aliveness she experiences, "It's almost like you're in this little haze and this bubble and I was looking down on the world watching everything happen and gradually as I got better, I became part of the world and then you start to experience everything as it is, it's not so out of whack, it's like everything is so intense when you're sick, I mean there's pain now, there's disappointment now, but it's not like, the intensity isn't as much, I don't know how to describe it, and it's not looking down on the world, I'm actually part of the world and I'm part of life."

Amanda describes a freedom from the self-consciousness that kept her from expressing herself freely. She laughs without restraint and feels overcome with joy at times—both new experiences for her. She shares her story of recovery at a local eating disorder not-for-profit foundation. She recalls how alone she felt when she was in her disorder and wants others to know that they do not have to go through an eating disorder or recovery alone. Rejecting the

religion of her parents and discovering her own spiritual path has also been essential in her recovery process.

Finally, she experiences a new level of intimacy with her husband, and now, with her daughter. For many years, she was the sick one. Now, she is well. Her husband is finally getting help for himself. She knows in her heart that she is a wonderful and imperfect mother. For Amanda, her old life holds no appeal, "I know when I think intellectually, I could go back if I wanted that slender body, then I think, no, I don't want, it's not like I can't anymore, I just don't want to, life is so good (tearing up), I mean it's painful too and it's so much better experiencing the real stuff than feeling so numb all the time."

Cecelia

Until high school, Cecelia lived in a racially and socioeconomically diverse neighborhood. When she was 14, her family moved to a predominantly Caucasian neighborhood in the suburbs with a majority of two-parent households and stay-at-home mothers. As an African-American teenager in a household with her sister and her working single mother, Cecelia's feelings that she did not fit in—feelings that she recalls having from a very young age—grew.

Cecelia developed bulimia at the age of 20. For four years, she binged, purged and starved almost daily. At the age of 24, she started attending OA and stopped engaging in bulimic behaviors. OA, for Cecelia, in early recovery was like "oxygen." It became her safe haven where she did not feel crazy and experienced hope for the first time in years. During her early recovery, Cecelia describes doing what she was told to do and following suggestions readily. Her behavioral recovery started with remission of purging, though her eating remained restrictive.

As she progressed, she became frustrated with her inner mandate to eat only diet foods; she began to allow herself to eat according to her hunger and relinquish her rigid thinking about weight. This marked her entry into the transitional stage of recovery. At around this same time, she sought treatment for alcohol abuse. She participated in an Intensive Outpatient Program (IOP) for six months in which she received group and individual counseling. Cecelia recalls the intensity of her reliance on her individual counselor for comfort, stability and direction during this period.

In some ways, Cecelia's is a story of "things got better." Once Cecelia made a firm decision not to purge, was eating according to her hunger and had stopped abusing alcohol, the chaos that had dominated her daily life for years eased dramatically. Cecelia, who described herself as completely beholden to pleasing others prior her recovery, began to experiment with noticing her own wants and needs.

Several months after completing her substance abuse program, Cecelia resumed individual treatment after, by chance, running into her former IOP therapist who informed her that her that he had started a private practice. She began seeing him once or twice a week in his living room, which he used as a home office.

At the age of 26, Cecelia had a two-day alcohol relapse that preceded a full-blown manic episode. As she began taking medication and working with a psychiatrist, she noticed a developing feeling of mistrust toward her therapist who she felt was not attuned to her struggle; at that time, she did not act on her feelings of mistrust or analyze them, but just observed them. Once she had stabilized, her doubts about her therapist grew stronger. She became increasingly aware of her idealization of him and that she frequently found herself doing what she imagined she wanted her to do. At the same time, she noticed her discomfort with the boundaries of the

relationship. When asked about her process of becoming more self-attuned, Cecelia described her evolutionary process:

> *My threshold had steadily been getting lower and lower and lower since early recovery because I felt like I can be a people pleaser and be in horrible pain or I can do what feels right to me and have people not like it, but have a life that feels good for me and so it was a trade-off and all along I was a little less people pleasing and a little more Cecelia-pleasing and a little less people pleasing and a little more Cecelia-pleasing and it was like grains through an hourglass, teeny microscopic little changes.*

For Cecelia, the emergence of her ability to know herself and follow her inner voice marks entry into the full-enough recovery stage. Cecelia ended the relationship with her therapist, not during a time of crisis, but in a time of calm self-awareness. She describes what were formerly her day-to-day efforts to remain stable with a level of ease, "it's what I do." She is no longer dominated by her need to please others. When asked what it is like to stand up for herself, she replies, "Yeah, it's really not a problem, it's really not a problem, (laughing) sometimes I think people must be like oh my God would she sit down for herself? Enough, we know you have an opinion!"

Though Cecelia acknowledges that at times she thinks her body is beautiful and at other times she is critical, she maintains an overarching sense of appreciation for feeling healthy and strong in her body. Having been raised in what she experienced as an oppressive religious environment, she has chosen an alternative spirituality in which Whoopi Goldberg is a higher power.

Cecelia, now 18 years in recovery, describes feeling awe as she experiences what the abundance in her life. When asked how she feels as she looks back at her early recovery, she

replies, “Oh God, I feel like I was heroic, it was so bad, but I just kept trying and kept staying and I was just so depressed and wondering will it ever get better. I feel like I was heroic, it’s like oh my God, we are the champions.”

Chapter 6: Discussion

This dissertation presents a new way of considering long-term recovery from eating disorders. In this final chapter, I offer a summary of the current model and present two other existing works that also engage in a developmental approach to recovery. The comparison serves as a lens for determining both the strengths and limitations of the present study, while also looking at implications for further study in the areas of eating disorder and mental health, as well as looking at clinical and policy implications.

Historically, the concept of recovery has been widely debated in the field. The aim of this qualitative study was to understand the process of progressing through levels of recovery based on the perspectives of women who have experienced the journey. The proposed model of "full-enough recovery" emerged from analyzing the data from fourteen intensive interviews with women who met criteria for what has generally been defined in the literature as "full recovery," from either anorexia nervosa, bulimia nervosa or both.

The model consists of three stages of recovery: early recovery, transitional recovery and full-enough recovery. Stages were initially defined based on the evolution of how the women described being guided or knowing (i.e., the theme of "Guidance/Knowing"). This theme appears in three different iterations across the three stages: externally guided in early recovery; blending internal and external knowing in the transitional stage; and flexible inner voice in "full-enough recovery." Each stage is comprised of the particular iteration of the "Guided/Knowing" theme and the themes that are associated temporally.

The early stage of the model is characterized as a time of not knowing or trusting oneself and depending on others for guidance and safety. The primary focus in this stage is on changing outward symptoms rather than changing the internal structures that perpetuated the disorder.

Entry into the transitional stage was marked by a shift in the way the women described being guided or knowing. For the women, who had spent years following their "eating disorder" voice, adhering to the guidance of others in early recovery was adaptive. At that point, any sense of internal voice is indistinguishable from the "eating disorder" voice. However, as recovery progresses, inner voice begins to emerge. The introduction of this new voice into the process represents the move into the transitional stage of recovery. Change occurs in this stage as the individual starts listening non-judgmentally to this inner voice and experiencing herself at a more visceral level. Change is reinforced as the individual actively chooses recovery over disorder. This stage leads into full-enough recovery as the individual attends to her inner voice and either internalizes or rejects the external guidance, and in this process, begins to build her own path of recovery. This process is one of incremental movements amounting to significant shifts over time.

The model introduces the concept of "full-enough recovery" as the final stage in the process. For many of the women, the term "full recovery" was unsatisfactory because it connoted an objective measure of achievement. The concept of "full-enough" contextualizes recovery into lived experience. The question changes from whether or not the individual has reached a certain level of recovery to whether or not the individual is recovered fully-enough for engaging in one's life, for example, to be present in a conversation with a significant other, feel comfortable going on vacation, spend the afternoon alone, etc. This new phrasing serves to reframe recovery from a goal, to a fluid process.

The mark of entry into "full-enough recovery" is the emergence of the inner voice. In "full-enough recovery" inner voice is easily accessible and, at the same time, amenable to external feedback. In this stage, there is a dual capacity to experience in an immediate visceral way and reflect on the experience; there is a profound sense of self-acceptance and a need to express oneself authentically; feelings of peace and of purpose are woven into the experiences of this stage.

Literature on Developmental Theories of Recovery from Eating Disorders

Though there are no other models that focus specifically on the progression within the recovery process, two developmental models of the recovery process appear in the literature that deal with this progression. Both theories offer models that are compatible with the presented model, though are based on distinctively different methodologies.

Ash (1979) developed a stage model of recovery from anorexia based on follow-up data from adolescents who completed an evaluation for suspected anorexia during adolescence. A one-time follow-up was conducted one month to sixteen years after initial evaluation. Though my study explored recovery among adults, I am including Ash's work as a comparative model because 79% of participants in her study were over eighteen at the time of the follow-up evaluation. Variable lengths of follow-up time were used in order to build a sample including individuals across all stages of the recovery process. The author constructed a multifaceted stage model based on her statistical analysis of the measures of stage of change, developed by Prochaska and DiClemente (1982,1983), and of the psychodynamic stage of relinquishing illness, an instrument developed by the author. Ash referred to the stages as "islands of recovery" to represent the non-linearity of the process. Ash described each "island" based on

symptomatological and psychological factors. Island one represented the most disturbance in both the symptomatological and psychological realms with individuals appearing not to have the intention or desire to relinquish illness. Island two represented individuals who were weight-restored, but continued to have high levels of symptomatological and psychological disturbance. Island three represented "early recovery" in which individuals remained underweight, but had begun the recovery process and had developed some strategies to help them. Island four, "middle recovery," was most like the "action" stage in the transtheoretical model of change. This island represented change in some, but not all areas, of recovery. The fifth island was designated the "maintenance island," the stage in which individuals were completely weight-restored, but continued to manifest psychological disturbance. The sixth island represented the "termination" stage in which individuals had achieved full symptomatological and psychological recovery. Ash included a qualitative component in which each participant composed a narrative describing current recovery. Ash used these essays to illustrate the stages in her model.

In comparing Ash's model to my proposed model, the fifth island or maintenance is most closely aligned with the "early recovery" stage, and "termination" is most closely aligned with the "full-enough recovery" stage. Ash's model offers quantitative support for the existence and relevance of a stage model of recovery. My own study complements Ash's model by offering an in-depth exploration of the phenomena associated with the stages and the mechanisms of change. Furthermore, my model revises the final stage to "full-enough recovery" which offers a more nuanced picture and more aptly captures the experience of recovery as described by those who have experienced the process.

Another model is offered by Liu, who writes as a popular author, blogger, eating disorders advocate and recovered person. Liu constructs her stage model of recovery from

anorexia, bulimia and binge eating disorder by organizing letters she had received from readers based on levels of symptomatology (or lack thereof) and the nature of the experience presented (2011). Additionally, she incorporates expert opinions on a wide range of factors related to recovery. The resulting model is comprised of six stages: turning points, setting the stage for recovery, treatment, restoration, discovery and wise minds.

Liu's first stage, turning points, marks initial entry into recovery. According to Liu, this stage occurs at the intersection of acute distress related to the eating disorder and a moment of hope for recovery. Liu's description is compatible with Reindl's notion of "sensing when enough is enough," an experience described by the women in her study as a mental shift that prompts the decision to recover (2002). The second stage in the model, "setting the stage for recovery," involves breaking the isolation of the eating disorder and reaching out for help. In Liu's model, the third stage is treatment. This is the stage in the model in which behavioral symptoms remit. Liu notes that after the treatment stage, the recovering individual is susceptible to falling into the "half-life" of eating disorders. Liu describes the half-life as a period in which other maladaptive coping mechanisms emerged once the eating disorder symptoms subsided. The fourth stage, restoration, involves exploring and rebuilding aspects of life that were subsumed by the eating disorder. The fifth stage, discovery, is characterized as a time of finding meaning in one's life. The final stage, wise minds, represents full recovery. Liu (2007b) describes the fully recovered individual as "someone who embraces genuine (as opposed to superficial) gains in confidence, trust, intimacy, personal power, perspective, insight, faith, joy, nourishment, health, peace, love, and pleasures of the body and mind."

While there is considerable overlap between our models, there are significant differences. Specifically, Liu incorporates treatment as an integral stage in the recovery process.

In a community-based prevalence study, Hudson et al. found that a high percentage of those with a lifetime diagnosis of an eating disorder never received treatment (2007). Similarly, several women in my study recovered without treatment. While many of the change processes in my model occurred within the context of treatment, the stages of the model are based on the experienced phenomena.

An additional distinction between our models involves the role of the "half-life" of recovery. Whereas Liu presents this phase as a common deviation from the recovery path, in my model the experience of emptiness and efforts to replace eating disorder symptoms with other ways of coping, healthy or unhealthy, were an integral part of the early recovery process.

In sum, while the general categories and structure of the three models are compatible, my model offers several unique contributions. Consistent with a grounded theory approach, stages of the model are constructed based on the component elements that appeared as recurrent themes in the interviews. Additionally, the model is based on a traceable process of change, the evolution of the "Guided/Knowing" theme, across stages. Finally, my model introduces the concept of "full-enough recovery," a term that aims to capture a range of experiences of recovery.

Addressing Limitations in the Present Study

While fourteen participants is a small sample by the standards of quantitative research, the sample size is suitable for qualitative research aimed at generating theory through in-depth data analyses. One limitation of the study is that inclusion relied on self-assessment and self-report. This was somewhat ameliorated by using diagnostic history as one screening criterion, making it less dependent on the self-assessment process, since each participant had at one point received a diagnosis from a licensed professional. Recovery status, on the other had, depended

entirely on self-assessment. While the majority of the women who were determined to have met criteria based on screening by telephone did, in fact, meet criteria for recovery, two of the selected participants, demonstrated in their interviews that they did not, in fact, meet criteria for recovery. This difficulty is an inherent aspect of the larger question of defining recovery.

The study was subject to the general limitations of qualitative research of participant and researcher bias, though the guidelines employed for enhancing scientific rigor served to minimize risk of bias. Additionally, though efforts were made to recruit a diverse sample in terms of racial, ethnic and sexual orientation, concerns about the homogeneity of the sample remained. The sample was heavily skewed toward higher levels of education with all participants having completed college and all but three participants having an advanced degree. Another concern was that exactly half of the sample was involved in speaking publicly about their processes of recovery. This factor did not appear to have an impact on the study results, since the themes that emerged did not vary between those who were so engaged and those who were not.

Exclusion of individuals with histories of binge eating disorder (BED) represents another limitation of the study. There has been a long history in the field of dismissing the legitimacy of BED as a diagnostic category. Because there are minimal data on long-term recovery from BED, and existing literature on long-term recovery served as the basis for the current study, I could not assume that the paradigm of levels of recovery would be relevant to the BED population. As a result, I did not include BED in my sample.

It is worth noting that two of the women in my sample reported histories of bingeing in the absence of purging or other compensatory measures, the primary symptom of BED. This fact raises questions about diagnostic crossover and the importance of considering BED in future studies on recovery from eating disorders.

Implications for a Common Process of Recovery from Eating Disorders

Reindl (1995) posited that recovery from anorexia and bulimia shared a common process. In the current study, frequency or prominence of themes did not vary by diagnosis. High rates of crossover from anorexia to bulimia offered further of support the notion of a common process (Eddy et al., 2008). Though rates of crossover in the general population are not available, evidence from my sample suggests the possibility of crossover to binge eating disorder from both anorexia and bulimia. Liu proposed a developmental model that applied to anorexia, bulimia and binge eating disorder (2011). Though there are limited data available on recovery from binge eating disorder, the question of a common process of recovery for all three disorders deserves further study.

Implications for a Common Process of Recovery for Mental Health Disorders

The U.S. Substance Abuse and Mental Health Administration (SAMHSA) recently released a new working definition of recovery for psychiatric disorders in general. The organization defined recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The definition included four factors that promote recovery (SAMHSA, 2011):

> Health: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
>
> Home: a stable and safe place to live;
>
> Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
>
> Community: relationships and social networks that provide support, friendship, love, and hope.

These four dimensions are resonant with the themes of behavioral change, emotional health, stability, safety, purpose and community that emerged in my proposed model of recovery from eating disorders. It is important to note that "common process" does not suggest a common pathway. As demonstrated by the women in my study, recovery did not follow any one path. However, the proclamation by SAMHSA raises the question as to whether there are certain common elements associated with recovery from mental disorders and substance use disorders in general.

Clinical Implications

As discussed in the review of the literature on treatment, established treatments for eating disorders focus on remission of symptoms and do not gauge levels of recovery in measuring efficacy. However, the preponderance of data suggesting that those in partial recovery--or early recovery, to use the terminology of the proposed model--experience high levels of distress and remain at risk of relapse raises questions about the sufficiency of current treatment models. There is no debate about whether or not remission of symptoms is essential to recovery. Without remission or reduction of symptoms as a proven outcome, it is difficult to argue that a treatment is effective. The proposed model, however, brings to light that treatment focused on symptom remission might be insufficient in promoting long-term stable recovery.

In the proposed model, changes in the transitional stage involve actively choosing recovery, experiencing in a visceral way and engaging in a mindful or non-judgmental fashion. As discussed previously, these three transformational processes map onto, respectively, explorations of action and commitment therapies, body-based therapies and mindfulness practices in the treatment of eating disorders. In considering a staged model of recovery, it is

possible that a corresponding staged model of treatment, in which specific interventions or treatment components are aligned with the developmental processes of the particular stage, might be effective in promoting long-term "full-enough recovery."

Another significant implication involves the development of "secure attachment." The women in "full-enough recovery" exhibited transformations in terms of their capacities to attach securely and regulate affect. As previously discussed, the evidence connecting "insecure attachment" and eating disorders is strong (Neumark-Sztainer et al. 2000; Polivy and Herman, 2002; Rorty and Yager, 1996; Schmidt et al., 1997). Again, in considering a staged model of treatment, incorporating interventions aimed at shifting attachment orientation might support the movement toward full recovery.

Implications for Policy

The data on recovery suggest that short-term treatment models might be inadequate in promoting long-term recovery. However, typically managed care insurance plans determine coverage for treatment based on medical necessity. Medical necessity is measured by current symptomatology. As a result, once behavioral and physical symptoms have remitted, access to health care coverage may be denied. Based on the evidence that the course of recovery is often protracted, covering treatment in such a limited way is likely to result in high rates of relapse. While the 1996 Mental Health Parity Law mandated that insurance companies provide comparable physical and psychological health care coverage, there remains a wide range of standards across individual companies and across states (Silber & Robb, 2002). Establishing policies that hold insurance companies accountable for covering treatment for the full course of recovery would be likely to reduce relapse rates and promote long-term recovery.

Implications for Future Research

The findings of the study offer insight into the process of achieving long-term stable recovery from eating disorders. The research illuminated gaps in the literature, as well as areas that merit further exploration.

The lack of recognition of binge-eating disorder (BED) as a diagnostic category has resulted in a deficit of research on the topic, despite evidence that it is the most common of the eating disorders (Hudson et al., 2007). Additional research is needed to understand the recovery process of this disorder. Binge eating disorder has historically been associated with obesity and has been approached as a medical issue, as opposed to a mental health issue. The data, however, suggest that a significant number of individuals with BED do not qualify as obese and a significant number of individuals who qualify as obese do not have BED (Bishop-Gilyard et al., 2011; Dingemans & van Furth, 2011). The addition of BED as a diagnostic category in the forthcoming DSM-V may result in increased attention to the psychiatric nature of the disorder and generate additional research in this area.

In terms of the specific model proposed, further research is warranted to determine the generalizability of the model. Quantitative research methods could serve to test the applicability of the theory on a larger sample. Additionally, investigations of treatment methods targeting specifically the early and transitional stages of recovery are warranted in order to understand how to help individuals achieve long-term recovery.

Implications for Social Work Practice

Consistent with social work practice models, the proposed model is based on a strengths perspective. For one, the model is not oriented around individual psychopathology. The model

approaches eating disorder symptoms in terms of function, as opposed to character pathology. The process of recovering involves practicing coping skills in early recovery; this is the stage in which symptoms have remitted and are no longer serving their prior function. This stage is followed by a resolution or easing of the underlying issues that created the need for coping. The model is based on the assumption of the potential for health and does not impose any preconceptions about inherent pathology.

At the same time, in keeping with a social work model of practice, the current model allows for different individual paths. Many of the women described treatment as a central component of their recovery processes. For Kristen, however, the garden was her treatment:

> *P: The thing is all the things you do in treatment, I do in the garden.*
>
> *I: What do you mean?*
>
> *P: When you're digging, this woman put into words so well, when you're in the garden you're clearing away the past, I'll send you the quote, you're taking a jumble of crap and you're clearing it and you're replacing with new and beautiful and workable and manageable, but it's never concrete, because in the garden if you don't like it this year, you can change it the next, but when you're thinking, what do you think about? You can think of embarrassing things you did in the past and you turn red, I do, I still have those zingers, that oh my God, I did this, but then you sort of can analyze them and say God I was wrong and I'd had some therapy so I knew the exchange, I just had the exchange with myself and God, you have a lot of hours to think.*

Though the model is based on common processes, it allows for a range of human experience.

Finally, the model is based on growth. In "full-enough recovery," the women narrated feeling fully themselves and experiencing themselves fully. According to Fosha (2008, p.290),

"We are wired for growth and healing. And we are wired for self-righting, and resuming impeded growth. We have a need for expansion and liberation of the self, the letting down of defensive barriers, and the dismantling of the false self (Ghent, 1990)." The model, based entirely on the experiences shared by the women in the study, is itself a story of striving toward becoming one's most authentic self.

Demystifying Recovery

Whether eating disorders are chronic or curable has been a topic of great debate in the field of eating disorders. Researchers, clinicians and individuals in recovery, categories that are frequently overlapping, have all contributed to the conversation. One view is that eating disorders are chronic illnesses with periods of remission and exacerbation. From the "chronic" perspective, individuals in remission may be highly functional and lead full lives, but the potential of return to the disease is always present (O'Toole, 2010). Fairburn, Zafra, and Waller (2008) maintain that eating disorder cases are highly complex due to the extent of co-existing problems that arise and that this "minority" subset is actually the norm.

Another camp maintains that it is possible to recover fully from an eating disorder. A slate of recent books, memoirs and collections of essays written by those in recovery, focus on offer guidance in the process of recovering fully (Costin & Grabb, 2010; Kandel, 2010; Liu, 2011; Roe, 2009; Schaefer, 2009). Like Liu's recent book, these books combine personal narratives of recovery with expert views. In Schaefer's first memoir, *Life without ed: How one woman declared independence from her eating disorder and how you can too*, the author developed the analogy of divorcing her eating disordered, personified as "Ed." In *Goodbye ed, hello me: Recover from your eating disorder and fall in love with life* (2009), the author extends

her analogy; at this stage, she has relinquished "Ed" completely and is committed to caring for herself. Schaefer creates a set of marriage vows that she promises to herself (p. 196):

> I, Jenni, take you, Jenni, to be my beautiful bride. Before God, my family, and friends, I promise to cherish and be true to you in good times and in bad, in sickness and in health. I will love and honor you all the days of my life. I will accept all of your faults and strengths with patience and gentle kindness. I will help you to meet your needs—emotionally, physically, spiritually. I will watch a movie with you when you need to laugh. I will feed you when you are hungry and give you rest when you are tired. I will help you to nourish your relationship with God. I will not leave you again. You never left me. I love you, Jenni.

It is important to note that Schaefer's work is intended to counter the potentially harmful message that eating disorders are chronic. As discussed in the Transitional Recovery section, rejecting the claim of chronicity represented a turning point in Shannon's recovery. A number of the women in my study pointed to Schaefer's work and other books on full recovery as inspirational forces in their recoveries. At the same time, many of the women reported feeling like their own experiences were more measured and did not match the experiences described.

The majority of the women did describe experiencing exuberance and euphoria at times, but these feelings were woven into the fabric of every day life, which included moments of frustration related to recovery, lapses in self-care, and even using food to cope. What distinguished their experiences of these difficulties in recovery was a confidence that allowed them to maintain an overarching sense of the process of growth. As Emily described, "It's not about the falling, it's about getting back up."

The narratives of recovery presented by the women in my study were neither fairy tales, nor bleak accounts. They were definitely stories of joy and overcoming, yet for many of the women there was an acknowledgment that vestiges of tendencies toward eating-disordered thinking might always be a part of their lives. This was not something the women fought, nor

was it something that occupied a great deal of time or energy. It was something they held or knew, sometimes in the foreground, but mostly in the background, as they proceeded to navigate what they experienced as fulfilling lives.

Fosha describes transformation as process, not as an endpoint (2012). The women in my study did not describe recovery or "full recovery" as a point or place that was reached. In asked about the term "full recovery," Holly explained:

> *I believe in it, but I don't believe in full recovery period, it's not like I have my PhD and I'll always have my PhD, I think it's something that you are granted through work or whatever, your own work, to reach this point, but I don't think that any human being gets to the point where that's great, stamp of approval, I think it's an ongoing process, I think recovery is something you do throughout your whole life and it changes.*
> *I: That's really interesting…*
> *P: And that's where I think, again, it's not like "Got Milk?"[8] It's not a yes or no. If people are talking about eating disorders, like other health things, I think it's important, I like that people say recovery is possible, I like that message of hope, but I really don't like the message that at some point you get to stop working on yourself, because no one I know and respect gets to the point where it just stops, I think you can reach a point where you're really highly functional but I think growth is endless and sometimes it's because you want to eat a whole cake and sometimes it's because you're really anxious and sometimes it's who knows, but it's like saying being human stops.*

While the search for a positivistic definition of recovery may continue, it is unlikely that there will ever be consensus. Ultimately, recovery is an experience and every experience of recovery is unique. The term, "full-enough recovery," is not intended to indicate a more accurate or finite definition of the concept. The term, "full-enough recovery" aims to capture the space between the notions of temporary remission and total relinquishment, the space that holds the vast range of lived experiences.

[8] "Got Milk?" is the slogan of a well-known advertising campaign for milk developed in the 1990s.

Appendix A: Psychiatric Status Rating Scale

#	Descriptiion	Psychiatric Status Rating Scale for Anorexia Nervosa (AN)
6	Definite criteria / severe	Meets DSM-IV criteria for AN and presents with a severe disturbance in level of functioning (i.e. GAF <= 50)
5	Definite criteria	Meets DSM-IV criteria for AN but does not present with a severe disturbance in level of functioning (i.e. GAF > 50)
4	Marked	Does not meet DSM-IV criteria for AN, but shows obvious evidence of this disorder (e.g. more than 10% below normal body weight BMI<17, AND some of following symptoms: amenorrhea / restricted eating / afraid of gaining weight / pathologically disturbed body image, compulsive exercise). Does not present with a severe disturbance in level of functioning (i.e. GAF > 50)
3	Partial Remission	Does not meet DSM-IV criteria for AN, shows less psychopathology than full criteria and 'Marked' criteria, but shows obvious evidence of the disorder (e.g. within 10% of normal body weight : BMI 17-27, AND same symptoms as in 'Marked' criteria, but less frequent or intense). Level of functioning no more than moderately impaired (i.e. GAF > 60).
2	Residual	Does not meet DSM-IVcriteria for AN, shows no evidence of disordered eating behaviour, but shows clear evidence of disordered thoughts concerning shape and weight. Within 5% of normal body weight: BMI 17.5 to 26.25.
1	Usual Self	Does not meet DSM-IVcriteria for AN, shows no evidence of disordered eating behaviour (i.e no restricted eating, no compulsive exercise) Shows no evidence of disordered thoughts concerning shape and weight (i.e not afraid of gaining weight and normal body image). BMI between 18.5 to 25, for females: regular menstruation

Appendix A: Psychiatric Status Rating Scale (continued)

#	Descriptiion	Psychiatric Status Rating Scale for Bulimia Nervosa (BN)
6	Definite criteria / severe	Meets DSM-IV criteria for BN and presents with a severe disturbance in level of functioning (i.e. GAF <= 50)
5	Definite criteria	Meets DSM-IV criteria for BN but does not present with a severe disturbance in level of functioning (i.e. GAF > 50)
4	Marked	Does not meet DSM-IV criteria for BN, but shows clear evidence of the disorder (e.g continues to binge and purge, but less than twice a week)
3	Partial Remission	Does not meet DSM-IV criteria for BN, shows considerably less psychopathology than full criteria (e.g. bingeing occasionally, without purging)
2	Residual	Does not meet DSM-IV criteria for BN, but still has to fight disordered thoughts concerning shape and weight
1	Usual Self	Does not meet DSM-IV criteria for BN, shows no evidence of BN, no evidence of disordered thoughts concerning shape and weight

Appendix B: Interview Guide

Context

The following interview guide is adapted from Reindl's earlier study of women's experiences of recovery from bulimia nervosa (1995). The current guide has been adapted to explore specifically the experience and movement from early to later recovery from anorexia nervosa and bulimia nervosa. As in Reindl's study, the interview guide is meant not as a script or a set of instructions to follow, but as a series of questions aimed at exploring specific aspects of the recovery journey. The aim will be to explore those content areas in ways that are meaningful to the participant, regardless of precise order or wording of the questions.

Construction of Questions

Gendlin describes the concept of a "felt sense" of an experience (2007). In order to help participants access the experiences that inform their narratives, the researcher will orient many of the questions to the present moment (e.g., "What comes up for you now as we explore the experience?"). Reindl (1995) describes using phrases like, "Looking back…" or "In your experience…" to help participants connect with their experiences as they construct their narratives. The researcher will use both of these tools in conducting interviews in the current study.

The 24 core questions used in data analysis are underlined.

I. Taking Stock: Most Important Changes

1) Looking back, as you think about your own experience of recovering from an eating disorder, what stands out for you?

2) <u>I am curious, specifically, about how the experience of recovery changes over time. Can you float back in your memory to your early days in recovery—in what ways have you changed over the years?</u>

    Probes:

    In terms of how you thought? Felt? Acted?

    Are there other changes?

3) ***(To access current experience fully, ask about the present moment)*** If it's OK with you, can we just notice what comes up for you as you describe your recovery now? Can you notice what comes up for you as we talk about what it was like for you early on? ***(This pair of***

focusing questions will repeat throughout the interview as we explore the different aspects of the process)

4) ***(If not mentioned spontaneously)*** I am curious about ways in which your experience of your body has changed. As you remember back, how did you feel about it, then versus now? ***(To access current experience fully, ask about the present moment, e.g. if it's OK with you, can we just notice what feelings you have about your body right now? Can you notice what comes up for you as we talk about what it was like for you early on?)***

   Probes:

   How did you feel in it, then versus now?

   How you knew about yourself?

   What about hunger, then versus now?

   How you experienced emotions?

   How you made decisions?

   Your spirituality?

   Your experience of fun or pleasure?

   Your experience of relationships?

   Any other changes?

5) I am also curious about your experience of going through those changes? What was the process of changing ***X (go through each one mentioned, unless some areas are combined)*** like for you?

6) How would you say that change began? What prompted the change? (Prompts: Then, what happened?)

7) What changes would you say are most important to you?

   Probe:

Are there other changes you would say have been really important for you?

8) In your experience, what have been the easiest things to change?

9) What have been the hardest?

II. Attribution of Change, Maintenance, Lapses, and Relapses

1) Looking back at your early recovery, how did you make the changes you did? What made those changes possible? ***(Probe for changes specifically from early to later recovery)***

2) How do you feel that you were able to change in the ways ***(If not already mentioned, go through the changes mentioned in I.4)*** that you have?

3) ***(If not redundant, ask about the present moment, e.g. if it's OK with you, can we just notice what feelings you have about making changes right now? Can you notice what comes up for you as we talk about what it was like for you making changes early on?)***

4) Looking back at your early recovery, how do you feel you've been able to maintain your recovery? What made that possible? ***(Probe for changes specifically from early to later recovery)***

5) ***(If not redundant, ask about the present moment, e.g. if it's OK with you, can we just notice what feelings you have about maintaining your recovery right now? Can you notice what comes up for you as we talk about what it was like for you maintaining recovery early on?)***

6) Looking at your whole recovery journey, were there setbacks, lapses, relapses? ***(Ask participant what terms she uses to describe or how she defines the terms given, setbacks, lapses, relapses. Probe for changes specifically from early to later recovery)***

7) ***(If not redundant, ask about the present moment, e.g. if it's OK with you, can we just notice what feelings you have about setbacks, lapses or relapses right now? Can you notice what comes up for you as we talk about what it was like for you setbacks, lapses or relapses early on?)***

8) Looking back, how did you make it past those times? ***(Ask about each specific time mentioned)***

III. Helpful and Harmful Treatment and Non-Treatment Experiences

FROM PARTIAL TO FULL-ENOUGH RECOVERY FROM EATING DISORDERS…

Treatment Experiences ***(If no treatment history, go to next section)***

1) As you look back, what experiences in treatment have had the greatest effect on you?

2) How do you feel ***X (Review treatment experiences mentioned)*** has helped you in recovery?

3) What experiences in recovery were not helpful or, even, hurt you?

4) Were there aspects of treatment that were more important in early recovery?

   What about at other points in your recovery? How would you compare your experiences early in recovery to more recent experiences?

5) ***(To access current experience fully, ask about the present moment, e.g. if it's OK with you, can we just notice what feelings you have about your treatment experiences right now? Can you notice what comes up for you as we talk about what it was like for you early on?)***

6) ***(If a specific person (or people) is mentioned or relationship(s))*** Looking back, what was your experience of the relationship?

   Probes:

   (If applicable) What was your experience of your relationship with ***X (specific treatment relationship)*** in early recovery versus ***X or Y (if different treatment relationship)*** later on? ***(Ask for all relevant relationships)***

   (If person does not mention a specific person (or people) is mentioned or relationship(s)) Looking back, are there any particular therapists or other people who helped you or treatment relationships that stand out? ***(If yes, start at the beginning of 5)***

   (If only positive experiences are mentioned, ask about negative and begin at 5. If only negative experiences are mentioned, as k about positive and begin at 5)

7) ***(To access current experience fully, ask about the present moment, e.g. if it's OK with you, can we just notice what feelings you have about that relationship now? Can you notice what comes up for you as we talk about what it was like for you early on?)***

Non-treatment Experiences

8) As you look back, what experiences have had the greatest effect on you?

9) How do you feel ***X (Review treatment experiences mentioned)*** has helped you in recovery?

10) What experiences in recovery were not helpful or, even, hurt you?

11) Were there aspects of treatment that were more important in early recovery?

    Probe:

    What about at other points in your recovery? How would you compare your experiences early in recovery to more recent experiences?

12) ***(To access current experience fully, ask about the present moment, e.g. if it's OK with you, can we just notice what feelings you have about that experience right now? Can you notice what comes up for you as we talk about what it was like for you early on?)***

13) ***(If a specific person (or people) is mentioned or relationship(s))*** Looking back, what was your experience of the relationship?

    Probes:

    (If applicable) What was your experience of your relationship with ***X (specific treatment relationship)*** in early recovery versus ***X or Y (if different treatment relationship)*** later on? ***(Ask for all relevant relationships)***

    (If person does not mention a specific person (or people) is mentioned or relationship(s)) Looking back, are there any people who helped you or treatment relationships that stand out? ***(If yes, start at the beginning of 5)***

    (If only positive experiences are mentioned, ask about negative and begin at 5. If only negative experiences are mentioned, as k about positive and begin at 5)

14) ***(To access current experience fully, ask about the present moment, e.g. if it's OK with you, can we just notice what feelings you have about that relationship now? Can you notice what comes up for you as we talk about what it was like for you early on?)***

IV. Pivotal Experiences

1) As you look back to experience of being in early recovery, is there any experience that stands out as a turning point in your recovery?

2) What made that a turning point for you?

3) Can you say what made it possible for you to shift then and not before?

4) Are there other experiences in your recovery journey that stand out?

5) How are these experiences, that prompted you to move forward in recovery, different from what led to you to begin your recovery in the first place?

V. Changes in Experience of the Self

1) If you can notice, even right now, what is your experience of yourself in recovery?

2) ***(If participant is having difficulty noticing in the moment)*** In general, what is your experience of your self in recovery?

3) How has that experienced changed as you have progressed in recovery? What are you noticing now as we are talking about it?

4) Looking back, what was your experience of your self in earlier recovery? What are you noticing now as we are talking about it?

5) What feelings come up for you as we talk about your self in early recovery?

6) How would you describe that process of change? What are you noticing now as we are talking about it?

VI. Current Experience of Eating Disorder and Recovery

1) Would you say that people fully recover from an eating disorder?

2) How would you describe yourself in terms of recovery or in whatever words make sense for you?

3) Are there moments in which you spontaneously notice the experience of having had an eating disorder or reminders of your eating disorder? What are those moments like?

4) Are there moments in which you spontaneously notice the experience of recovery or reminders of your recovery? What are those moments like?

5) What is that like for you now versus early recovery ***(ask about eating disorder moments and recovery moments)***?

6) As you look back on your early recovery, did it feel like what you imagined recovery should be? What was your experience then?

7) What about now?

8) What, if anything, remains challenging for you?

VII. Function of Eating Disorder

1) Sometimes, people are aware that the eating disorder served a psychological function, are you aware of a function or functions your eating disorder served?

2) As you look back, what happened in terms of the function of your eating disorder as you recovered? How was that different in early versus later recovery?

   Probes:

   Did something take its place? How did that happen?

3) Did you still need that function served? How did that change happen?

VIII. Relationships

1) What has been your experience in relationships? Changes from early to later recovery?

2) ***(probes)*** Mother? Father? Siblings? Other family? Friends? Colleagues? Intimate or romantic relationships?

IX. Wrapping Up/Debriefing

1) What has the experience of being interviewed been like?

2) What advice might you give to someone trying to recover? As you look back, do you think that advice would have been meaningful or useful to you in your own recovery?

Appendix C: Recruitment script

I am a doctoral candidate at the University of Pennsylvania's School of Social Policy and Practice and conducting dissertation research on recovery from eating disorders. I am currently recruiting volunteers who might be willing to participate in an interview about their recovery process with the aim of gaining a better understanding of how someone recovers from an eating disorder. Specifically, I am looking for women (over 18) with long-term recovery from anorexia nervosa or bulimia nervosa. The interview should last about two hours, and will be recorded and transcribed. I will be the only one who will see the identifying information. Only colleagues who are working on the project with me will have access to interview transcripts. If you know someone who might be interested, please feel free to give my contact information.

Thank you.

Appendix D: Flyer

I am a doctoral candidate at the University of Pennsylvania's School of Social Policy and Practice and conducting dissertation research on recovery from eating disorders. I am currently recruiting volunteers who might be willing to participate in an interview about their recovery process with the aim of gaining a better understanding of how someone recovers from an eating disorder. Specifically, I am looking for women (over 18) with long-term recovery from anorexia nervosa or bulimia nervosa. If you are interested in participating or know someone who might be, please call me at 914-231-7295 or email at mverba@sp2.upenn.edu

Appendix E: Letter to colleagues

Dear Colleagues,

I am a doctoral candidate at the University of Pennsylvania's School of Social Policy and Practice and conducting dissertation research on recovery from eating disorders. I am currently recruiting volunteers who might be willing to participate in an interview about their recovery process with the aim of gaining a better understanding of how someone recovers from an eating disorder. Specifically, I am looking for woman (over 18) with long-term recovery from anorexia nervosa or bulimia nervosa.

I would be grateful if you could present this study to any clients who might be appropriate and interested. Additionally, feel free to tell other therapists who work with this population. As I am hoping to be able to meet in person with participants, I am looking specifically for participants located in the Greater New York area, Pennsylvania and New England. Women interested in participating may contact me directly at 914-231-7295 or by email at mverba@sp2.upenn.edu.

Criteria for inclusion in the study:
1) Eating disorder history fulfills DSM-IV criteria for anorexia nervosa or bulimia nervosa

For individuals with histories of anorexia nervosa:
2) Maintenance of normal weight and return of normal menstruation (unless lack of menses or irregularities are due to medical conditions unrelated to the eating disorder) for past 3 years
3) "No extremes," defined as no interference in functioning, in the realm of weight-related thoughts
4) No bingeing or purging, as defined by self-induced vomiting, ipecac use, laxative use, weight-loss or diet pills, and excessive exercise in past 3 years

For individuals with histories of bulimia nervosa:
2) No bingeing or purging, as defined by self-induced vomiting, ipecac use, laxative use, weight-loss or diet pills, fasting, and excessive exercise in past 3 years
3) "No extremes," defined as no interference in functioning, in the realm of weight-related thoughts

Thank you for your help. Please feel free to contact me if you have any questions.

Sincerely,

Martina Verba, LCSW, MPH

Appendix F: Symptom Checklist

Anorexia nervosa:

__Refusal to maintain body weight at or above a minimally normal weight for age and height: Weight loss leading to maintenance of body weight <85% of that expected or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected.

__Intense fear of gaining weight or becoming fat, even though under weight.

__Disturbance in the way one's body weight or shape are experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.

__Amenorrhea (at least three consecutive cycles) in postmenarchal girls and women. Amenorrhea is defined as periods occurring only following hormone (e.g., estrogen) administration.

Type

__Restricting type: During the current episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behavior (self-induced vomiting or misuse of laxatives, diuretics, or enemas).

__Binge-eating–purging type: During the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behavior (self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Bulimia nervosa:

__Recurrent episodes of binge eating characterized by both:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
2. A sense of lack of control over eating during the episode, defined by a feeling that one cannot stop eating or control what or how much one is eating

__Recurrent inappropriate compensatory behavior to prevent weight gain

1. Self-induced vomiting
2. Misuse of laxatives, diuretics, enemas, or other medications
3. Fasting
4. Excessive exercise

__The binge eating and inappropriate compensatory behavior both occur, on average, at least twice a week for 3 months.

__Self evaluation is unduly influenced by body shape and weight.

__The disturbance does not occur exclusively during episodes of anorexia nervosa.

Type

__Purging type: During the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

__Nonpurging type: During the current episode of bulimia nervosa, the person has used inappropriate compensatory behavior but has not regularly engaged in self-induced vomiting or misused laxatives, diuretics, or enemas.

(APA, 2000)

Appendix G: Questionnaire

Date _____

1. Age _____ 2. Occupation _____

3. Ethnicity _____ 4. Religion_____

5. Highest level of education: _____

6. Check one: □ Married/Partnered □ Single □ Separated □ Divorced □ Widowed

If married, is your first marriage? ___ If no, indicate how many previous marriages___

7. Who resides in your household: _____

8. Do you have any children? Please give sex and age of each child:

_____

_____

9. How many children are there in your family of origin? Where were you in the birth order?

_____

_____

10. Mother's age:_____

11. Father's age: _____

12. Parents' marital status:

Married to each other___

Separated___

Divorced ____ Year of divorce _____

Mother deceased ____

Father deceased ____

If one or both parents are deceased, please give the year and cause of death(s) and your parents' marital status at that point in time:

13. Parents' religion_____

Eating Disorder Symptoms and Behaviors

On the next few pages, there are a number of questions associated with anorexia and bulimia nervosa. Could you please indicate whether you had each symptom or behavior, when you had it and when it stopped?

I realize that anorexia and bulimia can be episodic—meaning that these symptoms may have eased and returned several times along the way. Just indicate, as best you can, the time frame for each symptom or behavior. Any symptoms or behaviors you did not experience, please write N/A or leave blank.

I realize that these symptoms and behaviors do not address one's inner world and experience of the disorder. The interview will be our chance to talk about your experience of the disorder and your recovery.

Overconcern with body weight and shape

14. When you had your eating disorder, were you often concerned with your body weight and shape?

15. At what age did you begin to experience that concern?

16. When did that preoccupation ease or stop for you?

Dieting and Fasting

17. Have you ever been on a low-calorie diet? If yes, at what age, did you go on your first diet? How long would they typically last?

18. Have you ever fasted? If yes, how old were you and how long would your fasts typically last? When did you stop going on fasts?

History of Restrictive Eating and Low Body Weight

19. Have you ever had periods in which your body weight was lower than appropriate for your height and age?

20. At what age did you start? For how long?

21. Have you ever had amenorrhea (at least three consecutive cycles)? Amenorrhea is defined as periods occurring only following hormone (e.g., estrogen) administration. For how long?

Binge Eating

22. Were there times when you went on eating binges during which you would eat a lot of food in a short period of time?

23. At what age did you start bingeing?

24. How frequently did you binge and for how long?

25. How old were you when you stopped bingeing?

26. Have you ever felt your eating was out of control? For how long? At what age did that start?

Purging (meaning efforts to get rid of food or calories consumed)

27. Have you ever made yourself vomit? How frequently? For what period of time? At what age did that start?

28. Have you ever used laxatives, diuretics, enemas, diet pills or other medications to get rid of food or calories? How frequently? For what period of time? At what age did that start?

Compulsive Exercise

29. Have you ever engaged in compulsive exercising (defined as a regimen of frequent, vigorous exercise which you felt compelled to do 5-7 days per week)? At what age did you start? At what age did you stop?

Other Significant Issues

30. Have you ever been diagnosed with any other psychiatric problem? If so, what was the diagnosis? At what age were you diagnosed? Did the problem resolve? If so, when?

Previous Treatment

Individual Therapy Related to Eating Disorder:

Dates	Frequency	Therapist's Degree	Male or Female Therapist

Other Individual Therapy:

Dates	Frequency	Therapist's Degree	Male or Female Therapist

Family or Couples Therapy:

Dates	Frequency	Therapist's Degree	Male or Female Therapist

Group Therapy:

Dates	Frequency	Therapist's Degree	Male or Female Therapist

Hospitalization/Day Programs/Intensive Outpatient Programs for Eating Disorder:

Dates	Name of Hospital	Type of Program	Event or Condition that led to treatment

Other Hospitalization/Day Programs/Intensive Outpatient Programs

Dates	Name of Hospital	Type of Program	Event or Condition that led to treatment

Self-help Groups:

Dates	Frequency	Name of Group

Nutritionist or Dietitian:

Dates	Frequency	Male or Female Nutritionist/Dietitian

Medication:

Dates	Medication	Dosage	Prescribed for Reason/Symptoms

Other Treatment (e.g. alternative treatments):

Dates	Type of Treatment	Reason for Treatment

Medical Treatment:

Dates	Type of Treatment or Medication	Condition/Reason for Treatment

Appendix H: Consent Form

Consent to Participate in Study

Experiences of Recovery from Eating Disorders

Introduction and Purpose of Study
I am a doctoral candidate in the DSW program at the School of Social Policy and Practice at the University of Pennsylvania. I am conducting research on the process of recovery from eating disorders. I am inviting you to participate in this interview.

What is involved?

The interview will last about an hour to an hour and a half. I will make an audio recording of the interview and may take written notes.

I will ask you questions about your process of recovery from your eating disorder, as well as your experience of recovery. Specifically, I will ask questions about how your recovery has progressed over time, and what your current experience of recovery is like.

Confidentiality:

The information you share will be kept strictly confidential. I will not share information about whether or not you participate in this project with anyone. I will never use your name, personal information or information about where you live or work in my write-up of the interview. I may use direct quotes, but will conceal or change any identifying information.

Nothing with your name or other identifying information (names and places mentioned in the interview) will be visible to anyone except me. I will blot out your name on this consent form. I am the only person who will be able to listen to the audiotape. I will remove anything that might serve to identify you, including geographic locations and names of particular individuals you might mention in the interview, in the dissertation.

Risks of participating: The risks of participating are minimal. The ways that confidentiality will be protected have already been described. In the unlikely event that you find that what you discussed in the interview is upsetting to you after the interview is over, please be in touch with

me. I will provide you with some names and numbers of individuals or agencies that can provide further assistance.

Benefits of participating:

Although being interviewed may not help you directly, it is also possible that having a chance to share your story will be an interesting and possibly even a rewarding experience for you.

If you have questions about the project after the interview is over, please feel free to contact me:

Martina Verba at 914-231-7296 or martinaverba@yahoo.com

Your participation is completely voluntary:

You do not have to participate in this project. There will be no negative consequences if you decide not to participate. Any program or agency that you work with will not know whether you participate or not. If you don't participate, it will not affect your job or anything else.

If you do decide to be interviewed today, you can stop the interview at any time. You can also refuse to answer any questions that you don't want to answer.

By signing this consent form, you are indicating that you have had all of your questions about the interview answered to your satisfaction and that you have been given a copy of this consent form.

Participant signature: _____

Participant printed name: _____

Date: _____

Interviewer signature: _____

Interviewer printed name: _____

Date: _____

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