

**Intimate Partner Relationships and Recovery from an Eating Disorder**

by

Megan I. Hughes-Jones

B.A., The University of British Columbia, 2005

M.A., The University of British Columbia, 2009

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE AND POST DOCTORAL STUDIES  
(Counselling Psychology)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

March 2015

© Megan I. Hughes-Jones, 2015

## Abstract

It is well established in the empirical, clinical, and theoretical literatures that close relationships influence adult women's recovery from an eating disorder (ED), and research has consistently identified intimate partners as key figures in this process. Despite this recognition, very little is known about women's lived experiences of their intimate partner relationships as a support during recovery, or the meanings they attribute to this experience. The current qualitative study employed a hermeneutic phenomenological method to address this gap in knowledge. The research question guiding this inquiry was: "what is the meaning of lived experience of intimate partner relationships in supporting women's recovery from an eating disorder?" Ten adult women completed qualitative research interviews. Interviews were transcribed verbatim and a thematic analysis was conducted. Five common themes characterizing the women's lived experience of the phenomenon of intimate partner relationships supporting recovery were identified: *Sense of Safety*, *Sense of Mutual Commitment*, *Communication as Facilitative*, *Intimacy*, and *Sense of Identity Beyond the Eating Disorder*. Significant findings are discussed within the context of existing literature on adult women's experiences of an ED and recovery. Implications for theory, practice, and research are addressed, and recommendations for future research are identified.

## **Preface**

This research was conducted with the approval of The University of British Columbia (UBC) Office of Research Services (ORS), Behavioural Research Ethics Board (BREB), as per certificate of approval number H13-01065. It is the original, unpublished, independent work of the author, Megan I. Hughes-Jones.

## Table of Contents

<b>Abstract.....</b>	<b>ii</b>
<b>Preface.....</b>	<b>iii</b>
<b>Table of Contents .....</b>	<b>iv</b>
<b>List of Tables .....</b>	<b>vii</b>
<b>Chapter 1: Introduction .....</b>	<b>1</b>
<b>The Significance of Eating Disorders.....</b>	<b>1</b>
<b>The Relational Nature of Eating Disorders .....</b>	<b>2</b>
<b>Problem and Rationale: Situating the Study.....</b>	<b>3</b>
<b>Recovery From an Eating Disorder .....</b>	<b>4</b>
Further understanding of the role of relationships in recovery .....	6
Social support.....	7
“Support provider” experiences .....	8
Couples’ oriented treatments .....	9
Intimate partner relationships .....	10
<b>Relational-Cultural Theory.....</b>	<b>12</b>
<b>Re-statement of the Problem.....</b>	<b>14</b>
<b>Purpose of the Research .....</b>	<b>15</b>
Practice- and theory- oriented purpose .....	16
<b>Chapter 2: Literature Review .....</b>	<b>18</b>
<b>Eating Disorders and Recovery .....</b>	<b>19</b>
Brief overview of the literature .....	19
Initial efforts to capture women’s perspectives on recovery .....	20
The experience and process of recovery: Empirically derived theories .....	27
<b>Social Support .....</b>	<b>33</b>
Background .....	33
Social support in the area of eating disorders .....	34
<b>Intimate Partner Relationships .....</b>	<b>43</b>
Early work: Exploring group differences .....	45
Relational status and clinical presentation.....	48
Women’s experiences in romantic relationships .....	49
Partner experiences .....	51
Relational-Cultural Theory: Perceived mutuality in partner relationships .....	55
<b>Summary and Re-statement of Rationale for the Current Study .....</b>	<b>57</b>
<b>Chapter 3: Method.....</b>	<b>59</b>
<b>Ontological and Epistemological Positions .....</b>	<b>59</b>
Critical realism.....	59
<b>Philosophical Hermeneutics and the Hermeneutic Circle .....</b>	<b>61</b>
<b>Phenomenology: Historical and Epistemological Developments.....</b>	<b>62</b>
<b>Hermeneutic Phenomenology .....</b>	<b>63</b>
<b>Researcher Positionality and Subjectivity: Reflexive Practice .....</b>	<b>65</b>
Addressing forestructures and pre-understanding: Initial tasks.....	66
Ongoing reflexive practices .....	67

<b>Statement of Positionality .....</b>	<b>68</b>
Beliefs and biases .....	70
Assumptions and expectations .....	72
<b>Rationale for Study Inclusion Criteria .....</b>	<b>73</b>
<b>Procedure .....</b>	<b>76</b>
Participants .....	76
Recruitment .....	78
Data collection .....	79
Data analysis .....	85
<b>Representation of the Research Findings .....</b>	<b>90</b>
<b>Evaluating Interpretive Accounts: Establishing Trustworthiness in the Research.....</b>	<b>91</b>
General criteria to ensure quality .....	91
Evaluation of hermeneutic phenomenology .....	92
Methods for establishing credibility .....	93
<b>Ethical Considerations.....</b>	<b>97</b>
Ethical procedures .....	99
Risks and benefits .....	100
<b>Delimitations.....</b>	<b>101</b>
<b>Chapter 4: Results.....</b>	<b>104</b>
<b>Biosynopses .....</b>	<b>105</b>
<b>Common Themes .....</b>	<b>116</b>
<b>Sense of Safety .....</b>	<b>116</b>
Sense of acceptance and non-judgment .....	119
Sense of security in the relationship .....	125
<b>Sense of Mutual Commitment .....</b>	<b>129</b>
Shared valuing of the relationship .....	130
Joining in recovery.....	135
Sense of motivation and accountability .....	145
<b>Communication as Facilitative .....</b>	<b>153</b>
<b>Intimacy .....</b>	<b>162</b>
Shifting relationship to their body .....	163
Differentiation from other supportive relationships .....	170
<b>Sense of Identity Beyond the Eating Disorder .....</b>	<b>174</b>
<b>Summary of Results .....</b>	<b>182</b>
<b>Chapter 5: Discussion .....</b>	<b>185</b>
<b>Contextual Considerations .....</b>	<b>186</b>
<b>Significant Findings and Theoretical Implications .....</b>	<b>187</b>
<b>Relational Climate .....</b>	<b>188</b>
Acceptance and validation .....	188
Open communication .....	198
<b>Partnership .....</b>	<b>200</b>
From isolation to connection .....	201
Mutuality and joining.....	203
Motivational elements.....	208
<b>Relational-Cultural Theory.....</b>	<b>211</b>
<b>Implications of the Sample .....</b>	<b>216</b>

<b>Implications for Practice .....</b>	<b>222</b>
<b>Treatment of Eating Disorders .....</b>	<b>222</b>
Individual counselling.....	223
Couples' focused approaches.....	225
Resources for partners.....	230
<b>Implications for Research .....</b>	<b>233</b>
Directions for future research .....	234
Dissemination plans .....	238
<b>Conclusion .....</b>	<b>239</b>
<b>References .....</b>	<b>242</b>
<b>Appendix A: DSM-IV Eating Disorder Criteria.....</b>	<b>269</b>
<b>Appendix B: Recruitment Poster .....</b>	<b>271</b>
<b>Appendix C: Print, Electronic, and Social Media Recruitment Notice .....</b>	<b>273</b>
<b>Appendix D: Telephone Screening Form .....</b>	<b>274</b>
<b>Appendix E: Informed Consent Form .....</b>	<b>277</b>
<b>Appendix F: Informed Consent Form for Skype Interviews.....</b>	<b>280</b>
<b>Appendix G: Interview Orienting Statement .....</b>	<b>283</b>
<b>Appendix H: Interview Questions .....</b>	<b>284</b>
<b>Appendix I: Resources.....</b>	<b>286</b>
<b>Appendix J: Transcription Services Confidentiality Agreement .....</b>	<b>287</b>

## **List of Tables**

<b>Table 1 Summary of Participant Demographic Information .....</b>	<b>105</b>
<b>Table 2 Common Themes and Sub-themes .....</b>	<b>116</b>

## Chapter 1: Introduction

The current study employed a hermeneutic phenomenological method to explore the meaning of lived experience of intimate partner relationships in supporting recovery from an Eating Disorder (ED). To this end, the study sought to answer the following research question: “what is the meaning of lived experience of intimate partner relationships in supporting women’s recovery from an eating disorder?”

### *The Significance of Eating Disorders*

Eating disorders (ED) are a serious health concern and often result in significant physical, psychological, and emotional consequences (Dall Grave, 2011; Klump, Bulik, Kaye, Treasure, & Tyson, 2009). As defined by the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), EDs, including anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified (EDNOS) consist of over-evaluation of the individual’s shape and weight, and a number of behaviors aimed at controlling one’s shape and weight, including extreme restriction of dietary intake, episodes of bingeing and/or purging, and excessive exercise (see Appendix A for DSM-IV-TR criteria and APA, 2000 for further diagnostic and related information). Eating disorders are significantly more prevalent in women than men, and are estimated to occur in approximately 0.3-1% of the population (van Hoeken, Seidell, Hoek, 2003). That being said, prevalence rates are often considered under-representative, given the secretive nature of EDs and the number of individuals living with ED behaviors who do not seek treatment (i.e., and thus, do not receive a formal diagnosis and are not captured by epidemiological studies) (van Hoeken et al., 2003). Limitations inherent to current classification systems may also affect reported rates (Keel, Brown, Holland, & Bodell, 2012). Unfortunately, it is not uncommon for EDs to run a chronic course, despite professional



treatment and supports (Keel & Brown, 2010), and treatment drop-out is common (see Campbell, 2009). Indeed, for many individuals recovery is a long and challenging process, characterized by periods of remission and relapse (Herzog et al., 1999; Liu, 2011).

Given the serious nature of EDs, and the profound impact they have on the lives of women affected by an ED and their loved ones, much scholarly attention has been dedicated to understanding EDs. Researchers across fields and disciplines have explored numerous dimensions of EDs, including, but not limited to, risk factors and causes (see Polivy & Herman, 2002), prevention (see Mintz, Hamilton, Bledman, & Franko, 2008), motivation for change (see Vitousek, Watson, & Wilson, 1998), and treatment approaches (see Wilson, 2005). Taken together, this extensive literature highlights the challenges of change, the often enduring nature of EDs, and the complexity of recovery. It also reveals areas of knowledge and practice warranting further attention and exploration. One such area is adult women's relational experiences, namely, their experiences in intimate partner relationships.

### *The Relational Nature of Eating Disorders*

The empirical and clinical literature demonstrates that EDs are profoundly relational in nature. Research has consistently shown that interpersonal factors can play a significant role in the onset of ED symptoms (e.g., relational stressor, including a loss or ongoing conflict) (e.g., Polivy & Herman, 2002). Interpersonal factors have also been implicated in the perpetuation or maintenance of the ED (e.g., conflicted and/or disempowering relationships) (e.g., Treasure, Sepulveda, Whitaker, Todd, Lopez, & Whitney, 2007a), and in promoting, achieving, and sustaining change (e.g., strong social support, empathic relationships) (e.g., Cockell, Zaitsoff, & Geller, 2004). Importantly, supportive relationships have been identified as integral to successful recovery from an ED, with close others positioned to hinder and/or promote change (Bjork &

Ahlstrom, 2008; D'Abundo & Chally, 2004; Hsu, Crisp, Callender, 1992; Peters & Fallon, 1994; Pettersen & Rosenvinge, 2002; Rorty, Yager, & Rossotto, 1993; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003; Weaver, Wuest, & Ciliska, 2005). Given the challenges of recovery from an ED, it is argued herein that increased understanding of the relational dimensions of recovery is essential to improving outcomes for women struggling with an ED.

*Problem and Rationale: Situating the Study*

Despite empirical (Cockell et al., 2004; Peters & Fallon, 1994; Weaver et al., 2005), clinical (Bulik, Baucom, Kirby, & Pisetsky, 2011; Rieger, Van Buren, Bishop, Tanofsky-Kraff, Welch, & Wilfley, 2010; Tantillo, 2000), and theoretical (Miller & Stiver, 1997) support for the central role of interpersonal relationships throughout the process of recovery from an ED, understanding of women's subjective experience of being in a close relationship and/or social support as she engages in the recovery process<sup>1</sup> remains seriously limited. Specifically, very little is known about the nature of supportive relationships, exactly how these relationships may facilitate change, or the meaning women construct around these relational experiences as they relate to their recovery efforts. This is particularly true for women's intimate partner relationships (i.e., committed, intimate, romantic relationships<sup>2</sup>). Although intimate partner relationships have long been identified in the adult ED literature as an important aspect of women's experience (see Arcelus, Yates, Whiteley, 2012; Newton, Boblin, Brown, Ciliska, 2005b), virtually no attention has been paid to the role of these relationships during recovery (Arcelus et al., 2012; Newton et al., 2005b). Indeed, this issue has yet to be explored empirically. This is surprising, and also problematic, given that partners have consistently been identified as

---

<sup>1</sup> Intentionally works to reduce ED symptoms and behaviors and enhance overall health.

<sup>2</sup> Research has referred to the partner relationship in a number of ways, including the marital relationship or romantic relationship; in the proposed study, this relationship is referred to as the intimate partner relationship.

key figures in women's recovery process and appear to play a significant role in some women's attainment of change (Hsu et al., 1992; Pettersen & Rosenvinge, 2002; Rorty et al., 1993; Tozzi et al., 2003).

### *Recovery From an Eating Disorder*

Significant efforts have been made within the field of EDs to understand, conceptualize, and define "recovery." The literature abounds with varying perspectives on, and approaches to, the investigation of this process and experience (Bachner-Melman, Zohar, & Ebstein, 2006; Bardone-Cone et al., 2010a; Herzog et al., 1999; Noordenbos, 2011a, 2011b). In large part, the existing body of work is comprised of quantitative research, reflecting the predominance of a positivist paradigm of science to conceptualize and investigate EDs, both within the field of psychology and across disciplines (e.g., psychiatry). As such, historically, definitions of recovery have focused on physical and behavioral criteria and predictors, broad treatment outcomes (e.g., good, poor), and specified durations free of behavioral symptoms (see Herzog et al.; Noordenbos, 2011a). However, clinicians, scholars, and women self-identifying as "recovered," have emphasized the methodological and theoretical limitations of such an approach (e.g., Garrett, 1997; Noordenbos, 2011b), in which the lived experiences, expertise, personal meanings, and voices of women are inherently obscured or completely absent (Peters & Fallon, 1994). Indeed, contextualized and nuanced knowledge of women's experiences of recovering from an ED and the meanings they attribute to their recovery process remain largely inaccessible within a positivist paradigm of inquiry.

The field has reached general agreement however that recovery is not solely an outcome to be achieved, but rather a holistic process involving psychological, social, and relational factors and experiences (Bardone-Cone et al., 2010a; Noordenbos, 2011b; Peters & Fallon, 1994;

Weaver et al., 2005). A growing body of qualitative research continues to extend and deepen our understanding of the recovery process by exploring this experience from the perspectives of women themselves (Bjork & Ahlstrom, 2008; Cockell et al., 2004; D'Abundo & Chally, 2004; Garrett, 1997; Peters & Fallon; Tozzi et al., 2003; Weaver et al.). This research has shown that relationships with close others can have both supportive and/or hindering effects on efforts to initiate (Rorty et al., 1993) and maintain (Federici & Kaplan, 2008; Cockell et al., 2004; Wasson, 2003) change. Close relationships have been cited by women as an essential component of successful change (Bjork & Ahlstrom, 2008; Pettersen & Rosenvinge, 2002) and intimate relationships have been deemed one of the most important factors in their recovery process (Tozzi et al., 2003). While healthy relationships are clearly important, women have also reported that disconnecting from unhealthy relationships is an important step in recovering from the ED (Peters & Fallon; Rorty et al.). To this end, studies have revealed shifts in women's relational functioning that occur over the course of recovery (Peters & Fallon).

Although this research clearly speaks to the relational nature of women's healing process, it remains significantly limited. Specifically, extant qualitative research in the area of EDs and recovery reflects three general approaches to inquiry: (a) case studies, observations, or reviews; (b) identification and/or quantification of factors deemed relevant to recovery (i.e., reflecting its post-positivist underpinnings); and (c) theoretically grounded studies exploring the meaning and experience of recovery. Consequently, despite being relatively expansive in breadth (e.g., the number of factors identified as being important to recovery), our current knowledge is limited in depth. A variety of relational factors and experiences specific to the intimate relationship have been identified as important criteria for, or aspects of, recovery, including: husband or partner support (Hsu et al., 1992; Pettersen & Rosenvinge, 2002; Rorty et al., 1993); relationship with

spouse, partner, or lover (Garrett, 1997; Tozzi et al., 2003); acceptance of, and reliance on relationships, including with one's partner (D'Abundo & Chally, 2004); and negotiating relationships with close others (Bjork & Ahlstrom, 2008). However, few studies have explored women's recovery experiences in depth (D'Abundo & Chally; Garrett; Lamoureux & Bottorf, 2005; Peters & Fallon, 1994; Weaver et al., 2005). In addition, while these latter studies certainly offer substantive, integrated accounts of recovery, given their exploration of recovery in *general* (e.g., the experience, meaning, process), they do not address in any detail women's relational experiences, namely, their experiences of their intimate partner relationships and support during their recovery process. As such, beyond being identified as important, women's intimate partner relationships and the unique ways in which these relationships may support recovery have not been addressed or explored in the empirical literature.

*Further understanding of the role of relationships in recovery.* Intimate partner relationships have been implicated in adult women's recovery process in various other bodies of literature and empirical research, each contributing to the overall knowledge base within which the current study is grounded. This includes research focused on social support (Grissett & Norvell, 1992; Jacobson & Robins, 1989; Linville, Brown, Sturm, & McDougal, 2012; Marcos & Cantero, 2009; Rorty, Yager, Buckwalter, & Rossotto, 1999; Tiller, Sloane, Schmidt, Troop, Power, & Treasure, 1997), support provider or "carer" experiences (Leichner, Harper, & Johnston, 1985; Treasure et al., 2007a, p. 24), couples' oriented treatments (Bulik, Baucom, & Kirby, 2012; Bulik et al., 2011; Gorin, Le Grange, & Stone, 2003), and romantic relationships (Newton, Boblin, Brown, & Ciliska, 2005a). Each will be briefly addressed below, to further contextualize the current research.

*Social support.* Broadly speaking, research on social support in the area of EDs is limited; that is, it is generally quite dated, is predominantly quantitative, and lacks continuity. For example, this research is comprised almost exclusively of quantitative studies, with small samples and descriptive, cross-sectional designs. It has focused largely on the structural or objective aspects of support, in addition to satisfaction with support, with virtually no attention paid to the nature, quality, characteristics, or experience of support, particularly helpful support. Indeed, in most cases study design precludes understanding of the mutually influential nature of relationships, examination of processes over time, and any rich description of women's experiences. Insufficient effort has been made to remedy the limitations noted in previous work, or to build on previous findings (e.g., heterogeneity in study measures precludes meaningful comparisons).

Much like the aforementioned recovery literature, the social support literature in the area of EDs lacks explicit focus on the intimate partner relationship. As such, our knowledge of the ways in which this specific relationship may influence women's recovery is limited to what has been revealed through the small sub-groups of partners included within the context of broader studies. Under these circumstances, any partner-specific findings tend to be further obscured by the over-representation of mothers and fathers (e.g., Marcos & Cantero, 2009). That is, given that several studies have included younger adults and adolescents, with unique developmental and social characteristics and circumstances (e.g., rely on their families for support, are not yet in romantic relationships) (Marcos & Cantero; Rorty et al., 1999), representation of partners has been marginal<sup>3</sup>.

---

<sup>3</sup> It is acknowledged that many adult women may not be in an intimate relationship and/or may not identify their partners as sources of support, which may also contribute to this lower

*“Support provider” experiences.* A growing number of studies have illustrated the profound impact that being in relationship with, and caring for, someone with an ED can have (Dimitropoulos, Carter, Schachter, & Woodside, 2008; Graap, Bleich, Herbst, Trostmann, Wancata, de Zwaan, 2008; Highet, Thompson, & King, 2005; Huke & Slade, 2006; Leichner et al., 1985; Martin, Padierna, Aguirre, Quintana, Las Hayas, & Munoz, 2011; Perkins, Winn, Murray, Murphy, & Schmidt, 2004; Treasure, Murphy, Szmukler, Todd, Gavan, & Joyce, 2001). This research indicates that “support providers”<sup>4</sup> experience high levels of anxiety, depression, and decreased quality of life, among other areas of impact, and this appears to influence their ability to support their loved one’s recovery process (e.g., Leichner et al.; Perkins et al., 2004; Treasure et al., 2007a). For example, preliminary work by Geller and colleagues (2010a) has shown that support provider anxiety is associated with the delivery of directive support attempts (e.g., offering opinions about change, the ED, or recovery efforts; adopting a more demanding stance in one’s interactions around these issues), whereas research suggests that collaborative support attempts characterized by a concerned and encouraging stance are more helpful (Geller & Brown, 2006; Geller, Zelichowska, Jones, Srikameswaran, Dunn, & Brown, 2010b). Informed by these relational challenges, Treasure and colleagues (2007a) have developed “workshops” (p. 24) aimed at supporting family members, including partners, to provide effective responses and support to their loved one. These skills-based workshops acknowledge the distress experienced by those in relationship with someone struggling with an ED, and aim to decrease the unintended

---

representation. However, the literature indicates that many women with EDs are in committed relationships (Arcelus et al., 2012; Bulik et al., 2012).

<sup>4</sup> Family members, partners, and friends are often identified as “support providers,” “care providers,” or “carers” in the scholarly literature, reflecting underlying assumptions about the nature of these relationships (e.g., tending to negate the bi-directional flow in relationship and identify the woman as a passive recipient of support efforts; disempowering to women). While the implications and limitations of this language are noted, in the interest of describing extant research, similar language has been adopted.

consequences of this distress (i.e., the “interpersonal maintaining factors” associated with the ED; p. 24) by equipping support providers with information/education, strategies, and tools for supporting their loved one’s recovery process. This small but growing area of work offers further information about the immediate relational context within which recovery is situated, and highlights the tensions that can often exist in attempting to support someone’s change process. Partners are typically included in these studies, however their experiences are seldom the focus. Further, given the paucity of research on intimate partner relationships in the area of EDs, the extent to which these workshops are informed by, or tailored to, this particular relationship (i.e., versus relationships with parents, for example) is limited. In all, very little is known about how partners experience their role and/or relationship during their loved one’s recovery. The few studies that have examined partner perspectives and experiences suggest that these individuals often experience distress and challenges in attempting to support their partners (Leichner et al.; Huke & Slade).

*Couples’ oriented treatments.* Along a similar vein to the workshops proposed by Treasure and colleagues (2007a), efforts have been made to involve partners in cognitive behavioral approaches to treatment, including group cognitive behavioral therapy (CBT) for women with binge eating disorder (Gorin et al., 2003). More recently, significant efforts have been made to develop a couples’-focused cognitive behavioral therapy for women with AN and their partners (Bulik et al., 2012; Bulik et al., 2011). Bulik and colleagues’ (2011) work is grounded in evidence for the effectiveness of family-based interventions for adolescents with an ED. It draws from various bodies of research on global marital adjustment and distress, communication, sexual functioning, and as previously mentioned, the experiences of support providers. Bulik and colleagues (2011) concur that many women living with an ED do indeed



have intimate partner relationships, and assert that these relationships may be a source of support and/or distress, and thus, impact recovery efforts. To this end, they argue that treatments targeting this relationship are indicated, particularly given the limited evidence and efficacy of available treatments for adults with AN (Bulik et al.). Unfortunately, given the limitations to extant research on intimate partner relationships in the area of EDs, in particular the fact that women's perspectives regarding their relationships and the recovery process have yet to be sufficiently explored in the empirical literature, these treatment approaches may not be optimally informed by women's experiences and needs.

*Intimate partner relationships.* Existing research on intimate partner relationships in the area of EDs is limited in both breadth and depth, is very dated, and is characterized by significant methodological limitations (see Arcelus et al., 2012; Dimitropoulos, Lackstrom, & Woodside, 2007; Newton et al., 2005b for reviews). This area of inquiry saw some interest in the late eighties and nineties. Initial studies typically focused on problematic areas of functioning; examined associations between ED and related symptoms and marital status; and explored group differences among couples in which one partner was living with an ED, distressed couples, and non-distressed couples, respectively<sup>5</sup> (Van Buren & Williamson, 1988; Van den Broucke & Vandereycken, 1988, 1989; Van den Broucke, Vandereycken, & Vertommen, 1995a, 1995b, 1995c; Wiederman & Pryor, 1997). Since these early, descriptive, correlational studies, relatively little empirical work has been done (Arcelus et al., 2012), and no research has focused on the intimate partner relationship in the context of women's recovery efforts. Newton and colleagues (2005b) conducted an integrated review of the literature on romantic relationships, reviewing

---

<sup>5</sup> Most studies do not report participants' ethnicity, cultural background, or sexual orientation; when reported, samples have been comprised of heterosexual women, who are either married or living together. As a whole, this literature is extremely limited in its attention to diversity.

studies published between 1983 and 2004<sup>6</sup>. These authors identified primarily correlational studies exploring ED symptoms and relationship status, sexual experiences (i.e., attitudes and behaviors)<sup>7</sup>, communication within the relationship, intimacy, and relationship quality, respectively (Newton et al., 2005b). As might be expected, there was significant heterogeneity with respect to women's experiences, however relationship dissatisfaction emerged as a common theme. In light of the results of their review, including the nature and limitations of the overall body of literature on women's intimate relationships, these authors called for increased use of qualitative methods to explore women's lived experiences in relationships (Newton et al.).

Indeed, Newton and colleagues' (2005a, 2006) work has enhanced our understanding of women's experiences in intimate relationships, through their qualitative explorations of romantic relationships (Newton et al., 2005a) and intimacy (Newton, Boblin, Brown, & Ciliska, 2006) for individuals with AN. This research has highlighted the fluidity of women's experiences in intimate relationships, namely, the processes of emotional and physical connection and disconnection that occur over time, and the factors associated with such experiences (Newton et al., 2005a). While their work has not specifically addressed experiences of support, it extends extant research, contributes foundational knowledge about women's experiences in their

---

<sup>6</sup> The authors aimed to focus exclusively on studies with women with AN, but were inevitably inclusive of all diagnoses, given diagnostic migration and the limitations of diagnostic classification; the authors did not review studies focused explicitly on women with BN or EDNOS, however.

<sup>7</sup> Research has examined sexuality and sexual functioning in the area of EDs (e.g., Pinheiro et al., 2010). While numerous theoretical perspectives on this aspect of women's experience characterize the ED literature, there has been less empirical research, and extant studies reflect a medical model of conceptualization and inquiry. Generally speaking, this research has focused on women's "dysfunction" and the various factors contributing to difficulties with sexual intimacy. Given the current study's focus on the experience of partner support during recovery, a full review of the literature on sexuality is beyond the scope of this project, and the interested reader is therefore directed to Newton and colleagues' (2005b) and Pinheiro and colleagues' (2010) work for a more comprehensive review of this area.

committed relationships, and reinforces the importance of further, focused inquiry into intimate partner support.

### *Relational-Cultural Theory*

Generally speaking, across the aforementioned bodies of ED-related research there is a marked absence of theoretical coherence; that is, studies have not drawn upon, or been grounded in, theoretical frameworks. Relational-Cultural Theory is an overarching theory of women's development that situates women's psychological growth and wellbeing within the context of close relationships (Miller & Stiver, 1997). As such, RCT offers a framework within which the research on interpersonal relationships and EDs may be considered, and provides theoretical support for the importance of women's relationships to their experience of an ED and recovery.

RCT posits that psychological distress, including EDs, stems from relational disconnections (Miller & Stiver, 1997; West, 2005). Broadly speaking, these disconnections consist of empathic failures, may be fleeting or enduring, and result in various negative intra- and interpersonal consequences for the recipients (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). RCT speaks to the ways in which one's contexts, culture(s), and dominant and/or minority identity(ies) influence experiences of connection and disconnection, highlighting the complex constellation of factors and experiences that influence relational development, and thus, psychological wellbeing (Comstock, Hammer, Strentzsch, Cannon, Parsons, & Salazar, 2008). RCT proposes that psychological health, including recovery from an ED, is fostered within the context of mutually empathic and empowering relationships (Jordan, 1991; Miller & Stiver; Tantillo, 2000). To this end, growth (i.e., positive change) is thought to occur through connection with others, which is inherently influenced by one's culture(s).

Despite strong theoretical appeal and frequent clinical application (Duffey & Somody, 2011; Tantillo, 2000), very little empirical research has examined RCT's central tenets (Jordan, 2011), particularly in the area of EDs. For example, central to RCT is the notion that growth occurs in the context of mutual relationships, which are thought to foster motivation (Jordan, 1991) and empowerment (Miller & Stiver). However, this core theoretical tenet has yet to be empirically examined.

According to RCT, relationships characterized by high levels of perceived mutuality are thought to be growth promoting (Jordan, 1991; Miller & Stiver, 1997) and thus, related to women's recovery from an ED (Tantillo, 2000; Tantillo & Sanftner, 2003). Perceived mutuality is the extent to which a woman feels that her relationship with another is characterized by a bi-directional flow of thoughts and feelings, and empathic understanding (Genero, Miller, Surrey, & Baldwin, 1992; Jordan). To date, a small body of research has explored the construct of perceived mutuality (PM) in close relationships (e.g., mothers, fathers, partners, friends) with women struggling with body image concerns (Sanftner, Ryan, & Pierce, 2009), disordered eating (Wechsler, Riggs, Stabb, & Marshall, 2006), and EDs (Jones, 2011; Sanftner et al., 2006; Sanftner, Tantillo, & Seidlitz, 2004; Tantillo & Sanftner, 2003). Research has demonstrated that women living with an ED report lower PM in their relationships with their partner than women without a clinical diagnosis (i.e., control group) (Sanftner et al., 2004). Research has also revealed a relationship between PM and ED symptoms (Sanftner et al., 2006; Sanftner et al., 2004). Specifically, studies have shown that lower PM in the partner relationship is associated with greater body dissatisfaction (Sanftner et al., 2006), and that lower PM in parental relationships may be associated with greater symptomatology (Tantillo & Sanftner). That said, given that few studies have explored this aspect of women's relational experiences, the extent to

which RCT's tenets, constructs, and processes fit for women recovering from an ED remains uncertain, particularly within the context of intimate partner relationships. As such, while RCT offers a promising lens or perspective on women's recovery, emphasizing the relational contexts within which change may occur, further research is needed.

### *Re-statement of the Problem*

Considered together, the aforementioned bodies of literature depict the relevance of women's relational experiences during recovery from an ED and highlight the limitations of our knowledge to date. There exists converging evidence from the recovery, social support, support provider, treatment, romantic relationship, and RCT literatures illustrating relationships as being integral to women's ED and recovery process. However, this work reveals a number of limitations, including the frequent exclusion of women's lived experience, meanings, and voices and virtually no focus on the intimate partner relationship during recovery.

To date, very little is known about the *nature* of women's intimate partner experiences, *specific ways in which women perceive these relational experiences as being associated with recovery*, or the *meaning* women attribute to these relational experiences within the context of their recovery efforts. The paucity of research on adult women's intimate partner relationships and recovery reveals a disconcerting gap in knowledge, given that partner support has been identified as central to recovery for many women (Tozzi et al., 2003). Moreover, associations between ED symptoms, motivation for change, and marriage (Bussolotti, Fernandez-Aranda, Solano, Jimenez-Murcia, Turon, & Vallejo, 2002) have been documented. Research has also described the challenges often experienced within these relationships (Leichner et al., 1985; Van den Broucke et al., 1995a, 1995b, 1995c), partner distress in response to the ED (Leichner et al.; Huke & Slade, 2006; Perkins et al., 2004), and women's experience of dissatisfaction in their

intimate relationships (Newton et al., 2005b; Woodside, Lackstrom, & Shekter-Wolfson, 2000), depicting a complex relational picture requiring further empirical exploration. Indeed, further research certainly seems warranted given that new treatment approaches are being developed on what is arguably a limited body of research (Bulik et al., 2011). Greater attention to women's experiences in their intimate partner relationship during recovery is highly warranted – supported clinically, empirically, and theoretically – and is therefore the focus of the current study.

### *Purpose of the Research*

The current study employed a hermeneutic phenomenological method to increase understanding of the meaning of lived experience of intimate partner relationships in supporting recovery from an ED for adult women. The research question guiding the inquiry was: *“what is the meaning of lived experience of intimate partner relationships in supporting women's recovery from an eating disorder?”*

Phenomenology seeks to explore and understand experiential, pre-reflective human experience. It moves from a theoretical perspective and abstractions to experiences as lived in everyday life (van Manen, 1997b). Phenomenology is therefore uniquely suited to this particular area of inquiry, given its limited nature, the absence of women's subjective experiences and voices in the literature, and the imperative of accessing detailed descriptions from women themselves. A hermeneutic phenomenological inquiry, specifically, aims to deepen our knowledge, elucidate the contexts within which experiences are embedded, and importantly, access and identify the meanings associated with such experiences. To this end, rich descriptions of women's experiences were generated to both supplement and extend the existing literature.

Furthermore, this methodology reflects the study's roots in Counselling Psychology (CNPS), and thus, its efforts to privilege individual experiences and voices that have often been

overlooked and are missing within the traditional, positivist approaches to inquiry and knowledge generation (Morrow, 2007), as seen in the field of EDs. Indeed, the approach is congruent with CNPS philosophy in its attendance to the depth, complexity, and situated nature of human experience (Morrow).

*Practice- and theory- oriented purpose.* Findings from this research contribute to both clinical and academic domains, and possess both practice- and theory- oriented purpose and significance (Haverkamp & Young, 2007). This research aimed “to inform practice by providing rich, elaborated descriptions of specific processes or concerns within a specific context” (Haverkamp & Young, p. 274). It sought to generate knowledge appropriate for translation to clinical practice with women and their partners, and thus, contribute to advances in treatment and couples-focused approaches in the area of EDs (see Bulik et al., 2011). Specifically, this research sought to ameliorate and advance existing efforts to involve partners in the recovery process, treatment, and professional supports. Research of this nature is of paramount importance if treatments are to be informed by women’s experiences, especially within this unique relationship; moreover, it serves to ensure that treatments fit with women’s needs, and thus, are effective in promoting healing, outcomes, and the overall recovery process. Indeed, given that previous efforts to involve spouses in group based CBT treatment have failed to demonstrate significant benefits over individual CBT (Gorin et al., 2003), greater understanding of what women find supportive of their change efforts, and how and why, is sorely needed.

In addition, this research sought to “elaborate elements of a theory in new domains...and expand researchers’ understanding of specific constructs” (p. 273). Indeed, by virtue of exploring women’s relational experiences with a hermeneutic phenomenological approach (i.e., and broadly articulated research question), the study provides empirical findings relevant to the

application of RCT and associated concepts (e.g., connection, disconnection, mutuality, growth) in the area of EDs.

Overall, increased understanding of women's lived experiences and the meanings they ascribe to their *intimate partner relationships in supporting recovery* expands current knowledge in the field, informs future research, and offers insights into the ways we may enhance our clinical practice with women engaged in the process of recovery, and their partners, to better account for relational experiences and optimize recovery supports and outcomes.



## **Chapter 2: Literature Review**

In the following chapter I review and critique literature pertaining to the relational experiences of women engaged in recovery from an ED, with particular focus on the ways in which various bodies of research have explored women's intimate partner relationships. In this review I aim to elucidate important gaps in our knowledge, situate the proposed study within the existing literature, and reinforce the unique contribution this particular study will make in understanding women's experiences and meanings of their intimate partner relationships in supporting their recovery from an ED.

I begin with a review of extant research on recovery, with attention to qualitative studies that have examined the process of recovery from the women's perspective. This research emphasizes the centrality of interpersonal and social support experiences to change efforts and recovery. However, given studies' broad focus on recovery in general, the depth to which specific relational experiences, and the intimate relationship in particular, are explored remains seriously limited.

I then turn to other bodies of research that have explored interpersonal relationships in the area of EDs, such as the literatures on social support and intimate partner relationships. In reviewing this scholarship, it became increasingly evident that research in these areas is limited in scope, that is, it is predominantly quantitative, cross-sectional, and focused on discrete elements of women's experiences. These studies have afforded a general picture of women's social experiences and identified a number of relational difficulties of clinical relevance. Importantly, they have implicated the intimate partner relationship in a woman's wellbeing and eating difficulties. However, they have done very little to advance our understanding of women's experiences in this relationship or the ways in which these experiences may influence recovery.

It is therefore argued that, as a whole, the existing literature creates a solid foundation and rationale for more focused inquiry, as it affirms the centrality of relational experiences and highlights the need for further exploration of women's lived experiences in their intimate partner relationships, as they engage in the process of recovery.

### *Eating Disorders and Recovery*

*Brief overview of the literature.* Positivist approaches to inquiry have identified indices, predictors, and temporal patterns of remission, recovery, and relapse, respectively (e.g., Berkman, Lohr, & Bulik, 2007; Lowe, Zipfel, Buchholz, Dupont, Reas, & Herzog, 2001; Keel, Dorer, Franko, Jackson, & Herzog, 2005; Kordy et al., 2002; Ro, Martinsen, Hoffart, Sexton, & Rosenvinge, 2005; Von Holle et al., 2008), and steps have been taken to integrate cognitive and psychosocial factors into recovery focused research, conceptualizations, and definitions (Bachner-Melman et al., 2006; Bardone-Cone et al., 2010a). Findings from this research have been quite mixed, with respect to predictors of successful change (Herzog et al., 1999) and criteria for remission and recovery (Kordy et al., 2002), for example. Different approaches to measurement; definitions of recovery, remission, and relapse; and time of follow-up have all complicated the picture, and despite significant empirical efforts, the field lacks consensus around these issues (Noordenbos, 2011a).

A growing body of qualitative literature has been exploring recovery from women's perspectives, extending and deepening the existing body of quantitative research (Bjork & Ahlstrom, 2008; D'Abundo & Chally, 2004; Federici & Kaplan, 2008; Garrett, 1997; Matusek & Knudson, 2009; Noordenbos, 2011b; Peters & Fallon, 1994; Tozzi et al., 2003; Weaver et al., 2005). Qualitative methodologies have afforded a more textured, nuanced, and rich account of the process of recovery; this body of literature illustrates dimensions, experiences, and processes

deemed important by the women themselves. As previously noted, approaches to inquiry in this area have consisted of case studies or reviews, the identification of factors associated with successful recovery, and theoretically grounded studies exploring the meaning and experience of recovery. Considered together, these studies demonstrate the extent to which women's experiences are embedded within social and relational contexts (Peters & Fallon, 1994; Weaver et al., 2005), and speak to the central role of social support and interpersonal relationships to achieving (e.g., Tozzi et al.) and maintaining change (e.g., Cockell et al., 2004).

*Initial efforts to capture women's perspectives on recovery.* Root (1990) conducted one of the first investigations of recovery based on women's subjective experiences and perspectives. In this small study of female university students ( $N = 21$ )<sup>8</sup>, Root explored perceptions of recovery, history of relapse, and perceived stability of recovery (p. 398). Particularly noteworthy was the study's exploration of women's perceived stability of recovery, an issue that has received virtually no further empirical attention.

To examine women's perspectives on recovery, Root drew three general conceptualizations from the literature, and explored (a) the extent to which women endorsed these definitions, and (b) factors associated with the women's respective perspectives. To this end, women were asked to select the definition/conceptualization of recovery that best described their experience: (a) "I am recovered; I no longer struggle with food, weight, and/or body-image;" (b) "I am recovered, but I still struggle with food, weight, and/or body-image;" or (c) "I will never be completely over my eating disorder; I will always struggle with an eating disorder" (p. 399). Despite self-identifying as "recovered," the majority of women chose the second

---

<sup>8</sup> Root focused on women with a diagnosis of BN, however, 57% of the sample had a history of AN, highlighting the frequency of diagnostic migration and the limitations of classification for empirical purposes.

definition (71.4%), acknowledging an ongoing challenge with ED related issues. The meaning or definition of recovery adopted by the women appeared to be related to their confidence in being able to maintain changes; confidence was related to the duration of their recovery to date (i.e., longer duration free of ED led to greater endorsement of the first definition) and overall level of psychological distress. Psychosocial issues were frequently cited as risk factors for relapse; indeed, 81% of the women had relapsed after having thought she was “over” the ED (i.e., relapse was defined as engaging in  $\geq 1$  episode of bingeing and purging) (p. 399). Women reported relapses lasting from one episode to multiple episodes for periods of months, with the longest being 4 years ( $M = 5.4$  months), highlighting the enduring vulnerability many women experience throughout their recovery journey. Given the well established role of social support and interpersonal relationships in maintaining changes and reducing risk of relapse (Cockell et al., 2004; Federici & Kaplan, 2008; Keel et al., 2005; Wasson, 2003), these findings suggest that greater understanding of the ways in which close others may enhance women’s self-efficacy around recovery may have important long-term implications for women, their partners, and treatment approaches.

Case studies and reviews reflect additional efforts to explore women’s experience of recovery (Hsu et al., 1992; Woodside, Kohn, & Kerr, 1998). Hsu and colleagues (1992) reviewed six cases in an attempt to discern factors related to recovery from AN. While a range of key experiences were identified (i.e., treatment, willpower, fear, disconnection from unhealthy family relationships, faith), for half the women, their relationship with their husband proved to be the most significant or one of the most significant factors in recovery. There were a number of methodological limitations to the study, noted by the authors (e.g., assessment of recovery, recruitment, data collection), however, findings contributed to the developing picture of

women's subjective perspective of the factors associated with change. Woodside, Kohn, and Kerr (1998) adopted a similar approach to inquiry as Hsu et al., and reviewed the cases of four previous patients; two of the women cited romantic partners as influential in their recovery.

Rorty and colleagues (1993) investigated factors associated with recovery in a group of adult women with a history of BN<sup>9</sup> ( $N = 40$ ), who self-identified as being recovered for a year or more. These authors inquired about (a) what stimulated recovery; (b) what professional and nonprofessional treatments were utilized, and levels of treatment satisfaction; (c) how life experiences and important others may have “helped or hindered” recovery (p. 249); and (d) what aspects of BN were hardest to change and what would participants still like to change.

A number of women indicated that close others played a role in the initiation of recovery. For example, having someone close to them “take a strong stand,” experiencing an increase in self-esteem due to a new romantic relationship, and starting or ending a romantic relationship (p. 253) were all deemed facilitative experiences. Over half the participants reported that support from family, partners, and friends was very helpful. In fact, supports from these close others were rated the most helpful “non-treatment related life experiences” associated with recovery. Conversely, the least helpful experience was a “lack of understanding or insensitivity from partner, friends, or family,” endorsed by 33% of the participants. Second only to friends, partners were deemed the least harmful, in terms of hindering effects one might have on recovery. That said, 16% of the group identified their partners as “actively harmful” to their recovery process, and 13% felt that they received insufficient emotional support from their partner (Rorty et al., 1993).

---

<sup>9</sup> 31% of participants had previously been diagnosed with AN.

The women were also asked about the *ways* in which close others supported their recovery, with respect to emotional and practical support. Out of all support providers (i.e., mothers, fathers, siblings, partners, and friends), partners were deemed the most emotionally supportive; that is, 55% of the sample indicated that their partners provided emotional support, as compared to mothers (10%), fathers (10%), siblings (33%), and friends (45%). Partners appeared to provide much less practical support however (8%), compared to mothers (33%) and fathers (26%), but more than siblings (3%) and friends (0%) (Rorty et al., 1993).

Unfortunately these authors did not offer any descriptive information about participants' relationships; they noted that 87.5% of participants had never been married, but did not state how many women were in a relationship, nor did they report length of relationship or other relevant descriptive information (e.g., co-habitation) for those in a relationship (Rorty et al., 1993). This seriously limits interpretation of the results as presented (i.e., percentages of individuals who endorsed categories). In addition, it is unclear whether the categories of emotional and practical support, respectively, were generated by the authors or if they emerged as themes. As such, while the results of this study both affirm and supplement the aforementioned findings regarding the role of partners (e.g., frequently cited as a source of support during recovery, for many are the primary source of emotional support), the study's methodological limitations are substantial and leave a number of gaps in our knowledge.

More recently, other methods of examining women's perspectives have been employed. For example, Keski-Rahkonen and Tozzi (2005) reviewed material posted online by women contributing to an online support group; they found that relationships were cited as helpful to recovery. Although profoundly limited in terms of method and detail, this descriptive study is noteworthy in that it demonstrates an alternate, and inclusive, means of accessing women's

views about recovery. In other efforts, Noordenbos and Seubring (2006) generated a list of criteria for recovery, based on existing literature, and asked both women ( $n = 41$ ) and therapists ( $n = 57$ ) the extent to which they thought each factor was relevant to recovery. Findings from this study offered further support for the conceptualization of recovery as a holistic process involving physical, behavioral, somatic, psychological, emotional, and social dimensions. Interestingly, when the women's ratings were compared to therapist ratings, the women rated all but one of the five social criteria as being of more important to recovery than did the therapists (Noordenbos & Seubring, 2006). This discrepancy re-iterates the need for women's voices in the literature, the extent to which social dimensions are important to women's view of wellbeing, and the relevance of empirical attention in this area.

Indeed, a number of other studies have focused on the identification and evaluation of factors that women deem relevant to recovery (Bjork & Ahlstrom, 2008; Noordenbos & Seubring, 2006; Noordenbos, 2011b; Pettersen & Rosenvinge, 2002; Tozzi et al., 2003). Using a phenomenography method, Bjork and Ahlstrom (2008) explored women's perceptions of what it means to be recovered. Adult ( $\geq 18$ ,  $M = 27$ ) women ( $N = 14$ ) self-identifying as being recovered or "markedly improved" following treatment (p. 929) were invited to participate in this study. Ten of the women were in a relationship (i.e., married, living with partner, in relationship). Based on their findings from research interviews, the authors generated four categories, comprised of fourteen statements total, to describe recovery according to the participants. Participants emphasized the development of a more relaxed relationship with food, eating, and one's body; greater self-acceptance and esteem; and social re-connections. Women described a process of "[moving] toward social relations...instead of withdrawing" (p. 938), and engaging in more authentic ways with others. They spoke about cultivating a social life, including increasing

one's capacity for mutuality in relationships, hopes for parenthood, and developing the courage to be vulnerable and close in relationship. The women identified ability to listen to others, engage in open dialogue, and consider both others' and their own perspectives, as significant. With recovery, greater value was placed on both being authentic in relationships and the relationships themselves. Women also noted the importance of recognizing when distance in relationship was needed (Bjork & Ahlstrom). Overall, this study affirms that women view interpersonal functioning as relevant to recovery; in particular, these women identified their capacity to engage meaningfully with others as an indicator of wellbeing and healing.

In a larger study, Pettersen and Rosenvinge (2002) sought to understand 48 adult women's (i.e.,  $\geq 18$  years of age,  $M = 27.6$ ) perspectives on recovery, including (a) factors associated with or contributing to recovery, and (b) how women define recovery. Women with an ED (i.e., AN, BN, EDNOS) of duration of three years or more years ( $M = 11.1$  years duration) were invited to participate. Data were collected via interviews and questionnaires. Of note, the authors stated that the interviews were transcribed and analyzed based on approaches documented in the literature; no further methodological details were offered, limiting interpretation of findings.

Findings generated an overarching theme, "the desire for a better life," along with three sub-themes, "effects of professional treatments," "effects of nonprofessional care," and "effects of positive life events and important persons" to depict factors contributing to recovery (p. 65). This latter dimension was particularly relevant to the current study. Consistent with other research, partners, parents, and close friends were identified as supports; specifically, these close others were deemed to be sources of emotional and practical support, trust, and acceptance. Positive life events, such as having a partner, were also deemed important to recovery [just over



half the women in the study had a partner (52%)]. According to these women, close others were often the first to know about the ED and to encourage treatment. Interestingly, their support was viewed as integral to the women's self-esteem (Pettersen & Rosenvinge, 2002), suggesting a mechanism through which support may influence change efforts.

In another study aimed at identifying factors associated with women's recovery process, Tozzi and colleagues (2003) asked women for their perspective on both the causes of their ED, and the factors promoting recovery. Although participants were women with a lifetime diagnosis of AN, 58% of the sample had a history of BN or subthreshold BN, suggesting findings may be generalizable among women with various eating difficulties. With respect to recovery status, the majority of participants were "recovered" as per the study's definition ( $n = 62$ ; no longer meeting diagnostic criteria for an ED), however some women were still living with the ED ( $n = 7$ ).

In this study, a supportive relationship or partner was the most frequently cited factor related to recovery [27.45% of participants cited this factor, and just less than half the sample (46.4%) were married; no other relationship information was offered]. In fact, participants indicated this relationship was "the driving force that assisted them in recovery" (p. 151). The authors gave the following examples to represent the ways in which partners were mentioned by participants: "met husband;" "good, healthy relationship with husband, unconditional love and acceptance;" "supportive husband – treated [me] normally all the way through it;" "being valued by husband" (p. 148). The authors' conclusion that interpersonal factors play a central role in recovery seems warranted, as findings certainly resonate with extant knowledge in this area. In particular, the finding that partners are highly influential supplements the aforementioned findings to this effect, documented in case reports and reviews (Hsu et al., 1992; Woodside et al., 1998). However, given the study's method (e.g., very focused interview questions aimed

specifically at the identification of factors), findings lack substantive information about women's intimate partner relationships (e.g., nature and perceptions of support), and thus, while extending of the breadth of our knowledge in this area, do little to deepen it. Indeed, considered as a whole, all of the aforementioned studies offer evidence that women view close others as important to their attainment of recovery, but do little to elucidate or deepen our understanding of these relational experiences or how they effect change.

*The experience and process of recovery: Empirically derived theories.* Although limited in number, several authors have pursued comprehensive investigations of the recovery process (D'Abundo & Chally, 2004; Garrett, 1997; Lamoureux & Bottorf, 2005; Peters & Fallon, 1994; Weaver et al., 2005). This research extends our understanding of "what" constitutes and occurs during recovery, and expands and elaborates descriptions of "how" healing occurs. These qualitative studies have conceptualized recovery from an ED in a number of ways, including recovery as a process of "becoming the real me" (p. 183; Lamoureux & Bottorf), a "personal awakening" (Peters & Fallon), a "circle of acceptance" (D'Abundo & Chally), "transformation" (Garrett), and "self-development from perilous self-soothing to informed self-care" (Weaver et al.). They describe renewed relationships with self, embedded within and co-occurring with re/connections with others. Women's relational experiences are woven throughout these recovery stories with close others consistently playing an important role in the women's journeys.

Peters and Fallon (1994) were among the first who sought to explore and understand the complexities and processes of change and recovery, based on women's lived experiences. Situating their work within the existing literature at the time, the authors argued that a general reliance on outcome studies had "left no place for recovered women to instruct us about the

process of change, nor...allowed for the discovery of curative factors beyond the experimenters' assumptions" (p. 339). Indeed, their grounded theory research, informed by feminist theory and based on Peters' unpublished dissertation study, was one the earliest comprehensive accounts of women's experience of recovery, and highlighted a number of dimensions and processes that had yet to be discussed and examined in the empirical literature. Women in the study ( $N = 30$ ) had a previous clinical diagnosis of BN, and self-identified as being in the process of recovery or having recovered. While 17 women were asymptomatic, 13 were still experiencing ED symptoms; eleven of these latter women indicated that they had attained partial recovery. Average duration without ED symptoms was just over one year. Mean age of participants was 29 (19-46) and age of onset ranged from 10 to 28 years of age.

This study was foundational in highlighting women's perspectives on the contexts within which recovery occurs, and the processes and relational dimensions involved. Peters (1990, cited in Peters & Fallon, 1994) identified three continua along which the women moved during their recovery process: (1) denial to reality, (2) alienation to connection, and (3) passivity to personal power (p. 341). While psychosocial factors and changes certainly permeated the women's accounts, the relational nature of recovery was best captured by the notion of "alienation to connection" (p. 345). This continuum described women's process of re-connecting to parts of self and others, including increasing openness around the ED and one's struggle, growing capacity to both recognize and express needs and boundaries in relationships, and addressing sexual and emotional intimacy and romantic relationships. Bulimia was viewed as a "disorder of denial, disconnection, and disempowerment," and recovery as a "personal awakening to secrets, alienation, and powerlessness" (p. 353), during which, women's relationships with self, others, and culture shifted towards connection. Many of the changes described in the study were

relational, and thus, contrast the change process depicted in much of the clinical and outcome literature, where the focus lies on symptom reduction and behavioral change (e.g., Herzog et al., 1999; Kordy et al., 2002). These women's experiences, and the conceptualization of recovery generated, reinforce the need for further, focused exploration of the relational dimensions of change. In particular, the identification of intimacy as a relevant aspect of the women's recovery experiences supports further exploration of the intimate partner relationships of women in recovery. In addition, given the study's focus on women with a lifetime diagnosis of BN, findings may not resonate to the same degree for women who have struggled with other eating difficulties and patterns, and thus, more inclusive research on women's recovery may add to the transferability of these findings.

Weaver, Wuest, and Ciliska (2005) conducted perhaps the most rigorous study of recovery, focused on the experiences of women who have recovered from AN. Similar to Peters and Fallon (1994), Weaver and colleagues conducted a grounded theory study informed by feminist theory, with the aims of situating women's subjective experience of recovery within the context of family, community, and society. Citing the limitations to extant research on recovery, they call for greater attention to women's voices, experiences, and meanings. Noting that research has tended to focus on "isolated elements...[constricting] the phenomenon of recovering into discrete variables" (p. 189), they pay particular attention to the social contexts and processes involved in recovery.

In their study, recovery is described as a process of "self-development," in which individuals move from "perilous self-soothing" with the ED, to "informed self-care" in recovery (p. 188). Women shift from a place of not knowing self, identity, or place in society, and as they begin to find themselves, are better able to engage more authentically with both self and others;

shifts from disengagement to engagement with others occurs. Importantly, Weaver and colleagues assert that this process of reconnection is largely contingent upon the availability and quality of supports. “Letting others in” is another phase of the recovery journey, and is associated with the women’s recognition that “they need help from others to recover further” (p. 198). The women in this study observed that relational support had the potential to decrease isolation, validate their identity as individuals beyond the ED, and help distract from ED related thoughts. Both affiliative support and instrumental support were identified by the participants as being helpful to their recovery. Affiliative support consisted of “feeling heard, validated, and ‘of concern’ and ‘of interest’ to others,” whereas instrumental support consisted of “financial, child care, clothing, and transportation resources” (p. 198-199). In keeping with women’s navigation and negotiation of close relationships throughout recovery, some women identified their need to re-structure relationships to meet their needs. Consistent with the literature, lack of support was thought to hinder one’s recovery process.

Although the authors situate recovery within social/relational contexts, little is said about how close others facilitate or hinder change, or the extent to which this occurs, leaving questions about these relational processes unanswered. For example, how might partners be involved in women’s processes of “self-differentiation,” “self-awareness,” and/or “self-regulation” (p. 192), key tasks of recovery. Indeed, noting that self-development was “adversely affected when [the women’s] environments lacked social or therapeutic support,” the authors suggest “that the type and degree of support offered by family, friends, and health professionals be further investigated,” offering support for the current study.

Another grounded theory study exploring the experience of recovery was conducted by D’Abundo and Chally (2004). Participants were women who felt that they had made progress in

their recovery efforts, and, similar to other studies, these authors relied on women's self-reported ED and recovery status. Results led to a model of ED development and recovery identified by the authors as the "eating disorder curve" (p. 1098). Within this model, recovery was depicted as a "circle of acceptance" (p. 1098), reflecting women's acceptance of the ED, and their spirituality and relationships, all of which are thought to cultivate feelings of self-worth. Findings shed light on women's perspectives on the development of the ED, namely, increasing severity of symptoms, their peak (i.e., most severe), and a turning point. "Turning points" (p. 1099) included specific events or people that prompted change for the women (D'Abundo & Chally, 2004). With respect to the relationships that helped initiate and support recovery, most women cited deep long-term relationships, including significant others or family members; in fact, according to study participants, relationships with close others were more common and influential than relationships with professional supports. While this may be due in part to the group of participants (i.e., self-reported ED, lower clinical severity and thus, less treatment contact), it affirms the central role that close others play throughout the process. Relationships were considered sources of unconditional love, support, trust, inspiration, and hope (p. 1101), with mothers, partners, and fathers being cited most often. The "ED curve" ultimately reflects a reduction in ED symptoms, during which time women re-connected with others, re-building social relationships (D'Abundo & Chally). While relationships permeated the women's recovery process, enhancing self-worth and supporting change, little is said about partner relationships, and there is little elaboration regarding the role relationships play or the nature of support provided/received.

Yet another grounded theory study of recovery from AN was conducted by Lamoureux and Bottorf (2005). Women in this study had a previous clinical diagnosis of AN, and at the time

of the research, self-identified as being recovered ( $N = 9$ ). In this particular study, trust in relationship was identified as a key factor throughout recovery. Trust created safety in relationships and support systems, which was deemed central to initiating and achieving change. According to the women in this study, “simply having trustworthy individuals around...wasn’t sufficient to begin [the] process.” Rather, it was “individuals who offered the women unconditional and unwavering support” that “assisted them in learning to trust and build courage to move cautiously from relying on anorexia to relying on trustworthy individuals” (p. 176). Having this consistent support from family and friends fostered a sense of emotional safety, which in turn, allowed the women to move forward with the daunting task of change. Indeed, feeling safe within support systems enhanced women’s capacity to be vulnerable and seen, decreasing their reliance on the AN. Some women noted that having close others (i.e., another perspective, another voice), as a counter to the AN voice, helped them sustain change; this co-occurred with increasing confidence in one’s own values, thoughts, and needs, and the ability to privilege these over external voices. An ongoing sense of unconditional acceptance from others, in which there were no expectations about how one should be, also helped increase self-acceptance and confidence. Setting boundaries and creating distance in some relationships proved important, and “reclaiming personal power” proved fundamental to the healing process (p. 178). These findings re-iterate a general theme contained in this body of research, namely, women’s ongoing process of navigating and negotiating intra- and interpersonal relationships, and the critical role of close others in cultivating the safety necessary for this process.

Overall, this body of research has strengthened conceptualizations of recovery as a long, ongoing, and challenging process, comprised of both intra- and inter-personal tasks. While close others are consistently cited as supports, there is seldom mention or elaboration of the specific

role that intimate partners may play or women's experience of the support they receive from others. Research has yet to focus on this particular dimension of women's recovery journey.

### *Social Support*

*Background.* Social support has an extensive history in the social sciences (e.g., House, Umberson, & Landis, 1988; Sarason & Sarason, 2009; Umberson, Crosnoe, & Reczek, 2010) and has long been associated with mental health outcomes (e.g., Corrigan & Phelan, 2004; Kessler, Price, & Wortman, 1984; Thoits, 1995). Social support and close relationships seem to play a particularly important role in the lives and wellbeing of women (e.g., Belle, 1987; Miller & Stiver, 1997; Taylor, Klein, Lewis, Gruenewald, Gurung, & Updegraff, 2000). For example, during times of stress women have been shown to seek connection (Taylor et al., 2000) and access more social support, from more diverse sources, than men (Belle).

Broadly speaking, research on social support has explored objective and subjective components (e.g., network size and density, satisfaction with support), including structures and processes (e.g., type and frequency of contact with social ties, nature of support; see House et al., 1988). Support has also been conceptualized and investigated within the context of relational or dyadic coping (e.g., Kayser, Watson, & Andrade, 2007). This distinct yet related body of research offers information about support processes unique to intimate partner relationships (e.g., partners' relationship to the problem, patterns of engagement or avoidance, independent or dyadic coping), particularly when coping with some form of physical or mental health concern (e.g., Kayser et al., 2007). The social support literature has shown that intimate relationships play an important role in adults' health behavior (Umberson et al., 2010), are a strong overall indicator of social support, and are associated with higher levels of perceived support (i.e., married individuals report higher perceived support) (Thoits, 1995). Research has also suggested



however, that those closely related to the individual requiring support may not provide optimal support given that they too are impacted by the stressor (Thoits), and that genders and spouses may differ in the types of support desired and deemed helpful (Kayser et al., 2007; see Thoits for review).

Studies on social support have relied predominantly on quantitative designs (e.g., non-experimental, longitudinal, cross-sectional, and retrospective) (House et al., 1988), and despite ample attention, the complexities inherent to this area of inquiry have resulted in mixed findings, numerous unanswered questions, and gaps in our knowledge (e.g., mechanisms through which social support may influence wellbeing, moderating and mediating factors, nature of support over time, personal meanings) (Sarason & Sarason, 2009; Thoits, 1995). However, a consistent finding has emerged, in that *perception* of social support has been reliably associated with mental health related outcomes. In particular, perceived emotional support has been linked to lower psychological distress and identified as a buffer in the face of negative events and chronic strains (Thoits, p. 70). This reinforces the importance of subjective measures and accounts of experience. Indeed, qualitative work, although significantly more limited, has been highlighted for its unique contributions to our knowledge base, including the ability to address the meanings individuals endow their social support experiences (Thoits).

*Social support in the area of eating disorders.* As previously stated, interpersonal relationships are often implicated in the onset, maintenance, and reduction of ED behaviors, and research suggests that close others can either hinder or promote recovery efforts and successful change. Specifically, research with recovered individuals has shown that strong social support can both initiate (Linville et al., 2012) and maintain change (Cockell et al., 2004). In particular, research has found that social support seeking at one-month post-treatment predicts outcome at

six months post-treatment. However, individuals seek less social support following treatment (i.e., compared to during treatment) (Binford, Mussell, Crosby, Peterson, Crow, & Mitchell, 2005). Seeking social support has been related to outcome at up to 2.5 years follow-up (Blok, Van Furth, Callewaert, & Hoek, 2004). Relatedly, difficulties within social relationships/social stressors have been identified as predictors of relapse for women with BN and EDNOS (Grilo et al., 2012). Research with a non-clinical sample has also suggested that low social support coupled with negative life events leads to increased bulimic symptoms (Bodell, Smith, Holm-Denoma, Gordon, & Joiner, 2011). Taken together, these findings illustrate the profound impact social interaction and supports may have on ED recovery efforts.

It is also important to note that the literature suggests that many women with an ED experience difficulty with their relationships (see Arcelus, Haslam, Farrow, & Meyer, 2013 for review). Some studies indicate that women with an ED are dissatisfied with the social support they receive (Grissett & Norvell, 1992; Rorty et al., 1999; Tiller et al., 1997), and seek less support and have smaller social networks than women without an ED (Tiller et al.). Conversely, some studies deny the presence of poor social support (Jacobson & Robins, 1989), claiming that many women are generally quite satisfied with their social support, are able to identify several support providers, and are able to obtain various forms of support (Marcos & Cantero, 2009). Research suggests a number of intra- and interpersonal factors that may be related to satisfaction with perceived social support, including overall psychological distress and interpersonal functioning (Geller et al., 2010b), and social support more generally, including anxiety, substance use, family self-concept, and importantly, having an intimate partner (Marcos & Cantero). Very little is known however, about what constitutes helpful support, what factors might facilitate the delivery of helpful support attempts (i.e., support that is perceived as helpful

and beneficial to the individual), and how this support may facilitate change. Overall, research on social support in the area of EDs remains extremely limited, in both breadth and depth, and knowledge of partner support in particular, is scarce.

Furthermore, existing research in this area is quite dated and suffers from a number of conceptual and methodological issues. For example, virtually all studies are grounded within a positivist paradigm of inquiry; have generally focused on discrete elements of this multifaceted construct, such as network size or degree of satisfaction with support; employed different definitions and measures precluding meaningful comparison of results; and relied on small sample size (Grissett & Norvell, 1992; Jacobson & Robins, 1989; Tiller et al., 1997). Findings have been quite mixed, doing very little to advance our understanding of social support experiences, particularly those that may promote successful recovery, and we lack a cohesive picture of women's experiences.

Early studies of social support in the area of EDs are rooted in (a) findings that women with BN report a number of interpersonal and social difficulties (e.g., Herzog, Keller, Lavori, & Ott, 1987), and (b) the growing body of theoretical and empirical literature on social support and health outcomes established during the 1980s (see Grissett & Norvell, 1992). Jacobson and Robins (1989) published one of the first studies in this area. They examined social dependency and social support, and characteristics thereof, in adult women (i.e.,  $\geq 18$ ) with BN ( $n = 23$ ) as compared to women with no ED ( $n = 38$ ). To measure social support, participants indicated the extent to which specific support behaviors were offered by others, over the past four weeks. They responded to another questionnaire assessing their thoughts and feelings in close relationship, as a measure of social dependency. Results revealed that women with BN reported higher social dependency, however, there were no differences between the two groups on

amount of social support received. Noting surprise that there were no differences in social support, given the often tumultuous relationships of women with BN, the authors attributed the result, in part, to the measure of social support (Jacobson & Robins). That is, items referenced a number of relationships, which may have obscured the identification of any specific relational problem; it focused on positive behaviors (i.e., negative interactions have been shown to be particularly salient in relation to ED symptoms; Grissett & Norvell, 1992; Sanftner et al., 2004); and, the measure aimed for an objective index, and did not assess perceived adequacy, quality, or satisfaction. Indeed, findings say little about women's experience of the support.

In another small study, Grissett and Norvell (1992) examined perceived support, quality of relationships, social skills, and psychological distress in a group of women with BN ( $n = 21$ ) as compared to women with no diagnosis ( $n = 21$ ). Women completed measures of perceived social support from family and friends, quality of relationships (i.e., depth, conflict, and support), social interactions (i.e., positive and negative; perceived impact and personal attributions), and social competence (i.e., discomfort in social situations) to assess their relational functioning. Contrary to previous findings by Jacobson and Robins (1989), results revealed that women with BN reported less support from family and friends; women in this study also reported less social competence and, after controlling for overall psychological distress, more negative interactions and conflict than women with no ED. Bulimic symptoms were correlated with the number of negative interactions, perceived impact of such interactions, and conflict, respectively (Grissett & Norvell), offering further support for the notion that negative interactions are of particular relevance in this group. A unique strength of this study was its inclusion of an objective measure of social competence. Participants were asked to role-play an interpersonal scenario with a trained confederate (blind to group status), and were then rated by observers (also blind to group

status) on various social competencies. Results of this analysis corroborated the self-report findings, revealing that observers deemed women with BN to be less interpersonally effective overall (Grissett & Norvell). Of note, neither of these two aforementioned studies were conducted with clinical populations or reported the types of relationships targeted in measures.

Tiller and colleagues (1997) conducted the first study of social support with a clinical sample, including both women with a diagnosis of AN ( $n = 44$ ) and BN ( $n = 81$ ), respectively. This study was also the first to assess perceived adequacy, quality, and amount of support together. Relationships with mothers, fathers, siblings, partners, and friends were included. Just under half the women with AN (44%), and over half the women with BN (66%) had a partner; no further descriptive information was offered about these relationships.

Results revealed that women with an ED reported less emotional and practical support than women without an ED ( $n = 86$ ; students<sup>10</sup>). With respect to support from specific providers, both women with AN and BN reported less support from friends, and women with BN, in particular, also perceived significantly less support from partners, parents, and siblings as compared to the control group. Women with an ED also reported lower levels of ideal support than the control group; moreover, women with AN had lower levels of ideal support from a partner than both other groups. The discrepancy score between *actual* and *ideal* support scores was used as an index of satisfaction. Women with BN were significantly more dissatisfied with support than the control group, and with respect to support from parents, were more dissatisfied than both groups. The authors note that such findings refute the notion of a global, negative perception of support (Tiller et al., 1997); moreover, support needs may differ by relationship.

---

<sup>10</sup> The authors note that using students as a control group may have led to greater differences given that students may be more socially connected, and thus, report higher levels of support than other sub-groups.

Results regarding satisfaction must also be considered in light of general expectations about support, as ideal scores influenced differences in satisfaction between ED groups. Finally, duration of illness was not correlated with social support. Overall, the social support experiences of women with AN and BN appeared similar, with a few exceptions specific to various support providers.

Extending this small body of research, Rorty, Yager, Buckwalter, and Rossotto (1999) examined relations among social support, social adjustment, and recovery status in adult women ( $M = 24.5$  years) with BN ( $n = 39$ ), women in remission<sup>11</sup> ( $n = 40$ ; remission for  $\geq 1$  year, criteria for remission not defined), and women with no history of ED or disordered eating ( $n = 40$ ). The authors collapsed husband, partner, and friends into one category (i.e., friends), which they compared with family on network size and type of support (i.e., thing, help, emotional support, and advice giving, respectively). With respect to the nature of support, the non-ED group reported more emotional support available from family than both BN groups; there were no group differences on the three other support dimensions. The women in remission and non-ED groups each had more friends available to provide support than the women with a current diagnosis, and these former groups did not differ from each other. With respect to satisfaction, there were differences between friends and family. That is, the non-ED group reported higher levels of satisfaction with emotional support from family than both BN groups, who did not differ from each other. There were no differences among the three groups however, with respect to satisfaction with emotional support from friends, or advice giving from either friends or family (Rorty et al.). Finally, the women in remission were equal to the non-ED group on several

---

<sup>11</sup> Given the heterogeneity in recovery criteria seen across the research, this group, for whom the average time in remission was 43 months, is arguably comparable to ‘recovered’ groups in other studies.

indices of social adjustment (i.e., social and leisure functioning), with both groups higher than the women with a current diagnosis; there were no group differences on work functioning however. The authors concluded that women with BN had greater social impairment than women with no history of ED, with women in remission generally falling in the middle; they suggest this reflects both improvement and residual problems, for women with a history of BN (Rorty et al., 1999). Notably, the primary area of difficulty for women with current or lifetime BN was emotional support, and both these groups were largely dissatisfied with their social support from family members, suggesting ongoing challenges with these relationships. Unfortunately, little information was offered about these target relationships, and information specific to partner support was lost in the collapsed/inclusive category of “friend support.”

In general, findings from Rorty and colleagues’ (1999) study were consistent with those of Grissett and Norvell (1992) and Tiller and colleagues (1997), regarding both network size and degree of satisfaction with support. Results differed from Jacobson and Robins’ (1989) however, who reported that women with an ED were not dissatisfied with support. Rorty and colleagues (1999) suggest this discrepancy may reflect differences in measurement; for example, Jacobson and Robins did not separate family and friends, and they focused on support received or enacted (i.e., objective versus subjective measure) (Rorty et al., 1999). Overall, findings from Rorty et al.’s study supplement previous work, affirming difficulty with family relationships and perceived support, and increase our understanding of the ways in which these various components of social functioning may compare for women who are currently struggling with an ED versus those who have reached a point of remission or recovery.

Following these initial studies, virtually no research was conducted on social support until more recently (e.g., Brown & Geller, 2006; Geller et al., 2010a, 2010b; Linville et al., 2012;

Marcos & Cantero, 2009), with some empirical attention being paid to overall social and interpersonal functioning, adjustment, and/or problems (see Arcelus et al., 2013 for review). Marcos & Cantero (2009) recently explored social support in a larger group of women ( $N = 98$ ). Including women with a diagnosis of AN ( $n = 60$ ), BN ( $n = 27$ ), and EDNOS ( $n = 11$ ) afforded another look at differences between these groups and further information about the experiences of women with AN, given that much research in this area has tended to focus on women with BN. This study employed questionnaires to examine multiple domains of support, including support provider type, number of support providers, satisfaction with support, type of support received (i.e., emotional, informative, practical), amount of support received, and intrapersonal factors associated with support (Marcos & Cantero). Unlike previous studies that assessed social support in general, this study focused on support in relation to a specific issue, in this case, the ED.

A number of results from this cross-sectional study are noteworthy. Consistent with other research (e.g., D'Abundo & Chally, 2004), mothers were the most frequently cited support figure, with partners second. Partners were included in the support networks of just over half the sample; of the women with partners, 73.1% cited their partner as a support, whereas 27% did not. The authors note the younger age of the sample ( $M = 20.8$ ,  $SD = 5.61$ ) as a possible reason for the lower number of women who did not include a partner in their network. Regarding satisfaction with support, over half of those in a relationship were very satisfied with support from partners. Interestingly, women in an intimate relationship had more support providers overall than the women who did not have a partner, and they received more support in terms of listening, finance, offers of help, and support from friends. The authors noted some differences in terms of type of support, between women living with their partner and those that did not.



Specifically, women who were not living with their partner received more practical support, and support overall, than both women living with their partners, and women without a partner. The authors also found that women's family self-concept was related to multiple dimensions of support. That is, the extent to which women had a secure sense of belonging and support with their family was positively correlated with the number of support providers cited, their satisfaction with support, and informative, emotional, and practical supports.

The most frequently endorsed support attempts were listening, encouraging, advising, and informing, respectively, and women with AN received more informing and accompanying actions than women with BN. With respect to differences by diagnosis, results revealed that women with AN had slightly more support providers than women with BN; there were no differences between these groups on satisfaction with support, however. These findings are somewhat dissimilar to Tiller and colleagues (1997) study, in which there were (a) no differences in number of support providers by diagnosis, and (b) differences in the extent to which women with AN or BN were satisfied with their supports. Overall, in this study, satisfaction with support was high. As previously discussed, measurement differences may account for some of the variability in findings across this body of research.

In efforts to increase understanding of women's social support experiences, a small body of research has begun to investigate factors associated with support satisfaction (Geller, Jones, Zelichowska, Dunn, Srikameswaran, & Lockhart, 2010a; Geller et al., 2010b). Preliminary research has found that the individual's level of distress and interpersonal style, respectively, influence her or his satisfaction ratings. In addition, results suggest that individuals living with an ED find collaborative support attempts, characterized by encouraging and concerned interactions, to be optimal. Conversely, directive support attempts characterized by unsolicited

opinions have been shown to be less helpful, and associated with lower satisfaction (Geller et al., 2010b). Despite seeming intuitive, the literature suggests that delivery of collaborative support attempts, despite recognizing their utility, is often challenging (Brown & Geller, 2006), and is likely tied to support providers' level of distress (Geller et al., 2010a; Perkins et al., 2004; Treasure et al., 2007a).

Taken together, studies on social support reveal a number of mixed findings. Some research suggests that women with an ED experience a range of difficulties, including limited social networks, less than optimal support from others, and negative interactions (Arcelus et al., 2013). Other research concludes that women have adequate support and are generally satisfied with the support received (Marcos & Cantero, 2009). Research method, that is, a general reliance on a positivist paradigm and cross-sectional design, has certainly influenced the current state of knowledge in this area. To this end, the literature supports the use of qualitative methods to not only contextualize women's experiences, but to increase understanding of the meanings they construct around support and its relation to their change efforts. Further, most research to date has focused on social deficits (Arcelus et al.), with less empirical attention to the aspects of social and interpersonal relationships that promote wellbeing and change. The question remains, what are women's experiences of support, namely, with their intimate partners, and how do these support experiences actually influence their recovery efforts?

### *Intimate Partner Relationships*

Similar to research on social support, the literature on women's intimate partner relationships reflects a surge of attention in the late 80s and 90s (e.g., Van den Broucke & Vandereycken, 1988), with very little subsequent work until quite recently (see Arcelus et al., 2012; Newton et al., 2005b). Overall, existing research on women's intimate partner

relationships in the area of EDs is limited in both breadth and depth. The literature is quite dated, is predominantly descriptive in nature, is focused on heterosexual women who are married (i.e., versus women in long-term, committed relationships), suffers from small sample sizes and lack of attention to diversity (e.g., racial and ethnic identities, cultural background of participants, sexual orientation), and frequently attends to the negative or problematic aspects of functioning. Further, reliance on positivist paradigms of inquiry has minimized the extent to which women's voices, perspectives, and meanings have been included.

Initial research in this area sought to substantiate theoretical and professional assumptions and/or speculation about the role of marriage in the onset and maintenance of EDs (see Van den Broucke & Vandereycken, 1989), negating exploration of women's subjective experiences and meanings, and the ways in which their relationships may offer support or impetus for change (i.e., as documented in the recovery related literature; e.g., Hsu et al., 1992; Tozzi et al., 2003). Specifically, building upon clinical observation and case reviews, early studies in this area investigated differences between married and non-married women with an ED on various clinical variables (see Van den Broucke & Vandereycken, 1988). Subsequent studies continued this line of inquiry (Kiriike, Nagata, Matsunaga, Tobitani, & Nishiura, 1996; Wiederman & Pryor, 1997), and explored differences in conflict resolution (Van Buren & Williamson, 1988; Van den Broucke, Vandereycken, & Vertommen, 1995a), relationship satisfaction (Van Buren & Williamson), husband's distress (Van den Broucke, Vandereycken, & Vertommen, 1994), marital intimacy (Van den Broucke, Vandereycken, & Vertommen, 1995b), and marital communication (Van den Broucke, Vandereycken, & Vertommen, 1995c), respectively, among couples in which one partner had an ED, maritally distressed couples, and non-distressed couples. All studies were quantitative, cross-sectional, descriptive, and very

small; moreover, many of these studies appear to have employed the same group of participants (e.g., Van den Broucke et al., 1995a, 1995b, 1995c).

More recently, research in this area has examined changes in the marital relationship over the course of treatment (Woodside et al., 2000), the impact of marital status (Bussolotti et al., 2002) and co-habitation on ED symptomatology (von Soest & Wichstrom, 2008), and experiences in romantic relationships (Newton et al., 2005a) and of intimacy (Newton et al., 2006), respectively, for women with AN.

*Early work: Exploring group differences.* In efforts to empirically examine the clinical and theoretical claims regarding the role of the marital relationship in EDs permeating the literature at the time (e.g., more married women presenting for treatment, poor outcomes for this group, marriage as a maintaining factor; see Van den Broucke & Vandereycken, 1988) Van den Broucke and colleagues conducted a series of studies. In their research, they compared couples in which one partner had an ED, couples identified as maritally distressed (i.e., seeking marriage counselling, high scores on a measure of marital distress), and non-distressed couples (i.e., recruited from the community, low scores on measures of psychiatric symptoms and marital distress), on a number of clinical and relational domains, including conflict resolution, communication skills and style, relationship quality and satisfaction, intimacy, and husband's distress (Van den Broucke et al., 1994; Van den Broucke et al., 1995a, 1995b, 1995c). Of note, these researchers found no differences among the women by diagnosis, and thus, all diagnostic subgroups were included in one group, in each respective study. Furthermore, these authors did not typically report participants' heterosexual orientation, nor did they report cultural background.

Regarding relationship satisfaction, findings were somewhat mixed. In the first of these studies, Van Buren and Williamson (1988) found that women with an ED were less satisfied with their relationship than married women in a control group comprised of couples not seeking any professional treatment. Subsequently, Van den Broucke and Vandereycken (1989) found differences with respect to satisfaction with sexual and social aspects of one's relationship, but no group differences on *global* satisfaction. More recently, one study demonstrated that women's satisfaction with their marriage increases over the course of hospital day treatment (Woodside et al., 2000). In this latter study, women ( $n = 22$ ) reported lower satisfaction, as assessed by a measure of marital intimacy, at both pre- and post-treatment (i.e., 8 -14 weeks duration), as compared to their partners ( $n = 22$ ) (Woodside et al.). In contrast to their partners however, the women experienced an increase in satisfaction or perception of marital intimacy, as ED symptoms decreased. A closer look at women's perceptions of their relationship offers support for the notion that women and their partners may find specific aspects of their relationship more or less adequate; that is, both partners indicated they were significantly less satisfied with the affection, their sense of identity, and their sexuality, within the relationship. Considered together, results from these few studies suggest that although there is certainly heterogeneity in women's experiences, for many, there appears to be a general dissatisfaction in one's marital relationship; this seems particularly true for certain aspects of one's relationship, suggesting that specific domains of relational functioning may be fueling dissatisfaction. Relatedly, differences in measurement likely contributed to these results.

Similar discrepancies in terms of findings have emerged with respect to husband's distress. Specifically, initial efforts to explore husbands' perspectives on their marriage suggested that husbands experienced more distress than men in a normative sample (Van den

Broucke & Vandereycken, 1989), however, further research suggested otherwise, revealing no differences from men in non-distressed marriages (Van den Broucke et al., 1994). These latter results are surprising given that clinical (Leichner et al., 1985) and empirical literature (Huke & Slade, 2006; Perkins et al., 2004) indicates that partners experience significant distress in response to their loved one's ED. That being said, this latter research is qualitative, and to date, these earlier studies remain the only controlled comparisons of partner experiences (i.e., partner experiences are discussed further below).

With respect to communication and conflict resolution in the marital relationship, a number of patterns emerged across these early studies. In a self-report, questionnaire study, Van Buren and Williamson (1988) found that women with BN ( $n = 12$ ) tended to use less problem solving skills, and engage in greater avoidance or withdrawal from conflict, than women in their control group ( $n = 15$ ). In two more comprehensive studies involving both self-report questionnaires and direct observation, Van den Broucke and colleagues (1995a, 1995b) found that couples in which one partner had an ED ( $n = 21$ ) displayed less positive behavior than non-distressed couples ( $n = 21$ ), but less negative behavior than distressed couples ( $n = 21$ ), during conflict resolution (Van den Broucke et al., 1995a). Results from a second study on communication processes, focused on basic communication skills (i.e., speaking and listening), non-verbal communication, and equality and reciprocity in dialogue, supplement the aforementioned findings (Van den Broucke et al., 1995b). Results from this second study affirmed greater negative verbal and non-verbal communication than non-distressed couples, and less negative communication than the distressed couples. Considering their findings together, the authors suggested a pattern of communication whereby these couples “neutralize conflicts,” that is, as one partner's communication becomes increasingly negative, the other attempts to

moderate; however, in the absence of more positive behavior (i.e., relative to non-distressed couples), overall communication is hypothesized to lack the same effectiveness as seen with non-distressed couples (Van den Broucke et al., 1995a, 1995b).

*Relational status and clinical presentation.* Research has also examined differences between married and single women with an ED, with respect to a number of clinical and psychosocial domains (Kiriike et al., 1996; Wiederman & Pryor, 1997). Notably, these studies do not report participants' sexual orientation. Kiriike and colleagues (1996) in Japan found no differences in ED symptomatology between married ( $n = 40$ ) and unmarried women ( $n = 22$ ). Wiederman and Pryor (1997) replicated these results in a much larger study ( $N = 314$ ). Specifically, these authors found that after controlling for age, there were no differences in symptomatology between the women who were married and those who had never been married. Bussolotti and colleagues (2002) conducted a similar, yet more comprehensive study, and obtained different results. This group distinguished among (a) women living with a stable partner ( $n = 41$ ; minimum of 6 months), (b) women in a stable relationship but not co-habiting ( $n = 129$ ), and (c) women with no partner ( $n = 162$ ). Results revealed that women living with their partner were more symptomatic; these women were also older however, suggesting longer duration of illness. Women with a partner were also more motivated to recover than women without a partner. Relatedly, women with a diagnosis of BN were more motivated for change than those with a diagnosis of AN (Bussolotti et al., 2002). von Soest and Wichstrom (2008) conducted the first longitudinal study examining associations between ED symptoms and relationship status, namely, co-habitation. Findings from this study depict a different picture than Bussolotti et al., as co-habitation with a partner was shown to reduce certain bulimic behaviors. Specifically, co-

habitation led to a reduction of bingeing and purging behavior, leading the authors to assert some support for the role of social control (von Soest & Wichstrom, 2008).

Given the preliminary and thus limited nature of this body of research, many questions remain about the exact role that women's intimate partner relationships may play in the course of their ED and recovery. For example, in what ways might this relationship motivate recovery, and how do the women themselves view their relationship as influencing their symptoms?

*Women's experiences in romantic relationships.* Newton and colleagues have advanced our understanding of women's experiences in intimate partner relationships, conducting the first qualitative studies in this area (Newton et al., 2005a, 2006). Their phenomenological research on romantic relationships speaks to processes of connection and disconnection in romantic relationships (Newton et al., 2005a), and depicts experiences of intimacy for women living with AN (Newton et al., 2006). These authors found that relational engagement with partners occurs within the context of trusting and comforting relationships, as women feel understood and supported, and that this experience is facilitated by open dialogue. Conversely, relational disengagement or distancing occurred as women felt afraid of judgment and rejection, and as secrecy and one's focus on the ED pervaded (Newton et al., 2005a). These authors' research has also revealed the importance of emotional and physical closeness, and companionship to women's experience of intimacy (Newton et al., 2006). For the participants in Newton et al.'s studies, emotional closeness was characterized by feelings of trust and acceptance, feeling "known," and "partner congruence" (e.g., sense that partner is also contributing to the emotional closeness of the relationship) (p. 46). These qualities enabled the women to share their experiences with their partner, which was key to their experience of emotional closeness and engagement in the relationship (Newton et al., 2005a, 2006). Newton and colleagues' also found



that for women with families, mutual investment and shared goals around parenting contributed to closeness in the relationship.

Given the focus on women diagnosed with AN however, a gap remains with respect to the experiences of women whose ED symptoms do not meet this particular classification, including women with bulimic symptoms. Given the higher prevalence of BN and EDNOS in adult populations (APA, 2000), research including women with these particular difficulties is necessary. This seems warranted given the findings that women with BN, specifically, have less overall support (Marcos & Cantero, 2006) and greater dissatisfaction with social support (Tiller et al., 1997) than women diagnosed with AN. Furthermore, although Newton and colleagues' (2005a, 2006) work contributes significantly to the dearth of research in this area and advances understanding of women's subjective experience in intimate relationships, both of these publications stem from the same study and group of participants. Several other issues related to these studies warrant attention. For example, two of the eleven participants had not been in an intimate relationship, and thus, spoke to this experience, and 'expectations' about the phenomenon of intimacy (i.e., problematic in light of the phenomenological method employed). Furthermore, for those women in previous or current relationships, the duration of relationships was highly varied, ranging from weeks to several months; four women were in longer-term relationships (i.e.,  $M = 3.5$  years; ED preceded relationship in 50% of the women) (Newton et al., 2006). As such, only four women were in long-term, committed relationships during the course of their ED and recovery. The authors did not address the ways in which this heterogeneity may have influenced their findings. Finally, in a significant omission, the authors did not state the sexual orientation of their participants, leaving it unclear whether the group was comprised of

heterosexual women or whether there were any participants of sexual minority orientation, and/or same sex relationships.

*Partner experiences.* Research exploring the experiences of family, partners, and friends, often referred to inclusively as “support providers” or “carers,” offers additional perspective on the immediate relational contexts of women living with an ED (Highet et al., 2005; Huke & Slade, 2006; Leichner et al., 1985; Martin et al., 2011; Perkins et al., 2004; Raenker et al., 2013). The literature suggests that, in light of the serious medical and emotional sequelae of the ED, support providers often experience significant concern and distress (Perkins et al., 2004), which may unintentionally impact their ability to offer optimal support (Geller et al., 2010a; Treasure et al., 2007a).

Several studies have explored the effects of caring for a loved one with a serious ED. This work has explored the impact of being in this role (Dimitropolous et al., 2008; Martin et al., 2011), the experiences (Highet et al., 2005; Perkins et al., 2004; Raenker et al., 2013) and needs (Graap et al., 2008; Winn et al., 2004) of support providers, and established professional interventions to aid both family and women with the recovery process (Treasure et al., 2007a). In their study of care provider experiences of supporting someone with an ED, Perkins and colleagues (2004) highlighted the pervasive and consistent impact that this role, the ED, and the relationship can have. For example, participants reported a range of emotional and physical responses to the ED and their loved one’s struggle, including self-blame, frustration, anger, worry, overwhelm, fear, and guilt (p. 261). Some found it very difficult to cope with their loved one’s illness and reported the toll it took on their own physical health. Indeed, Graap and colleagues’ (2008) findings were consistent with Perkins et al.; Graap et al. reported that care providers experienced high levels of anxiety and depression, exhaustion, and in some cases,

physical health concerns, given the stress imposed by their loved one's ED. Unfortunately, this body of research has focused on family, with little explicit focus on committed, romantic relationships (i.e., spouses and partners). Raenker and colleagues' (2013) sample was sufficiently large to compare partner ( $n=28$ ), mother ( $n=144$ ), and father ( $n=80$ ) experiences, although the highly disproportionate number of parents remains consistent with other research (Dimitropoulos et al., 2008; Martin et al., 2011; Perkins et al., 2004). They found that partners did not differ from parents on a measure of the overall impact of the ED, and partners and mothers experience similar levels of distress and time spent "caregiving" (e.g., engaged in tasks related to organizational, practical, food, and medical care, respectively; and emotional support; p. 351). This is comparable to other research reporting similarities between partners' and mothers' experience of the impact of the ED and being in a supporting role (Martin et al.). However, results from this study showed that partners receive less support than parents, and rated this support less favorably, and are thus thought to be more isolated and in need of supports (Raenker et al.).

Findings from the above body of research supplement the paucity of research on partner experiences, specifically (Huke & Slade, 2006; Leichner et al., 1985; Van den Broucke et al., 1994). Leichner and colleagues' (1985) descriptive study of partner experiences in a support group indicates that partners often struggle with feelings of frustration, and uncertainty about how to best support their partner (Leichner et al.). Huke and Slade (2006) conducted a qualitative study focused on partner experiences, and found similar results to the body of research on "carer" experiences outlined above, echoing the sense of powerlessness that partners may feel in response to the ED. Specifically, Huke and Slade (2006) employed an interpretive phenomenological analysis to understand the experience of living with an individual with BN

( $N=8$ ). They reported the following main themes characterizing partners' experiences: "living with the secrecy and deception," "struggling to understand and find reasons," "discovering your powerlessness," "it's like growing to live with it," and "experiencing strains and strengths in relationship" (p. 439). They reported that despite wanting to provide support, partners often struggled to do so. Importantly, these authors noted partners' perception of strengths in their relationships, highlighting the potential role partners can play in supporting their loved one, and expanding the largely negative picture of these relationships to acknowledge the presence of inherent resources (Huke & Slade, 2006). Finally, Van den Broucke and colleagues (1994) compared the distress levels of husbands' of women living with an ED ( $n=21$ ), husbands in non-distressed couples (i.e., absence of psychological and marital distress;  $n=21$ ), and husbands in maritally distressed couples (i.e., couples seeking therapy;  $n=21$ ). Results revealed no differences in the levels of psychological distress reported by husbands of women living with an ED and husbands in non-distressed couples; both groups reported less distress than husbands in the maritally distressed group, which appeared to be accounted for by this latter group's interpersonal style, as opposed to their symptoms of psychological distress per se (i.e., measurement issue; Van den Broucke et al., 1994). These results reflect a different picture than the majority of the literature on partner experiences, which has been qualitative in nature, and must be seriously considered given that this study represents the only controlled investigation of partner distress.

As a whole, the literature has shown that as a result of reported distress, and despite having good intentions, family members, partners, and close friends often struggle to support their loved one in making desired changes (Graap et al., 2008; Huke & Slade, 2006; Leichner et al., 1985; Treasure et al., 2007a; Winn et al., 2004). Care providers report the highly challenging

task of determining what to say, how to say it, and when to say it, in terms of offering support and feedback (Perkins et al., 2004), and interpersonal communication has been highlighted as an area of significant difficulty (Graap et al.). For example, research has shown that high expressed emotion, namely, interactions characterized by expressions of negative emotion and criticism, may in fact perpetuate the ED behaviors and thus, hinder change (see Treasure et al.). Given the sensitive nature of the issues involved, and the functional benefits and egosyntonic nature of many EDs (Vitousek et al., 1998), navigating the recovery process for both the individual herself and her family, friends, and partner can be extremely challenging. Coupled with the aforementioned reports that support providers, including partners, commonly experience negative emotions and have strained communication with their loved one (Graap et al.; Leichner et al.; Huke & Slade, 2006; Perkins et al.; Van den Broucke et al., 1995a, 1995b), this finding suggests a tenuous and powerful relational climate capable of significantly impacting ED recovery.

A small program of research has begun to investigate the characteristics and support styles of family members, partners, and friends, with the aim of identifying factors related to helpful social support (Brown & Geller, 2006; Geller et al., 2010b). Preliminary findings have shown that, despite recognizing that collaborative support attempts are optimal, that support providers frequently use directive approaches (i.e., are less collaborative than they hoped to be) (Brown & Geller, 2006). There is also some evidence to suggest that this discrepancy between what is believed to be supportive versus what is actually enacted may be related to distress; that is, multiple regression analyses revealed that high discrepancy between beliefs about support and support behaviors was associated with anxiety (Geller et al., 2010b). This work has also begun to explore potential differences among mothers, fathers, and partners, with respect to their

experiences supporting their loved one. Results of an initial analysis revealed that these support providers did not differ in the types of support offered to their loved ones (Geller et al., 2010a).

*Relational-Cultural Theory: Perceived mutuality in partner relationships.* As previously discussed, RCT has been proposed as a framework for understanding women's experience of, and recovery from, an ED (e.g., Sanftner et al., 2004; Tantillo & Sanftner, 2003). As a theory of women's psychological development and wellbeing, RCT locates psychological distress within the context of close interpersonal relationships (Miller & Stiver, 1997). To this end, RCT views acute and/or enduring disconnections and connections in one's close relationships as etiological and recovery related factors, respectively, in the course of disordered eating and EDs (Tantillo & Sanftner, 2010; Tantillo, 2000). Although published research in this area has been very limited, conducted predominantly by one group of researchers (Sanftner et al., 2006; Sanftner et al., 2004; Tantillo & Sanftner, 2003), studies have revealed preliminary support for RCT's fundamental tenets. Research to date has explored associations between perceived mutuality in close relationships (e.g., mother, father, partner, friend) and a range of ED and related outcomes. For the most part, studies have been cross-sectional, employing correlational designs, and only one study has examined PM in romantic relationships for women with an ED (Sanftner et al., 2004). There is one additional study with college women however, that included assessment of PM in romantic relationships (Wechsler et al., 2006).

In their pilot investigation of perceived mutuality in the area of EDs, Sanftner, Tantillo, and Seidlitz (2004) found that adult women with an ED ( $n = 35$ ) had lower PM in relationships with both partners and friends, compared to women without a psychological diagnosis ( $n = 39$ ). Twenty-one women in the ED group had partners, and thus, completed the *Mutual Psychological Development Questionnaire* (MPDQ; Genero et al., 1992) for this relationship; women without

partners completed the measure for a close friendship. The authors also found a significant difference between the groups for the negatively valenced items of the MPDQ, that is, items describing negative relational qualities, feelings, and/or characteristics of less mutual interactions. This led the authors to speculate that “lack of connection” (p. 95), that is, relationships and interactions with less mutual empathy and feelings of empowerment may be particularly salient for women with an ED. Notably, 69% of the women in the ED group had a concurrent diagnosis of depression, and after controlling for depression, a significant difference between the two groups on the negatively valenced items remained. This finding is congruent with RCT’s position that disconnection in relationship is associated with psychological distress, and lends some support to this notion within the area of EDs, specifically. Results also revealed that PM with friends was a stronger predictor of ED symptoms than PM with partners. The authors acknowledged the surprising nature of this finding, given the literature suggesting the challenges often encountered in the romantic relationship, but were limited in their ability to explain this finding, as they had little further data about the sample and their overall relational functioning and experiences. Further research exploring the role of partners and respective relationships has been recommended (Sanftner et al.), including the use of other methodologies capable of accessing other dimensions of, or perspectives on, women’s relational experiences (Sanftner et al., 2006).

Three studies with non-clinical, student populations have followed, each with a larger sample size ( $N = 397$ , Sanftner et al., 2006;  $N = 102$ , Sanftner et al., 2009;  $N = 149$ , Wechsler, et al., 2006) and thus, greater inclusion of partner relationships. Both studies by Sanftner and colleagues (2006, 2009) reported an inverse relationship between perceived mutuality in one’s relationship with a romantic partner and body image concerns. In the first of these studies, low

perceived mutuality with one's partner ( $n = 238$ ) was related to a number of ED related issues, including body dissatisfaction, feelings of ineffectiveness, impulse regulation, and social insecurity (Sanftner et al., 2006). In the second study, low perceived mutuality with one's partner was also related to body dissatisfaction (Sanftner et al., 2009). Wechsler, Riggs, Stabb, and Marshall (2006) examined relations among perceived mutuality with one's partner, self-silencing, and eating disorder related symptoms ( $n = 105$ ). As one might expect, low PM was associated with self-silencing, interpersonal distrust, and interoceptive awareness, however, contrary to previous findings, PM was not significantly related to body dissatisfaction (Wechsler et al., 2006). Wechsler and colleague's inclusion of "self-silencing" as a relational construct to be explored within the context of women's intimate partner relationships extends previous work in this area in theoretically meaningful ways. "Silencing the self," that is, denying one's thoughts, feelings, and experiences within the context of a close relationship, and thus, relying on external information and others for self-regulation, has been implicated in RCT's general conception of psychological distress and health. Specifically, the "central relational paradox" espoused by RCT, posits that women disconnect from their sense of self in order to maintain connection in close relationships (Miller & Stiver, 1997, p. 81). Theoretically, recovery is associated with reconnection to self and others, a process that has been articulated in the recovery related research (e.g., Peters & Fallon, 1994; Weaver et al., 2005).

#### *Summary and Re-statement of Rationale for the Current Study*

Research on women's recovery process, social support, intimate partner relationships, and RCT all implicate close others, including partners, in recovery from an ED. In fact, it is documented across these bodies of research that many adult women identify their partners as key supports. As one moves beyond the qualitative research on recovery however, into the literatures



on social support and intimate relationships, numerous gaps in knowledge become evident. While elements of women's social context and interpersonal functioning have been examined within a positivist paradigm, contextualized perspectives and approaches privileging women's lived experience and meanings are largely absent. Consequently, the nature and depth of our knowledge regarding support experiences remains limited. Based on the literature reviewed herein, it is argued that further, focused inquiry into women's experiences of, and meanings around, intimate partner relationships and support during recovery is a critical next step in developing both academic and clinical knowledge relevant to women's healing and wellbeing.

### Chapter 3: Method

The current study employed a hermeneutic phenomenological method to explore adult women's experience of their *intimate partner relationships in supporting recovery from an eating disorder* and the meanings they ascribe to this experience. The research question guiding inquiry was: **“what is the meaning of lived experience of intimate partner relationships in supporting women's recovery from an eating disorder?”** A hermeneutic phenomenological method of inquiry is well suited to answering this research question and obtaining a rich, deep understanding of women's lived experiences, and the meaning they ascribe to such experiences. Hermeneutic phenomenology is also indicated when investigating an understudied phenomenon, such as women's experiences of their intimate partner relationships during recovery. Further, hermeneutic phenomenology contextualizes women's experiences and privileges the daily, taken-for-granted experiences often overlooked in both clinical and academic literature, affording new perspectives and knowledge regarding the phenomenon of interest.

#### *Ontological and Epistemological Positions*

The current research adopted a critical realist ontological perspective (Denzin & Lincoln, 2005; Finlay, 2009; Martin & Sugarman, 2001; Sims-Schouten, Riley, & Willig, 2007) and a hermeneutic epistemological position (Martin & Sugarman, 1999; Packer & Addison, 1989b). In adopting these positions for the research, I aimed to integrate the embodied, phenomenological experiences of the participants (i.e., pre-reflexive experiencing), while acknowledging the multiple influential contexts within which these women are embedded (e.g., social, cultural). I view these as intersecting dimensions of knowledge construction, as detailed below.

*Critical realism.* Denzin and Lincoln (2005) have described “critical realism” as a “transcendental realism that rejects methodological individualism and universal claims to truth,”

(p. 13) that views knowledge as socially constructed. In their comprehensive review, Danermark and colleagues (2002) explain that “critical realism” holds that there “exists both an external world independently of human consciousness, and at the same time a dimension which includes our socially determined knowledge about reality” (p. 5-6). The term “critical” within the current study follows from Danermark’s definition. This stance reflects a middle ground, a balance between essentialist and anti-essentialist, and realist and relativist positions, respectively. Martin and Sugarman (2000) argue that a critical realist ontological perspective affords recognition and integration of facets of both positivism and postmodernism, as they inform paradigms of inquiry in psychology (Martin & Sugarman, 2000). Finlay (2009), in her review of phenomenological methods, echoes this stance. She highlights the paradigmatic challenges and decisions faced by phenomenological researchers, and argues that phenomenologists must “go beyond the lines drawn by both modernism and postmodernism embracing both and neither” (p. 17).

The study’s ontological and epistemological positions are grounded predominantly in the work of Martin and Sugarman (1999, 2000, 2001) and Packer and Addison (1989a, 1989b), whose work draws fundamentally from the philosophy of Heidegger and Gadamer. Martin and Sugarman privilege the pre-reflexive, existential phenomenological human experience as a means of knowing, while necessarily locating that individual experience within broader sociocultural and historical contexts. As noted, Martin and Sugarman’s work is rooted largely in Gadamer’s philosophical hermeneutics (see Annells, 1996; Gadamer, 2004), and draws on Packer and Addison’s application of hermeneutic philosophy within the discipline of psychology (Packer & Addison, 1989b).

*Philosophical Hermeneutics and the Hermeneutic Circle*

Philosophical hermeneutics, the practice or process of interpretation, can be traced to the works of Martin Heidegger and Hans-Georg Gadamer (see Annells, 1996; Lopez & Willis, 2004; Langdridge, 2007). Gadamer's philosophical hermeneutics emphasizes the relationship between interpretation and understanding, the embedded nature of understanding within historical and sociocultural contexts, and the concept of the hermeneutic circle (Annells, 1996; Langdridge, 2007; Packer & Addison, 1989b). Gadamer held that knowledge and meaning are co-constructed, as individuals engage in dialogue, with language privileged as fundamental to understanding (Annells). Through dialogue, a "fusion of horizons" occurs, in which one's "prejudices" (i.e., considered by Gadamer to be one's pre-judgement or fore-understanding; Annells, p. 707) meet the other's perspective (e.g., research participant) or horizon, resulting in a broadening of understanding (Annells). Central to the philosophy of both Heidegger and Gadamer is the "hermeneutic circle," which can be thought to symbolize the "dynamic movement between the parts and the whole...within the seeking of understanding" (Annells, p. 707). Relatedly, notions of the "life world" and "being in the world" are key tenets (Lopez & Willis, 2004, p. 729), and speak to the inextricable relation between one's personal horizon, entrance to the hermeneutic circle, and meaning making process (Annells; Lopez & Willis; Packer & Addison).

Packer and Addison (1989a, 1989b) extend these ideas to the discipline of psychology and related methods of inquiry. As previously noted, hermeneutic psychology and methods of inquiry are concerned with the way in which the researcher enters the hermeneutic circle (Packer & Addison, 1989a). The researcher must approach a phenomenon of interest, of inquiry, with a "concerned engagement" (see Martin & Sugarman, 2001, p. 202). She will bring forth all of her

preliminary understandings, beliefs, assumptions, knowledge; all of which constitute her “horizon of meaning.” As she enters the hermeneutic circle, to seek what is yet unknown (i.e., from her current place of knowing), she sets out on a forward arc of projection, to establish a new point of view (Packer & Addison, 1989b). As she meets another horizon of experience and meaning, a fusion of horizons occurs (i.e., intersubjectivity) (Lopez & Willis, 2004; Martin & Sugarman) and meaning is constructed. Meaning construction is circular and reciprocal. It reflects an ongoing dialectic of parts and whole (i.e., obtaining new parts and assessing these against the whole, moving between what is known and what is yet unknown; Martin & Sugarman; Packer & Addison, 1989a, 1989b). It is in the backward arc that evaluation occurs; the researcher considers the meaning in relation to her ‘whole,’ her knowledge and pre-understanding (Packer & Addison, 1989b). Hence, the interpretive/hermeneutic epistemological position informing the current study holds that meaning emerges within a relational, intersubjective context, co-constructed through language as the researcher and participants engage in research conversations (Packer & Addison 1989a).

### *Phenomenology: Historical and Epistemological Developments*

As a method of psychological inquiry, phenomenology has a strong and extensive philosophical foundation. Rooted in the work of Edmund Husserl, phenomenology has been elaborated and extended by philosophers who would both converge with and diverge from Husserl’s original views (Langdrige, 2007). Consequently, phenomenology as an approach to inquiry has evolved in significant ways, with respect to epistemological and ontological assumptions and associated methodological implications.

Husserl’s phenomenological method aims to identify and describe the essential structures of a phenomenon (Langdrige, 2007). Husserl believed that one could “bracket” experience and

knowledge, and thus “set aside [one’s] natural attitude” in order to perceive the phenomenon as it appears (Langdridge, p. 17). Husserl’s descriptive or transcendental phenomenology has a long and well-established history within the field of psychology and remains widely used today (Creswell, 1998; Creswell, Hanson, Plano Clark, & Morales, 2007), whether authors have stated this explicitly or not (i.e., frequent omissions exist in the literature, regarding studies’ epistemological and ontological assumptions; see Wertz, 2005). It has been argued that descriptive phenomenology, and in many cases its post-positivist epistemology, remains “too close to describing meaning as expressed by the participants and [fails] to take this further through interpretation” (Langdridge, 2007, p. 158). Indeed, from a hermeneutic epistemological perspective, descriptive or empirical phenomenology may also be critiqued on epistemological grounds, for failing to account for what is conceived to be the inherent interpretive process of meaning construction. Hence the philosophical and epistemological shifts that ultimately expanded, and departed from, Husserl’s original approach (e.g., the work of Heidegger, Merleau-Ponty, and Ricoeur, respectively). Such shifts are evidenced perhaps most saliently in the work of Heidegger, who was interested in understanding the meaning of being in the world and interpreting lived experience. As previously stated, Gadamer’s philosophy aligned closely with Heidegger’s, with each forming the foundation for hermeneutic phenomenology (Annells, 1996).

### *Hermeneutic Phenomenology*

Comparing descriptive and hermeneutic phenomenology, Lopez and Willis (2004) emphasize the hermeneutic goal of extending beyond “mere descriptions of core concepts and essences to look for meanings embedded in common life practices” (p. 728). This reflects the core epistemological and methodological distinction between the two approaches to phenomenology. In hermeneutic phenomenology, the researcher aims to “grasp the essential

meaning” of the phenomenon, that is, to determine and depict “the structure of meaning of the lived experience...to effect a more direct contact with the experience as lived” (van Manen, 1997b, p. 77-78).

As previously discussed, hermeneutic phenomenology stems largely from the phenomenological philosophy of Heidegger and Gadamer (Annells, 1996; Langdridge, 2007), and is therefore located within an interpretive/constructivist paradigm of science (Annells; Haverkamp & Young, 2007; Ponterotto, 2005). Accordingly, knowledge is considered to be co-constructed between the researcher and participant, each situated within her own broader historical, sociocultural, and political contexts. Within this framework of understanding, meaning is thought to emerge in dialogue or conversation between individuals, who each bring forth their own individual fore-knowledge (Haverkamp & Young; Langdridge; Packer & Addison, 1989a). That is, “the interpretive, meaning-giving researcher and the phenomenon as described by the meaning-making participant [co-constitute] one another” within the hermeneutic process (Hein & Austin, 2001, p. 14). As such, it is recognized that my interpretive frame is an inextricable part of the construction of meaning in this study.

There have been claims that hermeneutic phenomenology is becoming increasingly prevalent as a method of inquiry within psychology (Hein & Austin, 2001; Langdridge, 2007; Smith, 2004). van Manen (1997a, 1997b, 2006) is often cited as a central figure in the development of hermeneutic phenomenological methods [e.g., Earle (2010); Hein & Austin; Langdridge], and his approach guides the current study. van Manen (1997b) proposes the following six steps for conducting a hermeneutic phenomenological inquiry:

- (1) turning to a phenomenon which seriously interests us and commits us to the world,
- (2) investigating experience as we live it rather than as we conceptualize it, (3)

reflecting on the essential themes which characterize the phenomenon, (4) describing the phenomenon through the art of writing and rewriting, (5) maintaining a strong and oriented pedagogical relation to the phenomenon, and (6) balancing the research context by considering parts and whole. (p. 30-31)

Employing a hermeneutic phenomenological method, I aimed to “identify and provide an understanding of the variety of constructions that exist about a phenomenon” (Annells, 1996, p. 708), that is, women’s experience of intimate partner relationships in supporting recovery from an ED. Prior to further description of the method, consistent with a hermeneutic perspective, I situate myself as the primary researcher.

*Researcher Positionality and Subjectivity: Reflexive Practice*

Researcher subjectivity, or positionality, is an integral component of conducting qualitative research (Finlay, 2002; Haverkamp, 2005; Langdridge, 2007; LeVasseur, 2003; Morrow, 2005; Tracy, 2010), particularly, hermeneutic/interpretive research (Geanellos, 1998a, 1998b). My statement of positionality is articulated below, and subjectivity was thoroughly explored and addressed as I conducted the study, through use of reflexive questions, journaling (i.e., personal and research journals), and conversations with colleagues and supervisors.

Within the context of a hermeneutic phenomenological study, the aims of initial reflexive practice are twofold: (a) to elucidate the researcher’s/my natural attitude (i.e., lack of curiosity) (LeVasseur, 2003), and (b) to increase awareness and insight around the ways in which the researcher’s/my subjectivity and positionality may influence the co-construction of meaning (Lopez & Willis, 2004). To be clear, these efforts are to be distinguished from those employed in descriptive phenomenology, where the aim is to “bracket” one’s views (e.g., Champlin, 2009) in order to preclude influence on analysis. Rather, the aim of these tasks, from a hermeneutic



approach, was to bring my knowledge, biases, beliefs, assumptions, and expectations into consciousness, reflect on them, and consider the ways in which they would influence both my interviewing and interpretation of the texts (Geanellos, 1998b). To this end, identifying and reflecting on pre-understandings and forestructures constitute the initial phase of interpretation within the context of a hermeneutic method. Citing Gadamer's work, Geanellos (1998b) states that pre-understandings may have a facilitative or hindering influence on the researcher's interpretive practices. However, by identifying and examining one's pre-understandings, the researcher optimizes their facilitative potential. That is, by considering "their origin, adequacy and legitimacy in relation to: (i) the phenomenon under investigation; and (ii) textual interpretation" (p. 243) she increases the likelihood that the phenomenon will reveal itself (i.e., she maintains an openness to it). Conversely, in the absence of diligent examination of pre-understandings, the researcher is at risk of finding or 'seeing' what she already expects or assumes she will find, in relation to the phenomenon; this may manifest as leading participants during interviews or identifying statements and themes that confirm one's beliefs during data analysis (Geanellos, 1998b). As such, the primary aim of this initial and ongoing reflexive practice is to prevent "premature interpretive closure" (Geanellos, 1998a, p. 157) through all phases of the research, and maintain an open and curious stance, affording the phenomenon the opportunity to reveal itself.

*Addressing forestructures and pre-understanding: Initial tasks.* In keeping with the imperatives of conducting a hermeneutic phenomenological study (see Geanellos, 1998b), I engaged in a number of practices in an attempt to bring forth and address my pre-understandings and forestructures (Geanellos, 1998a, 1998b). As per the recommendations made by Geanellos, I completed the following tasks: (a) rendered my understandings of the phenomenon explicit by

developing a conceptualization of *intimate partner relationships in supporting recovery from an ED*, (b) identified forestructures of *intimate partner relationships in supporting recovery from an ED*, and (c) formulated my pre-understandings of *intimate partner relationships in supporting recovery from an ED* (Geanellos, 1998b, p. 238). As part of this reflexive practice, I also explored and answered the questions outlined by Langdridge (2007) (e.g., why am I carrying out this study, what do I hope to achieve, how do I feel about the work, how might the findings impact on the participants; p. 59). This process helped me stay open to the research question and data, and thus, contributed to the trustworthiness of my interpretive process and findings. Findings from these reflexive exercises are summarized below, in my statement of positionality.

*Ongoing reflexive practices.* Given the complexities of negotiating reflexivity, particularly within an interpretive/constructivist paradigm, multiple perspectives or variants of reflexive practice were incorporated *throughout* the research. In particular, Finlay's (2002) conceptualization of reflexivity as "introspection" (i.e., examining one's personal experiences and meanings; p. 213) and "intersubjective reflection" (i.e., "explore the mutual meanings emerging within the research relationship;" p. 215) served as general guides. Adopting these approaches maintained epistemological and methodological coherence with the hermeneutic phenomenological method, and grounded the reflexive practices in the study's purpose, aims, and focus (Finlay, 2002). I also incorporated Haverkamp's (2005) recommendation to explore "professional reflexivity" (i.e., "whether or not, and how, our research practice and relationships with participants incorporate the relevant aspects of our professional selves;" p. 152). For example, given my professional role as counsellor, I was mindful of the ways in which clinical tendencies could arise during research interviews, and sought to maintain the bounds of my role

as the researcher. These reflexive practices occurred independently (e.g., journals, writing) and in conversations with colleagues and supervisors.

Taken together, engagement in ongoing reflexive practices [e.g., introspection, intersubjective reflection (Finlay, 2002); professional reflexivity (Haverkamp, 2005); journaling; conversations with colleagues and supervisors] helped me remain curious and open to the women's experiences and phenomenon. For example, I was able to notice when I had made a link between something a participant had shared, and my "pre-understandings" (e.g., knowledge from previous clinical experiences). Journaling afforded me increased awareness of my reactions and responses to the research interviews, both with respect to the participants' stories (e.g., noting surprise, feeling affirmed at the importance of the research, observing the different ways in which participants articulated their experiences and how this influenced my facilitation of the interviews), and the process itself (e.g., negotiating my role as researcher, namely, balancing the creation of an open space with the use of specific follow-up questions to achieve the aims of the interview and method, and ensuring the elicitation of concrete examples of lived experience). I also observed that through the process of journaling, I raised questions about the data; for example, I found myself asking, "what does this mean?" in relation to the experiences described and the phenomenon under investigation. Such questions further supported my efforts to remain open to, and curious about, the phenomenon; avoid premature foreclosure on interpretations (Geanellos, 1998a); and identify the relation between my "pre-understandings" and the co-construction of meanings with research participants.

### *Statement of Positionality*

I am a 32 year-old, presently able-bodied, married, heterosexual Caucasian woman of European heritage. I was born and raised in Western Canada. I am English speaking, highly

educated, and of middle-class socio-economic status. In light of my location within numerous intersecting, dominant cultures, I acknowledge that I live with significant privileges, and that these privileges influence and shape my experiences and relationships with others.

My personal and professional history has resulted in significant experience with, and knowledge of, EDs. For the past nine years I have worked in the area of EDs, as both a research assistant and counsellor in an adult outpatient ED program. My work as a research assistant at a provincial tertiary ED program increased my knowledge of the ED literature, treatment programs and approaches, and models of service delivery, and the multitude of empirical, theoretical, and clinical perspectives and trends present within the field. My research interests and pursuits have focused on the relational dimensions of change, including factors associated with readiness and motivation for change, social support, mutuality in relationships, and interpersonal difficulties. As previously stated, I have also acquired significant practice knowledge in my position as a counsellor in an ED program, where I engage in both individual and group therapy with clients. My work with adult women and men struggling with an ED has reinforced the extent to which I view EDs as being situated within relational contexts. Clients frequently share about their intimate partner relationships, or, their thoughts and feelings about intimate partner relationships in general, if they are not in a relationship. They describe ways in which their partners are supportive and/or hindering of their recovery. Notably, many clients who have achieved desired change have reported their partners to be a significant support; indeed, I feel as though clients often experience their partners, to varying degrees, in supportive ways.

My personal and professional histories have resulted in significant knowledge about EDs, recovery, and support, rendering me an ‘insider’ in many ways to the phenomenon under investigation. That being said, I have minimal clinical experience working with couples.

Nonetheless, I recognize that diversity and plurality of meaning always exists, despite shared or common experiences. Importantly, from a hermeneutic perspective, given that my lived experiences shape my pre-understandings and forestructures of *intimate partner relationships in supporting recovery from an ED*, and constitute my “horizon” and entry point into the hermeneutic circle, they are articulated in further detail below.

*Beliefs and biases.* I believe that sociocultural norms, messages, and expectations have a profound impact on women’s lived experiences and the development of EDs. I situate the development, maintenance, and recovery from EDs within this broad context. I adopt a bio-psycho-social etiological perspective, and acknowledge the multiple and converging pathways leading to the development and maintenance of an ED. I believe that ED symptoms and behaviors serve a function, and while the particular function may vary among women, the ED is typically a means of coping with something that is otherwise less- or un- manageable for the individual. To this end, I believe that the ED is often a very powerful and effective means of coping, however, offers short-term relief at the cost of long-term wellbeing, outcomes, and goals. Importantly, the ED is further reinforced by the broader sociocultural context, with its dominant, pervasive messages, as previously stated.

I believe that recovery from an ED is a process occurring over time, most often long periods of time, and that the duration of the recovery process varies among women. For the majority of women, the recovery process includes periods of remission and/or relapse (i.e., variability in symptom presence and frequency, and re-emergence of symptoms after periods of abstinence). My research, clinical, and personal experience all suggest that the meaning of, and criteria for, recovery also varies. For instance, some individuals feel that they have achieved a “full” recovery, and define this in various ways, whereas others consider themselves to be

symptom free, yet always “in recovery.” That being said, I believe that to have attained recovery from an ED a woman must no longer be engaging in ED behaviors (e.g., extreme restriction, objective bingeing, purging, excessive exercise). She may however continue to experience body dissatisfaction and/or other thoughts about controlling her shape and/or weight, but she does not act on these thoughts, as seen with active EDs. I believe that recovery involves both intra- and interpersonal shifts, including a heightened awareness of the underlying causes of the ED and efforts to address these (e.g., meet one’s needs in more healthful ways, process unresolved issues). Relatedly, recovery may involve increased ability to identify and challenge sociocultural messages that perpetuate EDs. However, given the pervasive yet subtle nature of many messages and norms, the extent to which women are critically aware will vary, and may be influenced by the tasks and/or treatments they pursue during their recovery journey. While I believe that a woman is ultimately responsible for immediate behavioral change during recovery, I recognize that her experience is situated within and influenced by relational, social, cultural factors and contexts, and that these systemic issues also require attention and change.

I believe that, for women in an intimate partner relationship during recovery from an ED, this relationship constitutes an immediate context within which recovery may occur. This relationship plays a central role in recovery, and may both promote and hinder recovery efforts (e.g., at different times/in different ways throughout the process). In order for a relationship to be supportive, I believe it must be safe, validating, understanding, and empathic. Importantly, partners must be able to communicate this understanding, validation, and empathy, and with their partner, cultivate and maintain trust and honesty. The relationship must afford space for experimentation with new behaviors and ways of being (e.g., emotional expression, communication about both positive and difficult experiences, autonomy and closeness), without

imposing great pressure for change. I believe that recovery requires hope, attention to the process and efforts (i.e., rather than sole focus on outcomes), and validation and celebration of small and incremental changes. These qualities must therefore be present within a supportive relationship. I also believe that recovery involves a delicate balance between acceptance and change, and that both the women and their partners must learn to navigate all experiences with patience and compassion.

Given my belief that the ED has profound consequences for close others' in the woman's life, I believe that most partners supporting a woman through recovery must be able to tolerate anxiety and distress, and manage their own needs, in order best support their partner through the challenges of the ED and recovery. This is consistent with my view that relationships are bi-directional or mutually influential, in that, the experiences and actions of each partner influence the other, and it is therefore difficult to consider "support" in isolation of the relationship itself.

*Assumptions and expectations.* In addition to the aforementioned beliefs and biases, which inherently influenced my expectations about the women's experiences and the phenomenon under investigation, I identified several other assumptions and expectations. In conducting this research, I expected that the participants would identify their relationships as safe, and that they would have disclosed the ED to their partners. I anticipated that partners would be described as having experienced varying degrees of distress, mixed emotions, understanding of the ED and the woman's experience, and challenges in the relationship. I imagined that the women would describe mixed feelings about this, including guilt, shame, and frustration. I anticipated that partners who were experienced as significant in the woman's attainment of recovery would have been open and willing to learn about the ED, including

strategies to support her. I also expected that the women would describe instances of both practical and emotional support.

As per my inclination towards RCT as a theoretical frame for understanding women's psychological wellbeing and growth, I anticipated the women would describe processes and periods of connection and disconnection in their intimate relationship. I also imagined that the supportive qualities and aspects of the intimate partner relationship would reflect both similarities and differences from those of other relationships, such as relationships with parents, siblings, extended family, friends, and/or professional supports. For example, I anticipated that sexuality, sexual intimacy, and body image would likely be addressed as the women shared about their intimate relationship during recovery. I also anticipated that the women would discuss their values and hopes for the future, including interpersonal and family related hopes (e.g., sustaining a strong relationship, not hurting their partner, starting a family), and their unique role in recovery.

#### *Rationale for Study Inclusion Criteria*

Given that variability exists with the field of EDs regarding a number of the constructs included in the current research, definitions for the study's key constructs are outlined and rationale for inclusion criteria therefore provided. These inclusion criteria draw from extant empirical and theoretical literature (e.g., RCT), and women's subjective perspectives<sup>12</sup>.

*"Eating disorder."* The study adhered to the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV-TR; American Psychiatric Association (APA), 2000; see Appendix A] classifications for EDs, and included women with a history of clinically diagnosable AN, BN,

---

<sup>12</sup> Potential participants were asked whether they perceive themselves as having recovered from an eating disorder. This subjective perspective was considered in conjunction with the objective criteria to determine eligibility to participate in the research.



and/or EDNOS. History of ED symptoms meeting criteria for a clinical diagnosis was required given the study's aim of understanding the relational experiences of women who recovered from a serious ED (see Halse & Honey, 2005). Diagnostic information was obtained via potential participants' self-report, during the telephone screening process (see Appendix D)<sup>13</sup>.

*"Intimate partner relationship."* In the current study, an intimate partner relationship referred to a romantic relationship with a person of the same or different gender or sex, lasting a minimum duration of six months. Partners may have been cohabiting, common-law, or married during the woman's recovery process. However, in order to remain inclusive of individuals' choices and extend the scope of extant research's exploration of intimate partner relationships (e.g., beyond those who are married), participants were not required to fit these additional criteria. Women must have been in this intimate relationship during their recovery process, as they worked to decrease ED behaviors, and experienced this relationship as significant in their attainment of recovery. Of note, women may no longer be in this same intimate relationship at the time of the study.

*"Recovery."* As previously discussed, significant empirical efforts have been made to conceptualize and define recovery from an ED (e.g., Bardone-Cone et al., 2010a), however, there remains a lack of consensus in the field. Positivist paradigms have typically considered it an endpoint to be achieved, measured primarily by behavioral and/or physical indices of change (e.g., symptoms, body mass index, menstruation) (e.g., Bachner-Melman et al., 2006; Herzog et al., 1999; Kordy et al., 2002). Research exploring women's subjective experiences of recovery

---

<sup>13</sup> Diagnostic assessment relied on potential participants' retrospective self-report of symptom severity, frequency, and duration. Formal diagnosis may have been assigned for some (e.g., those who entered treatment) but not all women interested in participating in the study.

consistently conceptualizes recovery as a process and espouses a multitude of ‘subjective definitions’ of recovery (Noordenbos, 2011b).

The current study drew from this body of empirical work and employed both objective criteria and women’s perspectives to determine recovery status. To this end, the following criteria needed to be met in order to satisfy the study’s conceptualization of having “recovered” from an ED: (a) the woman did not currently meet DSM-IV-TR criteria for an ED (APA, 2000; Noordenbos, 2011a); (b) the woman had not met DSM-IV-TR criteria for an ED in the past year; (c) the woman had not engaged in any ED behavior (i.e., extreme restriction, objective bingeing, methods of purging and/or inappropriate compensation; APA, 2000) in the past year<sup>14</sup> (see Bardone-Cone et al., 2010a; Herzog et al., 1999; Kordy et al., 2002); and (d) the woman identified herself as having “recovered” from her ED, in that she is no longer engaging in ED behaviors and the ED no longer consumes, compromises, or impairs her sense of self, her life, and her daily functioning (Bjork & Ahlstrom, 2008; Noordenbos, 2011b<sup>15</sup>; Root, 1990).

This conceptualization of “recovery” drew from empirical research, used conservative estimates for symptom free periods to safeguard participants’ wellbeing, and acknowledged that recovery is an ongoing process. With respect to this latter point, in keeping with the lived

---

<sup>14</sup> If a woman had engaged in minimal/residual ED behavior(s) in the past year, however, self-identifies as having recovered, I inquired in detail about the behavior(s) to determine whether the woman met this criterion. I used clinical judgment, coupled with empirical research, to make this decision. When necessary, I consulted with my supervisor to clarify and consider the implications of involvement or declining involvement.

<sup>15</sup> Noordenbos’ (2011b) review of the literature generated the following list of client-identified criteria for recovery: normalized eating and drinking behavior, physical activity, and exercise; flexible, relaxed attitude towards food; accepting, positive body evaluation; achievement of medical and physical stability; psychological health, including sense of self and esteem that are not tied to the ED identity; ability to effectively manage and express emotions; overall decrease in tension and anxiety, marked by increased relaxation; social and interpersonal engagement; greater sexual intimacy and enjoyment; an absence of psychiatric co-morbidity related to ED (p. 444).

experiences of recovery that have been documented in the literature to date, it was acknowledged that recovery takes time and some women may still experience thoughts and feelings related to their eating, shape, weight, and history of ED, while simultaneously self-identifying as being “recovered” (Bjork & Ahlstrom, 2008; Liu, 2011; Pettersen & Rosenvinge, 2002; Root, 1990). Importantly, the required duration of time elapsed since engaging in any ED behaviors aimed to maintain the safety and wellbeing of participants by ensuring they had reached a certain level of health prior to engaging in the research process<sup>16</sup>. To the extent possible, this served to minimize risk to participants that may exist when discussing experiences of the ED, and optimized the likelihood of capturing the phenomenon of interest (i.e., intimate partner relationships in supporting recovery from an ED).

*“Process of recovery.”* Within the context of the current study, to have been in the *process of recovery* means that participants identified as having been engaged in efforts to reduce ED symptoms (e.g., working to reduce cognitions, behaviors, and ameliorate wellbeing, and/or involved with professional support/treatment program) while in an intimate relationship lasting a minimum of six months.

### *Procedure*

*Participants.* Adult women (i.e.,  $\geq 19$ )<sup>17</sup> with a history of a clinically diagnosable ED (i.e., DSM-IV-TR; APA, 2000) who met the following inclusion criteria were invited to

---

<sup>16</sup> See Kordy et al. (2002) and Herzog et al. (1999) for findings from longitudinal studies on remission, recovery, and relapse, and periods of heightened vulnerability for relapse, which informed the current criteria. See Halse & Honey (2005) for discussion of ethical considerations when conducting research with women with a current or previous ED diagnosis.

<sup>17</sup> Most ED research has focused on adolescents and young adult women, with a growing body of work examining EDs in mid-life (e.g., Brandsma, 2007; Cumella & Kally, 2008). Less is known about EDs in mid-life however, and to date, little is known about EDs in later adulthood (i.e.,  $> 65$ ; prevalence, symptom presentation, course, outcomes) (Beck, Casper, & Anderson, 1996; Cosford & Arnold, 1992). The current study aimed to be inclusive of all adult women’s

participate in the current study: (a) were in an intimate relationship of six months or more while engaged in recovery from their ED; (b) were in this intimate relationship no more than 5-10 years ago<sup>18</sup>; (c) identify this intimate relationship as being significant in their attainment of recovery (i.e., supporting recovery); (d) meet study requirements for having recovered from an ED (i.e., do not currently meet DSM-IV-TR criteria; have not met DSM-IV-TR criteria in the past year; have not engaged in ED behaviors, namely, extreme restriction, objective bingeing, methods of purging and/or inappropriate compensation, in the past year); (e) self-identify as being “recovered.” In addition, given the methodological imperatives of a phenomenological study, the participants needed to be willing and able to both reflect on their experiences and articulate them in English, in conversation with the researcher (Polkinghorne, 2005).

The literature presents several views on the number of participants to be included in phenomenological studies. Creswell (1998) suggests that a phenomenological inquiry include no more than ten participants; review of published phenomenological studies seems consistent with this guideline [e.g., ( $N = 6$ ; Palmer & Daniluk, 2007); ( $N = 8$ ; Spivack & Willig, 2010)]. Wertz (2005) acknowledges that the number of participants must be considered in relation to the research purpose and question, and states that one may not know the final number of participants at the outset of the research. Benner (1994) suggests researchers anticipate the “size of the text” (p. 107) and recruit accordingly (i.e., if participants are interviewed twice, then fewer participants may be recruited). In general, the researcher is encouraged to adopt a flexible stance with respect to recruitment and data collection, with the aim of obtaining sufficient, rich data to

---

experiences, particularly those that have not been voiced in the extant ED literature. As such, there is no maximum age for participation. However, given available data on prevalence of EDs in later adulthood (Beck et al.; Casper & Anderson) it was anticipated that most women would be in early adulthood or mid-life.

<sup>18</sup> This time frame was recommended in order to ensure that women were able to recall the phenomenon under investigation.

capture and illustrate the phenomenon of interest in detail and depth (Morrow, 2007). To this end, it has been suggested that data collection continue to the point of theoretical saturation (Morrow). Recognizing that ‘true’ redundancy is unattainable within an interpretive/constructivist paradigm, Morrow explains that “themes are theoretically saturated when they account for all of the data that have been gathered and illustrate the complexity of the phenomenon of interest” (p. 217), thereby suggesting some degree of redundancy for the purposes of the research.

In keeping with the aforementioned recommendations, including the depth and length of the research interviews and the notion of theoretical saturation (i.e., no new themes emerging), ten women were recruited to participate in the study. Sufficient interview data was collected to ensure I was able to co-construct and comprehensively describe the essence of the phenomenon of interest, the experience of intimate partner relationships supporting recovery from an ED, and to reach theoretical saturation of the data.

*Recruitment.* I employed purposive sampling in order to elicit rich, informative accounts from women who were willing and able to reflect on and articulate their experience of the phenomenon, *intimate partner relationship in supporting recovery from an ED* (Langdridge, 2007; Polkinghorne, 2005). Langdridge (2007) states that recruitment in a hermeneutic phenomenological study is “likely to be purposive and homogeneous,” in that the researcher seeks to include individuals who have shared the experience under investigation and “do not vary significantly across demographic characteristics,” in order to “develop detailed descriptions” and “make claims about these people and their particular shared experience” (p. 58). Adult women were widely recruited using recruitment posters and print and online notices, including the use of social media pages (i.e., Facebook; British Columbia Eating Disorder Centre for Excellence;

British Columbia Association of Clinical Counsellors online newsletter; Looking Glass Foundation website), in efforts to reach women who had recovered from an ED and found their intimate partner relationship to be a support during this process (see Appendices B and C).

During the initial telephone contact (see Appendix D) I informed women of the purpose of the study and welcomed any and all questions (e.g., regarding the research, participation, my experience and interest in the area of study). I followed a detailed screening form to ensure that potential participants met the study inclusion requirements. If women met the inclusion criteria and offered verbal consent to participate in the research, we scheduled a research interview for a mutually agreed upon date, time, and location. I did my best to ensure that participants fully understood the nature of the interview process (e.g., duration, topic discussed, disclosure of sensitive personal information) so they were able to make an informed decision about an appropriate location. Interviews took place in quiet, private areas, including both library and church study spaces, a building amenity room, private office space, and via Skype<sup>19</sup>. Written informed consent was obtained at the start of the interview, and this process is discussed in detail below (see Appendices E and F).

*Data collection.* Consistent with a hermeneutic phenomenological method, research data consisted of women's personal accounts of experiencing the phenomenon, that is, an *intimate partner relationship in supporting recovery from an ED*. Data was collected using in-depth, audio-recorded interviews. As the co-investigator and primary researcher responsible for execution of the study, I conducted the research interviews. Seven interviews were conducted in person at various locations within the community. Three interviews were conducted using Skype

---

<sup>19</sup> Various issues were considered when supporting the women to identify a comfortable place for the interview, including means of transportation, privacy, and proximity to the participant's home.

technology (Deakin & Wakefield, 2013; Hanna, 2012). In light of connectivity issues, one of the Skype interviews lost its video option and thus, turned into a phone interview (i.e., using the Skype technology) (Holt, 2010). Although in-person interviews have long been considered optimal in qualitative research, there is growing support for the use and benefits of technology as a means of data collection (see Deakin & Wakefield; Hanna; Holt). Specifically, the use of Skype as a medium has received support given that it preserves the synchronous, face-to-face aspects of the in-person interview, and also, allows individuals at a geographical distance or with limitations to their availability, to participate in the research (Deakin & Wakefield). In the current study, the three participants for whom Skype was used were all living in regions that precluded travel for an in-person interview. In addition, it afforded convenience for one participant with a young child at home. There were no other notable distinctions between participants who engaged in a Skype interview and participants who engaged in an in-person interview. Further implications of using Skype, with and without the video function, are discussed throughout this section on the data collection process.

Oral depiction or narration of experience enabled the women to “stay close to [the] experience as it is immediately lived” (van Manen, 1990, p. 67). Polkinghorne (2005) encourages the obtainment of detailed, inclusive, “intense, full, and saturated descriptions of the experience under investigation” (p. 139). Morrow (2005) recommends that researchers possessing significant knowledge of the subject area (i.e., familiarity with the phenomenon being explored; insider) seek clarification around, and move deeply into, the participants’ subjective meanings and embodied experience (see Langdridge, 2007). I kept these recommendations in mind as I engaged in the interviews, specifically, as I used follow-up questions to deepen my understanding and elicit concrete examples.

It has also been argued that researchers with a counselling psychology background and clinical skills may establish rapport and elicit participant stories and experiences with greater ease, reducing the time necessary to attain depth during interviews (Haverkamp, 2005), and thus, the need for multiple interviews with participants. In light of my counselling psychology training and being sensitive to the total time required for participation in the study, I conducted one interview with each participant. I proposed the possibility of conducting a second data collection interview to participants at the outset of the study, during the screening interview and prior to obtaining consent, in the event this was felt to be necessary or beneficial (i.e., by myself or a participant), however, this did not occur. A primary aim in the interviews was to create a safe relationship that supported the women's articulation of their experience and the obtainment of a deep, rich description of the phenomenon and the meanings women attribute to their experience. To this end, I adopted a collaborative stance (i.e., as described below, in the overview of the interview orienting statement) and employed basic counselling skills (e.g., active listening, non-verbal and verbal prompts).

For the Skype interviews with video, I made a concerted effort to communicate both verbally and non-verbally as clearly and audibly as possible, to optimize the extent to which this information was conveyed through the video function, and to aid in the establishment of rapport. To the best of my knowledge, and in the absence of feedback from participants stating otherwise, I believe that the Skype interviews with video were effective means of obtaining interview data, and retained the benefits of in-person interviews. For the Skype interview with no video function, I relied more heavily on verbal prompts and communication. I acknowledged the challenges imposed by not having face-to-face contact (i.e., loss of non-verbal communication), and its impact on the 'flow' or bi-directional nature of our dialogue (Holt, 2010); the participant



expressed understanding of the implications and we agreed to address issues openly as we proceeded through the interview. A collaborative stance was therefore employed, as the participant and I negotiated our dialogue. For example, to facilitate the interview in the absence of visual cues, I inquired more frequently about whether she had more to say on a topic, and as previously noted, used verbal prompts to encourage her to continue. In doing so, I informed the participant of my intentions in communicating in this manner. Notably, Holt has identified the benefits of using the telephone as a means of interview data collection, one of which being the need for “full articulation” on the part of both researcher and participant, and thus, a “much richer text” (p. 116). Importantly, literature suggests that participants evaluate this means of interviewing positively (Holt), and I did not receive any feedback suggesting otherwise.

Before starting each research interview, I invited and addressed any additional questions or concerns about the research that may have arisen since the initial telephone contact. We then reviewed and signed the informed consent form (see Appendices E and F). Review of the form included discussion of the study’s purpose, procedures, confidentiality and limits thereof, potential risks and benefits, and contact information. After ensuring the participant understood the implications of involvement in the research, she was asked to sign the form. Each participant was given a copy of the informed consent form for her records. For participants who were interviewed via Skype, the informed consent form was emailed to them prior to the date of research interview, such that we could review together. The participant then provided verbal consent and signed the informed consent form, which was then sent to me at her earliest convenience following completion of the interview. At this time, I asked all participants to generate a pseudonym for use throughout the duration of the study and the dissemination of findings. Lastly, I let the participants know that I had additional support resources available to

them, should they feel the need/want to follow-up after the interview, and I gave them each a list of these resources (see Appendix I). These resources were emailed to participants completing the interview via Skype. Notably, no participant contacted me following the data collection interview to check-in or request additional support, and thus, to the best of my knowledge no participants required or followed-up with the resources provided.

Once the informed consent form was signed and the participant indicated she was ready to begin the interview, I turned on the audio recorder and informed the participant of the same. I stated the date and pseudonym of the participant, and began the research interview with an orienting statement (see Appendix G) followed by the primary research question (see Appendix H). I reminded participants that they were welcome to share as much and/or as little as they wished regarding their experience and that we could pause, take a break, or stop the interview at any time, at their discretion. I invited participants to direct the flow and pace of the conversation, but let them know that I may respond with additional questions, seek clarification, or re-direct our focus, in the interest of the research purpose (e.g., to ensure I understood, encourage more detail to enhance and deepen the description and/or elaboration of meaning, and/or keep us well oriented to the research question) (see Appendices G and H). To this end, the research interviews were largely unstructured, allowing space for the women's experience and meanings to emerge (Benner, 1994), with some structure imposed as the interview progressed, to ensure detailed information about the phenomenon was collected (Langdridge, 2007). As noted above, a series of interview questions was used during the interviews, and introduced as a means of re-focusing the participant on the phenomenon, encouraging detailed description of the phenomenon, eliciting concrete examples of the phenomenon, exploring meanings attributed to the phenomenon, and in general, deepening exploration and depiction of the lived experience (see

Appendix H). I also used probes and clarification when necessary, to ensure I understood the narratives and the meanings the participants were expressing (Benner, 1994). In addition, as per van Manen's (1997b) suggestions for the hermeneutic phenomenological researcher, I kept the following principles in mind as I facilitated the interview: (a) stay close to experience as lived; (b) focus on concrete experiences (i.e., re-direct when the interviewee begins to make generalizations about the experience or becomes very reflective or theoretical); (c) ask the interviewee to think of a specific instance, situation, person, or event; and (d) explore instances of the experience to the fullest. van Manen urges the researcher to stay oriented to her primary research question, and I remained mindful of this, and relied on the research question as an anchor throughout the interview process.

Consistent with the collaborative spirit of the research process, determining when to end the interview was a joint decision, and occurred when the "conversation gradually diminishe[d] into a series of more and more pauses, and finally to silence," suggesting that "something has been fulfilled" (van Manen, 1997b, p. 99) and we had attained a comprehensive description of the experience and meanings, as per both the participant and myself. Interviews ranged in length from one hour and fifteen minutes to two hours and thirteen minutes; mean duration of the interviews was one hour and thirty-seven minutes.

A final component of the data set was my research memos. Memos consisted of observations obtained during the interview (e.g., if/when a participant became tearful) and reflections from both during and after the interview, regarding its content and/or process. Memos were not transcribed in full and analyzed, but rather, used as an aid to my interpretive process. To this end, memos were reviewed alongside each transcribed interview to ensure that all relevant information about the interview was contained in the transcript. In addition, as I

proceeded with the analysis, as described further below, I referenced the memos from each individual interview to ensure I was considering and/or including observations, thoughts, or questions about meaning from the interviews, in the interpretive process, as relevant (e.g., some comments were redundant with what participants had said, or were reminders for me of areas to follow-up on in the interview).

All data was stored in a locked filing cabinet in the primary researcher's (M. Hughes-Jones) residence. Data will be kept secure for the duration of the study and destroyed after five years as per UBC policy.

*Data analysis.* As previously described, examination of pre-understandings and forestructures constitutes the first stage of interpretation and analysis in hermeneutic phenomenology (Geanellos, 1998a, 1998b). I continued to engage in reflexive practices over the course of data collection and analysis, with the aim of preventing “premature interpretive closure” (Geanellos, 1998a, p. 157); that is, to ensure I was not leading the participants during interviews and/or identifying aspects of the transcripts that merely confirm what I may expect to find.

All interviews were audio-recorded and transcribed verbatim by a hired, professional transcriptionist, who signed a transcription services confidentiality agreement (see Appendix J). All participants were informed of the transcription process during the informed consent process and associated discussion regarding confidentiality. The transcription process is considered to be a step in the interpretive process, during which the researcher immerses herself in the data and begins to formulate initial interpretations about the data (Lapadat & Lindsay, 1999). It could therefore be argued that hiring a professional transcriptionist to complete this step compromised my ability to be fully immersed in the data and continue formulating impressions at this stage. In

order to address these implications, upon receiving the completed transcripts, I made additional efforts to immerse myself in the data. Specifically, I re-read each individual transcript while listening to the audio-recording and reviewing my memos, to ensure that the transcript was a verbatim, detailed, and accurate reflection of the participant's account, and included all the information I obtained about the women's experience. To this end, I added or emphasized pauses, silences, and/or breaks; participants' expressed emotion (e.g., tears, smile, laughter); and/or nuances in speech (e.g., pace, tone), based on my experience of conducting the interviews and in consult with my memos from the interview. This latter step also ensured consistency across all transcripts with respect to how the audio was translated into the written text (e.g., noting and differentiating between silences, breaks, and pauses) (Lapadat & Lindsay). I also formatted the transcripts to include wide margins for notes, comments, and initial analytic reflections (Langdridge, 2007).

Acknowledgment of the potential benefits of having the interviews transcribed is also warranted. Having the audio-recordings transcribed afforded me perspective from the data, allowing me to return to the interviews with 'fresh eyes,' and prompting me to reflect upon the participants' experiences in new ways, as I re-reviewed the data and incorporated additional information. To this end, I feel that having the interviews transcribed aided my interpretive process. In addition, by incorporating this step into my research procedure, I became more reflexive about the transcription process itself, and the implications of transcription to the interpretive process; this reflexivity around transcription has been encouraged and identified as an important research step in and of itself (Lapadat & Lindsay, 1999).

Consistent with the ongoing interpretive process of hermeneutic phenomenology, I continued to formulate impressions about the women's individual experiences during the initial

review of the transcripts (i.e., as is highlighted by van Manen and hermeneutic philosophy, this process of interpretation began within the context of the data collection interview itself as the woman and I engaged in dialogue around her experience). I captured these initial impressions of the women's experience of their intimate partner relationship supporting recovery by generating and writing down statements that depicted possible meaning structures.

While descriptive phenomenology typically adheres to methods of analysis proposed by Giorgi, Colaizzi, or Moustakas (see Creswell et al., 2007; Sanders, 2003; Willig, 2008), hermeneutic inquiry in psychology (see Parker & Addison, 1989b) and hermeneutic phenomenologists specifically (van Manen, 1997a, 1997b, 2011) encourage a more flexible conceptualization of, and approach to, analysis (Hein & Austin, 2001; Langdridge, 2007). I therefore retained this "openness" during the data analysis phase of the research, while using van Manen's (1997b) approach to guide the process.

As previously stated, van Manen (1997b) proposes the following six steps for conducting a hermeneutic phenomenological inquiry:

- (1) turning to a phenomenon which seriously interests us and commits us to the world,
- (2) investigating experience as we live it rather than as we conceptualize it, (3) reflecting on the essential themes which characterize the phenomenon, (4) describing the phenomenon through the art of writing and rewriting, (5) maintaining a strong and oriented pedagogical<sup>20</sup> relation to the phenomenon, and (6) balancing the research context by considering parts and whole. (p. 30-31)

---

<sup>20</sup> Langdridge (2007) suggests that a researcher in the field of psychology substitute the word "psychological" for "pedagogical," to reflect her or his particular orientation to the phenomenon (p. 123). I followed this recommendation.

van Manen (1997b) refers to themes as meaning units or structures of meaning<sup>21</sup>, stating that “reflecting on lived experience then becomes reflectively analyzing the structural or thematic aspects of the experience” (p. 78). He outlines three approaches to thematic analysis: (1) wholistic, (2) selective or highlighting, and (3) detailed or line-by-line, and recommends a combination of two of these approaches to ensure a comprehensive analysis. I engaged in the first two approaches to data analysis.

As per the wholistic approach, as I first read the text (i.e., individual transcript) as a whole, I asked myself “what sententious phrase may capture the fundamental meaning or main significance of the text as a whole?” (van Manen, 1997b, p. 93). I then crafted a statement that captured this overall meaning of the experience for the participant. This statement was revised with subsequent review of the transcript, as my understanding and interpretation of her experience was further developed, deepened, and refined. As per the selective approach, I then re-read each interview text and asked myself “what statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?” (van Manen, p. 93). I then highlighted these statements in the transcript and constructed a statement for each that articulated its meaning. This process generated a number of meaning structures for each individual participant’s experience. van Manen offers these additional questions to guide one’s reading of the texts: “what is going on here?” “what is this an example of?” “what is the

---

<sup>21</sup> van Manen’s (1997b) conceptualization of “themes” includes the following: (1) Theme is the experience of focus, of meaning, of point; (2) Theme formulation is at best a simplification; (3) Themes are not objects one encounters at certain points or moments in a text; (4) Theme is the form of capturing the phenomenon ones tries to understand; (5) Theme is the needfulness or desire to make sense; (6) Theme is the sense we are able to make of something; (7) Theme is the openness to something; (8) Theme is the process of insightful invention, discovery, disclosure; (9) Theme is the means to get at the notion; (10) Theme gives shape to the shapeless; (11) Theme describes the content of the notion; (12) Theme is always a reduction of a notion (p. 87-88).

essence...of [the phenomenon] and how can I capture this” (p. 86), and I therefore kept these in mind throughout the analytic process.

I completed the above analytic process for each individual transcript. Throughout this process I began to generate interpretations of the data set as a whole. I captured these interpretations by writing down statements that depicted possible meaning structures, common to all the women. As such, I had begun the process of considering individual “parts” in relation to the “whole.” I continued to review my initial findings from the individual level analyses (i.e., each respective transcript), considered them in relation to the entire data set (i.e., all transcripts), and attempted to identify themes common to the experiences of all the participants. I therefore sought what was universal, from the particular (Langdridge, 2007), to distinguish *essential* versus *incidental* themes structuring the phenomenon (van Manen, 1997b). To this end, I engaged in a process of “free imaginative variation,” asking myself “is [the experience of intimate partner relationships in supporting recovery from an ED] still the same if we imaginatively change or delete this theme from [said] phenomenon?” and “does the phenomenon without this theme lose its fundamental meaning?” (van Manen, p. 107). This “across” participant analysis generated the *essential* meaning structures of the phenomenon, which constitute the results reported in the next chapter.

Importantly, the generation, development, deepening, and refinement of these essential themes occurred through an iterative process of writing, re-writing, referencing individual transcripts, and returning to the data set as a whole (i.e., ongoing movement between the parts and the whole). With my initial essential themes in mind, I returned to each individual transcript. I re-reviewed both the transcript itself and the meaning structures generated from the individual level analysis to ensure that the essential themes were indeed captured in each woman’s



experience. This resulted in further development and refinement of the essential themes (e.g., some themes were collapsed into others, some themes became sub-themes, some themes were deemed incidental); this refinement also occurred through the process of writing and re-writing the themes (van Manen, 1997b). In addition, the analytic process included several meetings with my research committee members, during which we discussed the process of analysis and findings to date, including whether themes were essential or incidental, whether the ways in which themes were conceptualized and articulated reflected and captured experience as lived, and the extent to which themes were distinct. A number of the aforementioned questions posed of the data during analysis were once again explored in these meetings.

Overall, the data analysis process involved deep immersion in the data (i.e., reading and re-reading the transcripts, moving between the individual transcripts and the data set as a whole, selecting illustrative quotes), phenomenological reflection around meanings (i.e., generating and writing<sup>22</sup> statements that capture meaning structures), and writing and re-writing with the aim of bringing these meanings to life in a rich and evocative text (van Manen, 1997b, 2006).

### *Representation of the Research Findings*

The results of this hermeneutic phenomenological study consist of a comprehensive written description of the essential meaning structures (i.e., the essential themes) of women's experience of their *intimate partner relationships in supporting recovery from an ED* generated from the "across" participant analysis (Langdridge, 2007; van Manen, 1997b; Wertz, 2005). The lived experiences and voices of the women are highlighted throughout the final text with rich, illustrative quotes. Additionally, in order to contextualize the study's findings, I present a brief biographical description of each participant in the Results chapter.

---

<sup>22</sup> van Manen (1997b) considers writing to be an inherent aspect of research method; specifically, he views writing as the path to "seeing" themes (p. 79).

Congruent with the study's interpretive/constructivist paradigmatic frame, it is also acknowledged that the essential themes generated reflect *one* possible interpretation of the data/text, and other investigators and/or readers may make different interpretations and/or generate different findings (Hein & Austin, 2001). Likewise, findings reflect the experiences of the study participants and may not necessarily reflect the experiences of all women who experienced their intimate partner relationship as significant to their recovery from an ED. Such contextual considerations for interpretation of the findings are presented in the Discussion chapter.

*Evaluating Interpretive Accounts: Establishing Trustworthiness in the Research*

Given the underlying positivist assumptions of “validity” (i.e., correspondence theories of truth; see Packer & Addison, 1989a) and thus, the incommensurable nature of this concept with a hermeneutic phenomenological mode of inquiry, the current study adopts various methods of “evaluation,” through which the trustworthiness of the research may be considered (Packer & Addison, 1989a). To this end, I employed relevant criteria put forth for qualitative inquiries in general (Morrow, 2005; Tracy, 2010; Yardley, 2000), hermeneutic psychological inquiry (Packer & Addison, 1989a), and hermeneutic phenomenology (Langdridge, 2007; van Manen, 1997b) respectively, to ensure the rigor and credibility of my work.

*General criteria to ensure quality.* Morrow (2005) identifies social “validity” (i.e., social relevance), subjectivity and reflexivity, adequacy of data, and adequacy of interpretation as overarching criteria for trustworthiness, irrespective of philosophy of science (i.e., to be addressed in a manner that is consistent with my epistemological stance, herein constructivist/interpretive). Similarly, Yardley (2000) outlines the following principles as general guides to evaluating qualitative research: sensitivity to context, commitment and rigor,

transparency and coherence, and impact and importance. Given the paramount importance of establishing the “quality” of qualitative research (Tracy, 2010), I have attempted to fulfill the aforementioned broad criteria throughout my research process (e.g., level of detail in conducting and reporting the research, reflexive practices, epistemological coherence).

*Evaluation of hermeneutic phenomenology.* Morrow (2005) suggests evaluation criteria specific to an *interpretive/constructivist paradigm*, including fairness, authenticities, and meaning (p. 251) (see also Denzin & Lincoln, 2005; Guba & Lincoln, 2005). Indeed, particularly important to a hermeneutic phenomenological study are issues of representation, attainment of deep understanding, and articulation of the co-constructive process of meaning-making (Morrow). Packer and Addison (1989a) emphasize that although evaluation itself is not interpretation free, four processes can aid one’s efforts in assessing the trustworthiness of an interpretive account. Specifically, they suggest one consider coherence, external evidence, consensus, and practical implications, as they relate to the researcher’s epistemological position<sup>23</sup>.

Langdridge (2007) outlines four criteria for evaluating a *phenomenological study*: analytical rigor, producing a persuasive account, collaborative working (i.e., with colleagues), and participant feedback (i.e., as indicated by epistemological position), revealing his subtle bias towards ensuring the credibility of one’s work within the academic community. van Manen (1997a, 1997b, 2006) emphasizes the quality of the written text as a key component in establishing the value of a *hermeneutic phenomenological study*, specifically. He asserts that “the researcher as author is challenged to construct a phenomenological text that possesses

---

<sup>23</sup> Some of these ‘terms’ (i.e., language) appear to be epistemologically incongruent with the study, but Packer and Addison (1989a) emphasize the ways in which the researcher might understand and approach each criteria area, consistent with hermeneutic epistemology.

concreteness, evocativeness, intensity, tone, and epiphany” (1997a, p. 368). According to him, the final text must be “oriented, strong, rich, and deep” (1997b, p. 151). Indeed, he privileges resonance, the final text’s ability to evoke feeling and connect with one’s senses, as the ultimate goal.

I consider the various aforementioned criteria for evaluating the trustworthiness of a hermeneutic phenomenological study to be largely subsumed under the notions of rigor and credibility. Indeed, both Morrow (2005) and Tracy (2010) echo the idea that any claims of transferability included in the final report are largely contingent upon well-established rigor and credibility. As such, I describe below the specific steps taken to ensure the credibility of my research.

*Methods for establishing credibility.* Credibility was achieved through rigorous attendance to, and communication of, each stage of the research process (Morrow, 2005; Tracy, 2010). To this end, I have provided a detailed description of the methodology, including procedures (e.g., recruitment, participants, data collection, and analysis) and researcher reflexivity; this level of detail ensures transparency and epistemological coherence throughout the research process. During the data collection phase, my supervisor Dr. Haverkamp listened to the audio-recording and read the transcript for my first interview to ensure that I adopted an open stance and conversational style conducive to attaining a rich, concrete, detailed description of the phenomenon, and maintained an appropriate researcher-participant relationship (i.e., versus a counselling relationship). My research committee was consulted throughout the data analysis and writing processes to ensure I presented clear and persuasive descriptions of the meaning structures of the phenomenon (Langdridge, 2007; Yardley, 2000). With respect to representation of the findings, I situate the participants within their respective personal contexts (i.e., synopsis

of biographical information) and present thick, detailed, descriptive accounts of their experiences, augmented by illustrative quotes (van Manen, 1997a, 1997b).

Another central means for establishing credibility was member checks (Morrow, 2005; Tracy, 2010). Member checks are follow-up interviews with participants to increase the likelihood that the final report achieves resonance (Tracy). My initial interpretations (i.e., common themes) and respective biographical synopses were brought back (i.e., emailed) to each participant following completion of all data collection interviews and the initial thematic analysis. The aim of the member checks was to optimize trustworthiness and resonance of my interpretation of the women's experience and meanings of their intimate partner relationship supporting recovery from the ED. They were also used to confirm demographic information included in the biographical synopses. Each member check interview was scheduled for a mutually agreeable time and participants were given a choice of conducting the interview in person or over the telephone. All interviews occurred over the phone, and some participants provided feedback around the findings via email. The member check interviews ranged in duration from 15 to 60 minutes ( $M = 35$  minutes).

As previously noted, findings were presented to participants tentatively, as "initial" results, in attempts to ensure participants felt safe to disagree or amend in an honest and meaningful way. In this sense, my adherence to a collaborative researcher-participant relationship aimed to moderate researcher authority and power, and privilege the participants' voices. I asked each participant whether the common themes resonated with her personal experience and meanings, that is, if this is "what the experience is really like" (van Manen, 1997b, p. 99) and if the themes captured the experience of having an intimate partner relationship support recovery from an ED. Participants were also asked questions such as "was

there anything in the findings that surprised you,” “ was there anything you expected to see more or less of,” or “do you feel like anything is missing.” The purpose of these questions was to support and invite the women to provide their thoughts. It was acknowledged with each participant that some aspects of the experience, as depicted by the themes, may resonate more than others, given that the interpretation reflected the common and essential aspects of the experience, rather than the nuances of each participants’ individual experience.

During the member-check interviews, all of the participants affirmed that the common themes reflected their personal experience, and depicted the phenomenon of having an intimate partner relationship support recovery from an ED. They shared they “felt heard;” that the findings, and hearing other women’s voices, were “so beautiful;” that they “couldn’t believe some of the similarities” in experiences among themselves and others; that results were “spot on” and they were “totally shocked” at how much the findings resonated and reflected their experience. Some commented that reading the results was yet another reminder of how impactful their intimate relationship had been. Many women noted that they were uncertain as to whether certain illustrative quotes were their voice or not, given the similarity in experiences and extent to which they related. A few of the women acknowledged that certain themes resonated more than others, or that some themes felt most resonant or reflective of their experience. These responses were validated and normalized. Notably, throughout the member-check interviews I maintained awareness of, and grounded in, literature exploring the management of interpretive discrepancies (Borland, 1991), to ensure that all of the women’s reactions and responses were discussed and managed with the utmost ethical sensitivity.

Despite finding that the results resonated with her experience, one participant observed that the overall description of the phenomenon appeared “very positive,” and commented that her

relationship also had its challenges. We discussed this reaction to the results (see Borland, 1991). Specifically, I validated her perception, contextualized the findings in relation to the research question and purpose (i.e., focus on supportive experiences), identified the ways in which I had tried to capture the depth, dimensions, and variability in the relationships, and suggested ways I might translate some of her feedback into the findings (i.e., state more frequently or explicitly the difficulties that accompanied the support). The participant expressed understanding and agreement around all of the above. As such, I re-visited the results, identified aspects of the women's experience that may have included some reference to challenges in the relationship, and, as appropriate, incorporated specific statements to enhance and deepen my description through the depiction of the co-occurring support and challenges.

Similarly, despite affirming that the findings fit for her, and described the phenomenon of interest, one participant queried the extent to which the theme "*Mutual Commitment*" was reflective of her experience. Again, her impressions were validated, normalized, and discussed (see Borland, 1991). Specifically, we explored her thoughts and feelings about the theme, including aspects that she related to and aspects that she felt less certain about (e.g., she shared that, at times, she questioned her partner's commitment to her), and discussed the nature of the interpretive process. I offered specific examples from her narrative that had informed my understanding of her experience, and this theme specifically, to illustrate my meaning making process around her experience. Over the course of our discussion, the participant acknowledged the ways in which this theme reflected her experience, and re-affirmed once again that the finding fit, albeit, somewhat less than others (e.g., for this woman "*Intimacy*" was a particularly salient component).

Finally, another participant commented that there were also instances when she felt “triggered” by her partner’s struggle to understand the ED and related behavior. In order to capture this variability in experience, and in light of its congruence with the feedback described above regarding relational challenges, a statement was added to the sub-theme “*Sense of Security*” in an attempt to contrast the supportive experiences (i.e., partner’s ability to tolerate distress and confusion around the ED), with an instance that felt less supportive, and thus, further elucidate the complexities of the women’s relational experiences.

Overall, high standards of fairness and equity in representation of the women’s experiences were goals (Morrow, 2005). However, Finlay’s (2002) assertion that “preoccupations with collaboration and egalitarianism can result in claims which disguise the inequalities actually present” (p. 226) reminded me that, as I negotiated and represented the women’s voices and my own, ultimate responsibility and authority around representation rested in my hands and required tremendous ethical sensitivity (see Borland, 1991; Haverkamp, 2005).

Finally, each participant’s biosynopsis was sent to her for review (i.e., for accuracy, amount and level of detail, and comfort with the information presented). Biosynopses were then edited if necessary, and have been approved by each participant.

### *Ethical Considerations*

Given that conducting qualitative research involves multiple, complex ethical dimensions, particularly when research is being undertaken with vulnerable populations (Jones & Pye, 2012), the research process was informed by the writing of various scholars (e.g., Haverkamp, 2005; Tracy, 2010) and the *Canadian Psychological Association* (CPA) code of ethics (CPA, 2000) to ensure sound ethical decision making at every stage of the research process.



Tracy (2010) highlights four broad domains of ethical practice: procedural ethics, situational ethics, relational ethics, and exiting ethics. In brief, *procedural ethics* are concerned with institutional requirements, *situational ethics* are concerned with the specific context within which the research is being conducted, *relational ethics* are concerned with the researcher's relationship with participants and invoke an ethic of care, and finally, *exiting ethics* are concerned with the manner in which the researcher manages and communicates the findings (see Tracy, 2010 for detailed description). Haverkamp (2005) asserts that while procedural ethics and codes offer moderate guidance around ethical decision-making, the ambiguity often arising over the course of qualitative research, particularly within an interpretive/constructivist paradigm, requires an acute ethical awareness and sensitivity. This awareness includes knowledge of alternate, or supplemental, frameworks (e.g., virtue ethics, feminist ethics of care) to extend the reach afforded by principle ethics. Haverkamp identifies three "cornerstones" to aid researchers with ethical dilemmas: the examination of foundational ethical principles, conscious application of an attitude of care, and consideration of virtuous character (p. 150). She emphasizes relational ethics as particularly salient when conducting applied research, and urges researchers to exert great caution and care with researcher-participant relationships. Within the context of said researcher-participant relationships, and the associated concerns of power, voice, and representation, Haverkamp (2005) emphasizes the imperative of attending to the inherent power imbalance in the relationship. She suggests that the researcher adopt a "fiduciary role in reference to...research participants...in which one party with greater power or influence accepts responsibility to act in the other's interest" (p. 151).

As I navigated my roles and responsibilities as the primary researcher conducting the study, I was cognizant of the boundaries between research and counselling when engaged in

long, in-depth interviews with participants on the sensitive topic of intimate partners facilitating recovery from an ED (e.g., dual roles) (Haverkamp; Jones, Pye, & Palandra, 2014; Kvale & Brinkman, 2009). I employed basic counselling skills to create a safe research relationship for participants and journaled to maintain professional reflexivity. As previously articulated, I adopted a collaborative stance at each stage of the research process to minimize the power differential, while sustaining fiduciary responsibility. For example, participants were consistently invited to ask questions and/or check-in around the progress of the research, and were provided with a formal update during the analysis phase of the research, prior to circulation of the common themes and member check interviews. In addition, participants were all invited to provide feedback and suggestions regarding the dissemination plan for the research (i.e., see Discussion chapter for further details).

*Ethical procedures.* A behavioral ethics application was submitted to the behavioral research ethics review board at UBC. Given my dual role as a clinician and researcher in the area of EDs I was aware that potential participants may be previous clients or individuals with whom I have had some form of clinical contact<sup>24</sup>. Likewise, there is always the possibility that a participant may seek professional support in the future and thus, the potential for future contact. I addressed these possibilities during the telephone screen and informed consent process, respectively. One woman with whom I had a previous clinical relationship expressed interest in participating in the study. During our telephone screen interview I explained that our previous relationship precludes her participation in the study and she expressed understanding around this decision. Issues of confidentiality were discussed at length during the informed consent process,

---

<sup>24</sup> I was previously a research assistant at the local tertiary care eating disorders program. In this position I met with many treatment seeking women for research assessments, which included a clinical interview focused on their ED symptoms and their readiness and motivation for change. Women with whom I had previous *research* contact were eligible for participation.

including use of a professional transcriptionist, management of disclosures regarding third-parties during interviews (e.g., individuals with whom participants are/were in a relationship), limits regarding participant and others' safety, representation of findings (e.g., use of pseudonyms, use of direct quotations in documents), use of Skype technology to conduct the interview (i.e., for three participants), and communication and dissemination of findings (e.g., presentations and publications within academic and clinical contexts) (Haverkamp, 2005). Participants were also informed of the overall time commitment required for participation in the research study, including the initial interview, possible follow-up interview, and member check interview. Informed consent adhered to all institutional policies, and was considered an ongoing process, negotiated with the research participants and monitored closely as the research progressed (Haverkamp; Thompson & Russo, 2012).

*Risks and benefits.* Potential risks and benefits of participating in the research were outlined in detail, to the extent possible in qualitative research (Halse & Honey, 2005), and discussed with participants during the initial informed consent process (Haverkamp, 2005) (see Appendix E). Although there were no clear anticipated risks associated with participating in the study, I acknowledged that the research focuses on a sensitive issue and vulnerabilities may present themselves as the women discussed their history of an ED and process of recovery (e.g., identification of issues that triggered ED behaviors, struggles associated with recovery) within the context of an in-depth interview. As such, it was acknowledged that women may experience some uncomfortable feelings during and/or after the interviews (e.g., shame around ED, sadness around losses incurred during ED, frustration around less helpful relational experiences). The women were invited to contact me at any time for debriefing and/or to discuss additional professional support if needed (e.g., referral to counsellor). Information regarding community

supports and resources was provided to all participants (see Appendix I) before the initial data collection interview began. As previously stated, no women contacted me about support needs, referrals, or resources following the interview.

Some scholars have suggested however that participating in qualitative research can be rewarding for participants (e.g., van Manen, 1997b). van Manen indicates that participants may feel “hope, increased awareness, moral stimulation, insight, a sense of liberation, a certain thoughtfulness” and in some instances, experience changes in their life (p. 162). For example, it was acknowledged that the women may be reminded of the supports they received during their recovery. Indeed, the study participants consistently expressed a strong sense of gratitude for their partners and a desire for their appreciation to be known to their partners. These sentiments were re-iterated by many participants after reading the results, as they were reminded of the powerful experiences they shared with their partner. It has also been suggested that women who have recovered from an ED engage in some form of activism around the issue or a cause that is important to them (see Liu, 2011). As anticipated, several participants expressed value in contributing to knowledge regarding what they believed to be the important role of partners in recovery from an ED, and as previously noted, many of these sentiments were re-iterated upon reviewing the study findings, hence, the outcome of their contribution.

### *Delimitations*

Several delimitations are now addressed, namely, the study’s conceptualization of key constructs, and delineation of inclusion and exclusion criteria. Given that participants were required to have had a previous ED diagnosis the study referenced a medical view of EDs and inevitably precluded the involvement of women who subjectively identified as having had difficulty with disordered eating and/or shape and weight concerns without meeting a clinical

threshold, or those who reject these labels altogether (Garrett, 1997; Halse & Honey, 2005). Similarly, with respect to the duration criteria set around recovery process and status, although both objective and subjective criteria were employed, inclusion of the empirically based criteria may have precluded the involvement of some women who self-identify as “recovered,” yet, did not meet the outlined objective criteria. This also excluded women currently working to reduce ED symptoms, who did not yet meet the criteria. The duration criteria for length of intimate relationship also excluded women in intimate relationships of shorter durations.

During recruitment I relied on retrospective self-report accounts from potential participants to determine whether they have a history of ED symptoms meeting criteria for an ED diagnosis. Likewise, self-report was used to determine if potential participants met criteria for recovery status. Additionally, the participants were English speaking, and this requirement precluded the involvement of women who may have met inclusion criteria but were not English speaking.

Given that the study focused specifically on the supportive and facilitative aspects of the women’s recovery and relational experiences, participants must have experienced their intimate partner relationship as significant to their attainment of recovery from an ED. As such, the study excluded women who did not identify their relationship as having been particularly supportive of their recovery (e.g., women with more challenging or conflicted relational experiences, women who were in an intimate relationship but identify with other predominant sources and supports of recovery). To this end, it must be acknowledged that current findings illustrate adult women’s experiences of having an intimate partner relationship support their recovery from an ED and do not necessarily represent the full range of recovery related experiences (e.g., supports and challenges) or fully depict the complexities of the intimate partner relationship during recovery

(e.g., less supportive elements, experiences that may have hindered recovery efforts). Relatedly, despite efforts to recruit widely, all participants identified as heterosexual, in heterosexual relationships. Given that the dominant Western cultural context of these women and their male partners is highly gendered, privileging heterosexual orientation and emphasizing traditional sex roles, it was deemed theoretically and methodologically sound to pursue investigation of the phenomenon of interest with this group, despite absence of same sex couples and greater diversity. The implications of this sample are discussed further in the Discussion chapter.

## Chapter 4: Results

The research question guiding this hermeneutic phenomenological inquiry was: **“what is the meaning of lived experience of intimate partner relationships in supporting women’s recovery from an eating disorder?”** This chapter begins with biographical synopses of the study participants, to contextualize the lived experience of *intimate partner relationships supporting recovery from an ED* described by the women (see Table 1). These “biosynopses” are followed by presentation of the essential meaning structures, or common themes, constituting the women’s lived experiences (see Table 2). These common themes are presented as follows: *Sense of Safety*, *Sense of Mutual Commitment*, *Communication as Facilitative*, *Intimacy*, and *Sense of Identity Beyond the ED*. Three of the common themes also consisted of sub-themes, specifically, *Sense of Safety* included the sub-themes *Sense of Acceptance and Non-judgment* and *Sense of Security in the Relationship*. The theme *Sense of Mutual Commitment* included the sub-themes *Shared Valuing of the Relationship*, *Joining in Recovery*, and *Sense of Motivation and Accountability*. Lastly, the theme *Intimacy* included the sub-themes *Shifting Relationship to Their Body* and *Differentiation From Other Supportive Relationships*. While the common themes are not presented in any particular order, *Sense of Safety* was a foundational and pervasive aspect of the women’s experience, consistently woven throughout the other themes, and is therefore presented first. The lived experiences and voices of the women are highlighted throughout the text with rich, illustrative quotes.

***Biosynopses***

Table 1

## Summary of Participant Demographic Information

Pseudonym	Age	Racial/ Ethnic Identity	Duration of ED	Treatment	Time in Recovery	Duration of Relationship	Status of Relationship
Chelsea	22	Caucasian	6 years	Outpatient Residential	1 year	1 year	Ended
Lauren	27	Caucasian	10 years	Outpatient Residential	2 years	4 years	Married
Paula	36	Caucasian	7 years	Outpatient	10 years	11 years	Married
Elizabeth	27	Caucasian	10 years	Outpatient	2 years	2 years	Ended
Sundari	39	Caucasian	8 years	Outpatient Residential	10 years	12 years	Ended
Ruth	26	Caucasian	8 years	Outpatient	6 years	8 years	Married
Brooke	24	Caucasian	10 years	Outpatient	1 year	3 years	Ended
Mary	32	Caucasian	15 years	Outpatient Residential	1 year	15 years	Married
Sally	24	East Indian	2 years	Outpatient	4 years	2 years	Ended
Abby	32	Caucasian	9 years	Outpatient	5 years	7 years	Common- law

*Note.* Mean age = 29. Mean duration of ED = 8.5 years. Mean duration of recovery = 4.2 years. Mean duration of relationship = 6.5 years. All participants and their partners identified as heterosexual. Seven of the 10 women lived with their partners. For women whose relationship had ended, three identified as having recovered during the course of the relationship and two identified as having recovered after the relationship's end.

*Chelsea*

Chelsea is a 22-year old heterosexual, presently able-bodied, Caucasian woman. Her religion was an important aspect of her recovery and healing, and she continues to see her faith



as an important aspect of her life. At the time of her relationship she was studying Arts, but taking some time off of her studies, and working part time. She is currently engaged in full-time studies in efforts to complete her Bachelor's degree. Chelsea struggled with symptoms consistent with Bulimia Nervosa (BN) for approximately six years, starting at age 14. She also experienced difficulties with alcohol abuse and self-injury, which impacted both her recovery from the ED and her intimate partner relationship. Chelsea identifies as having been recovered for approximately one year. Over the course of her ED and recovery journey Chelsea pursued various forms of treatment, including outpatient counselling and sessions with a Psychiatrist; specialized outpatient ED treatment, including sessions with a counsellor, dietitian, and physician; and residential treatment. She also accessed support through an online support group. Chelsea and her partner met during late adolescence and early adulthood, respectively, and were together for approximately one year. Her partner, also Caucasian, held a certificate, and worked, in the area of trades. They did not live together during their relationship, and Chelsea was living at home with her parents. Although Chelsea had pursued outpatient treatment prior to meeting her partner, she was also involved in counselling and sessions with a Psychiatrist during their relationship. Her partner did not attend treatment with her. Chelsea and her partner are no longer in a relationship, and Chelsea is currently single. Notably, Chelsea found that the ending of this intimate relationship was an incredibly significant turning point in her recovery. She shared that the loss of this relationship was extremely motivating of change and fueled her pursuit of further intensive treatment, specifically, enrolment in a three month residential treatment program, and led to her full recovery.

*Lauren*

Lauren is a 27-year old heterosexual, presently able-bodied, Caucasian woman. During the period of her recovery with her partner, she was completing a college diploma in the area of social services and now works with children, and also, in the area of aesthetics. Lauren struggled with symptoms consistent with Anorexia Nervosa (AN) for approximately one year, starting around age 13, and subsequently, symptoms of Bulimia Nervosa (BN), for approximately nine years. Lauren identifies as having been recovered for approximately two years. Over the course of her ED and recovery journey she pursued outpatient treatment with a specialized ED program, including sessions with a Psychologist and dietitian, respectively, medical monitoring with a physician, and both individual and group therapy. She also completed a residential program, and returned to the outpatient program for further support upon completion of the intensive, three month long residential program. While the majority of Lauren's ED treatment occurred prior to her relationship, she continued to see a counsellor during the early stages of her time with her partner. While Lauren's partner was not involved in her treatment, he remained actively involved in her recovery efforts and translation of skills and strategies from treatment into their every day lives. Lauren's partner is also Caucasian, and holds a certificate, and works, in the area of trades. Lauren and her partner met in their mid-twenties. They met through mutual friends, and have been together for approximately four years. Lauren shared initial apprehension about entering an intimate relationship, however, indicated that over time and through the establishment of a friendship with her partner, she opened up to the romantic relationship. They moved in together shortly after initiating an intimate relationship, are now married, and since the time of our initial interview have welcomed their first child into the world.

*Paula*

Paula is a 36-year old heterosexual, presently able-bodied, Caucasian woman. She shared that she has a learning disability, which affected her self-esteem and experience with education growing up. During her recovery, and the associated period of time in her relationship, she was pursuing studies in the social sciences. She now holds a Master's degree and works in the area of social services/healthcare. Paula found both Eastern philosophy and Aboriginal healing practices to be significant to her recovery from the ED and healing process. In particular, she felt that Aboriginal healing practices were important to her intimate partner relationship, and continue to be central in their lives and relationship. Paula struggled with symptoms consistent with Anorexia Nervosa (AN), including purging, for approximately seven years. She shared that symptoms emerged in her late adolescence, and worsened around age 19. She first connected with treatment around age 21, at which point she consistently attended medical monitoring appointments with her physician, and participated in some adjunct therapy as part of her treatment and recovery journey. She identifies as having been recovered for approximately 10 years. Paula and her partner met when they were in their mid-twenties. They moved in together after dating for a year, and following a year and a half of living together, separated for six months before re-uniting. Paula shared that her partner struggled with alcohol and substance use, and that this affected their relationship. Paula and her partner have now been together for over 11 years, and are married with a child. Paula's partner is 36 years of age, Aboriginal, and college educated. At the time of her recovery, he was working in the trade industry, however, now works with youth. During their relationship Paula continued to see her physician and pursue arts-based therapy. While her partner was not involved in her professional ED treatment, as previously noted they engaged in Aboriginal healing practices together and he was therefore present for this

part of her healing process. While her partner was less actively involved in supporting her to make ED related changes, she believes their creation of a life and involvement in pursuits together was particularly significant to her recovery journey and healing. Notably, Paula shared that the birth of their child was a final milestone in her recovery process, as she gained a growing acceptance of her body after pregnancy and birth.

### *Elizabeth*

Elizabeth is a 27-year old heterosexual, presently able-bodied, Caucasian woman. At the time of her relationship she was enrolled in full-time studies, working towards an undergraduate degree at university. She now holds a Master's degree and works in the area of social services/healthcare. Elizabeth struggled with symptoms consistent with Anorexia Nervosa (AN) and Bulimia Nervosa (BN) for approximately ten years, starting at age 15. She shared about her family environment growing up, namely, perceived pressures to be thin and restrict the nature and amount of food eaten, and the ways in which she feels this influenced the development of her ED and her relationship to her body. Over the course of her ED and recovery journey Elizabeth pursued outpatient counselling with a Psychologist and medical monitoring with a physician. She identified as being in recovery for approximately two years. Elizabeth and her partner met in late adolescence, and were both attending university, where they were living in residence. Elizabeth's partner, also Caucasian, was studying at the time of their relationship, and has now completed a graduate degree. They were together for approximately two years. They did not live together during this time, however they lived in the same residence on campus, and during breaks from school spent time at each other's respective home towns. During the relationship Elizabeth pursued outpatient counselling, however, her partner did not attend this treatment with her. Elizabeth noted that while she feels her partner would have been open to

attending treatment with her, she preferred to pursue this independently. Elizabeth shared that her partner had increased knowledge about EDs due to his lived experience with supporting a family member with an ED. She acknowledged that, at times, this appeared to increase his overall sense of anxiety around her ED, but also aided him in providing support to her. Elizabeth and her partner are no longer in a relationship. At the time of our interview she was single, but has since entered a new intimate relationship.

### *Sundari*

Sundari is a 39-year old heterosexual, presently able-bodied, Caucasian woman. During her recovery, and the associated period of time in her relationship, she held a Bachelor's degree and was working in the area of social services/healthcare. She now holds a Doctor of Philosophy degree and continues to work in the area of social services/healthcare. Sundari struggled with symptoms consistent with Bulimia Nervosa (BN), including fasting and over-exercise for approximately eight years. While she experienced some ED symptoms as an adolescent, symptoms worsened during her twenties. She identifies as having been recovered for approximately ten years. Over the course of her ED and recovery journey she pursued various forms of outpatient treatment, including therapy with a Psychologist, therapy with a Social Worker, medication monitoring with a Psychiatrist, sessions with a Dietitian, and group therapy. Sundari and her partner initially met during their late adolescence, prior to the onset of her ED, and many years prior to entering an intimate relationship with each other in their late twenties. They had a romantic relationship when they were younger, and although they separated they stayed in touch over the years; they ultimately re-united and married. Her partner, age 40 and also Caucasian, works in the area of trades. In the early stages of their intimate relationship Sundari pursued intensive ED treatment. Shortly after completing this treatment, Sundari and her

partner married and moved in together. Her outpatient treatment continued throughout their relationship, and she considered it to be a significant resource in her recovery. To this end, she felt that many of her support needs were met by virtue of professional treatment, and also, that engagement in treatment increased her sense of what she needed and what would be helpful in terms of her intimate relationship supporting her recovery. Sundari and her partner were together for approximately 12 years, during which time they had a child. Sundari's recovery occurred within the first several years of their relationship. They have since separated and divorced, and Sundari is currently single. Sundari reflected that the aspects of their relationship and relational qualities of her partner that proved instrumental to supporting her in her recovery, were also related, in some ways, to the eventual ending of the relationship. She noted that as she attained recovery and left the ED behind, her needs and desires shifted, and acknowledged that this may have played a small role in changes, and separation, in the relationship over time.

### *Ruth*

Ruth is a 26-year old heterosexual, presently able-bodied, Caucasian woman of Christian faith. During her recovery, and the associated period of time in her relationship, she was completing a Bachelor's degree at university. She now holds a Master's degree and works in the area of social services/healthcare. She struggled with symptoms consistent with Anorexia Nervosa (AN) and Bulimia Nervosa (BN) for approximately eight years, starting around age 12. She shared that her symptoms worsened over time, and were most serious in her mid- to late-adolescence (i.e., age 15-19). She identifies as having been recovered for approximately six years. Over the course of her ED and recovery journey she pursued specialized outpatient treatment, which included both individual and group therapy, and follow-up with a Psychiatrist; she also accessed online resources and supports. Ruth and her partner met in late adolescence

and early adulthood, respectively, and have been together for approximately eight years. They dated for four years, and were then married; they began living together following marriage. They do not have any children. Ruth's partner, also Caucasian and of Christian faith, was also completing a Bachelor's degree and working part time during her recovery. He now has several occupations and pursues work in education. Ruth shared that her partner was a strong motivator for her to seek professional treatment, and she had not been involved in any specialized ED treatment prior to the relationship. She began ED treatment approximately four to six months into their relationship. While her partner did not attend any treatment with her, he accompanied her to appointments, and she felt he was very interested and involved in this aspect of her recovery process.

### *Brooke*

Brooke is a 24-year old heterosexual, presently able-bodied, Caucasian woman. During her recovery, and the associated period of time in her relationship, she was completing a Bachelor's degree at university and working part time. She now holds a Bachelor's degree and currently works in marketing. Brooke struggled with symptoms consistent with Bulimia Nervosa (BN) for approximately 10 years. She began to experience ED symptoms in early adolescence, around age 13, however, her symptoms worsened in her late adolescence (i.e., between the ages of 15-20). She identifies as having been recovered for approximately one year. Over the course of her ED and recovery she pursued various forms of outpatient treatment, including counselling, sessions with a Psychiatrist, sessions with a Psychologist, and follow-up with a physician. She was involved in this treatment during her relationship, and her partner attended several counselling sessions with her. She acknowledged that the most intense and significant period of her recovery was while she was in her intimate relationship with her partner. Brooke and her

partner met through work when they were in their early twenties. They were together for approximately three years, during which time they lived together for a period of time. Her partner, also Caucasian, held a vocational degree and worked in a trade. Brooke and her partner ended their relationship approximately six months ago, and she is currently single. She noted that aspects of their relationship that had proved essential to her recovery, also contributed to the ending of the relationship. That is, over time, as her needs and hopes changed, she felt that the relationship was no longer optimally conducive to her and her partner's growth.

### *Mary*

Mary is a 32-year old heterosexual, presently able-bodied, Caucasian woman, of Christian faith. During her recovery, and the associated period of time in her relationship, she was pursuing an undergraduate degree. She now holds a university degree in a health care field and a post-graduate college certificate, and works in healthcare. Mary struggled with symptoms consistent with Bulimia Nervosa (BN) for approximately 15 years, starting at age 16. She identifies as being recovered for approximately one year. Over the course of her ED and recovery journey she pursued various forms of treatment, including outpatient counselling and residential treatment. She was involved in this treatment at various points during her undergraduate studies, and completed residential treatment during the course of her relationship with her partner. Mary's partner was involved in her ED treatment, in that he accessed resources for family members and attended some counselling sessions with her. Mary and her partner met in late adolescence and early adulthood, respectively. They have been together for approximately 15 years. They first moved in together when Mary was 19, however, lived apart for periods of time, while Mary pursued school and her partner served in the Military. Mary's partner, also Caucasian, now holds a college degree in the area of public services, and is currently pursuing



further studies. Mary and her partner married when Mary was 26, and they now have two young children. According to Mary, her family and children played a significant role in her attainment of recovery.

### *Sally*

Sally is a 24-year old heterosexual, presently able-bodied, East Indian woman. Her Eastern religion was an important aspect of her recovery. During the time of her recovery and relationship, Sally was engaged in full-time studies at university. She now holds a Bachelor's degree and is currently pursuing graduate studies in a professional field. Sally struggled with symptoms consistent with Anorexia Nervosa (AN) and EDNOS for approximately two years. While she began to experience ED symptoms in her late adolescence, symptoms worsened in her early twenties. She identifies as having been in recovery for approximately four years. Over the course of her ED and recovery journey she pursued outpatient counselling with various practitioners, and group therapy through her university. She was involved in this treatment during her relationship with her partner, however, felt that she had already begun her recovery process upon meeting him. Sally's partner attended some counselling sessions with her, and was actively involved in her recovery, namely, supporting her to practice and employ alternate coping skills. Sally shared that her partner's interest in her experience with the ED, and engagement in her recovery process, contrasted her experience with her family and was particularly important to her experience of support. Sally and her partner met in their early twenties and were together for approximately two years. Her partner, also East Indian, held a Bachelor's degree and was pursuing a graduate diploma at the time of their relationship. Sally shared that they practiced different religions, although both of Eastern origin, and she felt that this was very helpful to her recovery, as it offered her another way of thinking about her

wellbeing and healing. Sally and her partner did not live together during their relationship, and Sally lived at home with her family. While Sally and her partner are no longer in an intimate relationship, they maintain a friendship.

### *Abby*

Abby is a 32-year old heterosexual, presently able-bodied, Caucasian woman. During the time of her recovery and relationship she was pursuing her undergraduate degree. She now holds a Bachelor's degree and is currently pursuing graduate studies in the social sciences. Abby struggled with symptoms consistent with Anorexia Nervosa (AN) and Bulimia Nervosa (BN) for approximately nine years, starting at age 17. She identifies as being recovered for approximately five years. Over the course of her ED and recovery journey she pursued various forms of treatment, including outpatient counselling, sessions with a dietitian, family therapy, and medical monitoring with her physician. Abby and her partner met their mid twenties and early thirties, respectively, and have been together for approximately seven years. They identify as common law partners and were living together during her recovery. Her partner is Caucasian, holds a Bachelor's degree, and works in the area of trades. Abby was involved in extensive ED treatment prior to entering her intimate relationship, however, her outpatient counselling and sessions with a dietitian continued during her relationship, and she identifies this work as being particularly significant to her attainment of recovery due to her greater level of readiness and motivation for change at that time in her life. Although her partner did not attend treatment with her, he supported her decision to relocate for a period of time in order to pursue this treatment. Abby shared that her relationship was a significant motivator for pursuing further treatment and working towards recovery.

### ***Common Themes***

The thematic analysis generated five common themes, which are now presented as follows: *Sense of Safety*, *Sense of Mutual Commitment*, *Communication as Facilitative*, *Intimacy*, and *Sense of Identity Beyond the Eating Disorder* (see Table 2).

Table 2

Common Themes and Sub-themes

Common Themes	Sub-themes
Sense of Safety	Sense of Acceptance and Non-judgment
	Sense of Security in the Relationship
Sense of Mutual Commitment	Shared Valuing of the Relationship
	Joining in Recovery
	Sense of Motivation and Accountability
Communication as Facilitative	
Intimacy	Shifting Relationship to Their Body
	Differentiation From Other Supportive Relationships
Sense of Identity Beyond the Eating Disorder	

### ***Sense of Safety***

All of the women in the study described a deep sense of emotional, psychological, and relational safety in their relationship with their partner. This sense of safety permeated their experiences and was viewed as being fundamental to their recovery process. While safety manifested itself in a variety of different ways for the respective women, it was consistently

associated with a *sense of acceptance* for who they are, a *sense of non-judgment* on behalf of their partners, and a *sense of security in the relationship*.

The perceived sense of feeling safe was a foundation for the participants' change efforts, and remained integral to their engagement in the recovery process over time. The women consistently associated a sense of safety with their ability to manage and overcome feelings of anxiety and fear associated with both the ED and the "letting go" of the ED. That is, a sense of safety within their relationship was described as an essential component of approaching and exploring their ED behaviors and the role and function of the ED in their lives. Thus, for these women, a sense of safety enhanced their capacity to change their relationship to the ED. One woman described experiencing the security of a "safety net," having someone there to "catch you," and the comfort this afforded as she worked towards recovery. She shared the following about her experience:

...it was like a big warm blanket that you need when you just wanna, you just need some time to be nice to yourself and just to kind of step away from always feeling not worthy or not good enough or not pretty enough or not skinny enough...it's not that it fixed it, it just kind of made it feel not as bad, and then when it didn't feel as bad or as strong then you can kind of you know, start fighting.

For the women in this study, that sense of comfort within their relationship provided some respite from the internal dialogue and negative self-perceptions maintaining the ED, and contributed to the sense of safety and "space" required for the work of recovery:

...the comfort was paramount in my recovery just because I had felt so uncomfortable with myself in the way that I couldn't just, I couldn't give myself the permission to get better because I didn't think I deserved it. And when I felt that anxiety of who I was, was

kind of alleviated, even temporarily, it kind of gave me some room to give me permission to really start working on recovering.

It appeared that, for these women, a sense of safety was inherently related to their capacity to be vulnerable in the relationship and with recovery; that is, an ability to be vulnerable appeared to be a key precursor to experimenting with new ways of being, relating, and behaving. One woman's words captured this experience, as she shared that safety afforded "the space for [the ED] to be there in our relationship, to sort of explore and come to know, rather than it always being something I was hiding and ashamed of." Indeed, the women's capacity to be vulnerable within the safety of their relationships afforded them opportunities to take risks in their recovery, including being able to speak openly with their partner about a range of recovery related experiences, being able to identify and process distressing emotions, and/or being able to challenge themselves around eating. One woman shared how her partner "helped [her] with the bravery component of healing" because he was there by her side; she felt she "had somebody" with her in her life. She shared the many ways in which this partnership encouraged her to open up to life, its possibilities and its gifts, versus remaining within what had in many ways been experienced as the safe, yet restrictive confines of her ED. This illustrates how, for many women in the study, the relationship came to provide the safety that was once ensured by the ED.

The women described the ways in which, over time, this sense of safety and the development of new capacities it afforded reduced their reliance on their ED and de-stabilized the functions it was serving. They described the establishment of new ways of coping, and emphasized safety as a key aspect in their growing capacity to manage any discomfort and challenges associated with the recovery process.

*Sense of acceptance and non-judgment.* Integral to the women's sense of safety in their intimate relationship was their experience of acceptance and non-judgment on behalf of their partners. All of the women shared a profound sense of being accepted by their partners, and closely tied to this sense of acceptance was a sense of non-judgment. The women described feeling accepted by their partners for all aspects of their being, the wanted and unwanted aspects of self. They felt completely seen by their partners, "the good, the bad and the ugly, in so many different ways," and felt no judgment. One woman's words illustrate the power of being in this relational climate, in terms of her recovery process:

I really needed to be in a non-judgemental space, and for me to go through my process what was really fundamental was that non-judgemental kind of non-conditional loving space...I think really what was essential, at the core, was being in an environment where I was accepted, there was no judgement and I felt loved...and that alone, feeling loved, feeling acceptance, feeling non-judgement, feeling I'm okay as I am, feeling care and the responsiveness, all of that helped me, you know, even though it's not like directly helping me in a specific way, it helped me to be able to take that journey and to go through it...I could go through it and I could complete it. It was like a safe container, it was like the safe womb space.

Many women described feeling as though they were "enough" in their relationships, in contrast to the image and sense of self as insufficient, or of not meeting their own expectations or the perceived expectations of others. Reflecting the experience of many other women in the study, one participant shared the constant sense of pressure she lived with, and the release from expectations that her intimate relationship afforded her:

You're just carrying so many different things on your shoulders, so being able to just feel like you're enough is huge because you never, you never feel like you're enough or you're doing enough or you're going to amount to enough. And so to be in a relationship where they value just who you are right now and really make that known...he's very good about validating just who I am right now and validating me for me, not me because of my work or because of how much I did in a day or whatever, [that's] huge.

The women shared a sense of relief as they described experiencing some "space" and distance within their intimate relationship from distressing thoughts and feelings associated with, and fueling, the ED. In the words of one participant:

He was a giant place for me to be able to just like step away from all the pressures I'd put on myself and all the pressures that, you know, that breathing room, he just provided that in so many ways for me.

The words of another participant re-iterate the value the women placed on these relational qualities and the climate they created. In particular, this participant's words highlight the sense of peace the acceptance and non-judgment afforded these women:

...the possibility that I could just be and continue, like, just be [myself]...the way that I was, and didn't have to keep striving towards something was like this incredibly sort of calming...like you can relax...that was sort of how that felt.

Indeed, the women were unanimous in that they felt able to just "be" with their partners, without needing to change themselves or be different, and that this was powerfully healing. These words were echoed by yet another participant who shared the sentiment that being with her partner can be "so calm...it's a really peaceful place when I'm with him," which for her, contrasted with the constant sense that she needed to be or do something different, something more.

Of particular importance to the participants' experience of acceptance and non-judgment was their partners' demonstration of openness around the women's experience of, and struggle with, the ED. Several participants described how liberating this was, as illustrated here by one woman:

I feel like I was really trapped in a lot of ways, and so it was a kind of freeing for me to be known by someone and to be accepted in that way...with a lot of people I had felt like they like me because they don't know this about me, or I'm okay with this person because they don't know this about me, and for this person to know this about me and still like want to love me and be close to me and to be my significant other, it really influenced how I looked at myself.

These sentiments were echoed by another woman, who shared:

I was always terrified that once he found out, and once he knew just how crazy I was, he'd run away – and I would not judge him for doing so. But to – when they stick it out and they talk to you, you realize, maybe I'm not as crazy as I think I am.

Indeed, the majority of the women spoke emphatically about the positive impact of experiencing acceptance and non-judgment with respect to their ED, despite the fact that their partners did not fully comprehend the reasons for their ED and/or symptoms. Partner acceptance and non-judgment in spite of not understanding, relating to, or agreeing with the ED resonated profoundly with the women and served to deepen and strengthen the value and validity of their overall sense of acceptance. As captured by the words of one participant:

Seeing that he was willing to still support me and be by my side while he still didn't understand it, was something that meant a lot me. So even though he didn't get why I was doing it to myself, he still wanted to understand or be there, and I remember him saying



like, ‘I won’t get why you’re doing this, I don’t think I will ever get why you’re doing this, but I still wanna be with you.’

The women believed that their partner’s ability to sit with, or manage, their own confusion, uncertainty, and/or frustration around the ED, while simultaneously providing support, was deeply affirming of their partners’ commitment to them and their recovery. To this end, the women expressed awareness around the challenges their partners may have experienced in their efforts to provide support.

Relatedly, several women described feeling compassion from their partners. They shared an appreciation for their partner’s extension of kindness in response to their experience with the ED, despite their partner’s struggle to understand or relate to the ED. Reflecting the experience of many women in the study, one participant described the ways in which her partner’s acceptance, non-judgment, and openness reduced her sense of isolation in her ED:

I felt like no one understood me, even professionals at the time. I had had bad experiences and I had felt like there was no hope for me. So when he told me that he didn’t judge me for it and that he didn’t understand but that he would try to, it made me believe again that maybe someone would...even though he didn’t understand, he had a desire to, and that comforted me.

Similarly, another participant viewed her partner’s compassion as a reflection of his ability to connect to her deeper struggles and suffering as she fought to overcome the ED:

...that flavour definitely carried through for most the time, just this kind of unconditional acceptance and compassion, even though he couldn’t understand everything, that was okay...he couldn’t understand everything but he could still be compassionate about it and support me without needing to understand...there was a love, there was a gentleness

towards me and even though he couldn't understand the details of what this is or why I needed what I needed, there was still a love and an acceptance and a deeper understanding...he understood on a different level. Even though on one level he didn't get the whole eating disorder thing, but he understood the deeper struggle.

Acceptance, non-judgment, and compassion appeared to be powerful antidotes to the feelings of shame characterizing the women's experience of their ED. Being both fully witnessed and accepted, in and of itself, appeared to be healing for these women, as it served to challenge some of the negative beliefs underlying the ED and compromising their wellbeing. One woman captured the healing power of her partner's acceptance, and how the gradual internalization of her partner's messages changed her relationship to herself and her ED:

...in my eyes I was flawed, maybe in his I was too, but it was like it didn't matter because he still loved me, and that wasn't important...it was that much more of a powerful message to get, that one of compassion and acceptance and love and worth and all the rest, because I was so wrapped up in this struggle of thinking I was fat. So, yeah...the confidence began to grow and the self-worth and the self-compassion and um, the shame and the self-hatred and all those sorts of things began to sort of like, shrink a little bit.

For many women shame was associated with avoidance, with remaining hidden – be it from aspects of themselves and/or their ED. The women noted the consequences of avoidance, namely, a sense of 'stuckness' in their ED and immobility in their efforts to change and recover. They described a consequent struggle to attend to, and address the ED, and feeling entangled with the mechanisms maintaining their ED, including feelings of low self worth or efficacy, and/or feelings of fear and self-doubt. Reflecting the experience of the other participants, this woman described the relief associated with feeling fully seen and accepted by her partner:

...being able to expose yourself so much to someone kind of lets you know that you don't really have anything else to be afraid of. Because I think a lot of fear has to do with showing another person your darkest places, and having that already on the table you don't have to really be afraid of that anymore, 'cause it just is what it is...they know your best parts and darkest parts, and what's going on in your life, and some things you might be ashamed to expose so...having someone that you can feel comfortable enough to tell all those things to or share all those things with, I mean that in itself kind of eliminates the fear.

For these women, their partner's acceptance, non-judgment, and compassion, and the sense of safety they instilled, appeared to create the conditions essential to recovery. Another participant illustrated the relationship between acceptance and space for healing:

...as far as what I needed, especially in that first year of my recovery, was I just really needed a container or a womb space where I could completely you know, be held or be accepted for who I was...he was just like a beautiful holding space that sort of allowed my journey without you know, getting involved, or demanding that I be a different way, or expressing his discontent with me. And I think that was probably pretty huge because I think that was at a time in my life where I guess I just really needed to be completely accepted for who I was, so I could just internalize that myself.

Another example of these facilitative conditions was captured by the women's experience of disclosing their ED to their partners. Many participants shared their felt sense of acceptance and support in response to their disclosure. In the words of one woman:

...a very supportive, understanding, compassionate [response], a lot of that sort of lifted and it was like ah, relief. And it was still there, and it was still heavy, and it was still

painful, but it was like okay, there it is, wow you know, I said it. And then it gave space to talk about it and I think that...the shame continued to kind of strip away or be broken up...which allowed for me to be able to bring more attention to it, because you know, without that shame being there I was able to actually think about it.

Relatedly, most participants shared that their partner's acceptance and non-judgment contributed to their ability to make behavioral changes around the ED, including changes to their eating, as depicted by this woman:

...so instead of feeling guilty or bad or ashamed that I have to eat food in this way, for now, for me to be okay, it was completely accepting that this is how it is now, and I'm going to respect and honour that. And I had control to do that, like no one was going to tell me otherwise or make fun of me or make me feel ashamed.

Overall, in contrast to the encompassing nature of the ED, and associated feelings of shame and immobility, the women's experience of acceptance and non-judgment in their intimate relationship appeared to foster a sense of separation from ED related thoughts and feelings. This distancing afforded participants opportunities for change; specifically, the women consistently shared that within the safety of their relationship, they felt more capable of approaching their ED and underlying issues and needs, which they viewed as paramount to recovery.

***Sense of security in the relationship.*** Contributing further to the sense of safety described by the women was their sense of "security" in their relationship. Security was established in various ways, and included the belief that their relationship with their partner was not contingent upon their recovery from the ED; importantly, this was true for all women in the study, including those for whom their intimate relationship had since ended. Security was

manifest through a sense of reliability or consistency in the presence of their partner, including their partner's availability, and the experience of unconditional regard and support from their partner. To this end, many women voiced trust that their partner would be there for them, no matter what. One woman described this as a deep sense of connection and "grounding," and spoke of the ways in which the "security" of this "attachment" allowed her to experiment with making changes:

...if you have one anchor person, one person that you can go to and you know, their behaviours may not be great and there may be challenges to them, but you know that their intentions towards you are good. And, and if you have that, then you've got the attachment where you can start to go...

This experience reflects the women's shared sense that their partners provided a starting place, "home base," or "secure base" for growth and engagement in recovery. It also acknowledges the women's identification of challenges and complexities in their relationships, and in doing so, illustrates the perceived value the women attached to their partner's commitment and support. For participants in the current study, the relationship's supportive qualities were experienced as being prominent and strong enough to overcome the relational and recovery-related difficulties encountered along the way. Similar sentiments were captured in the words of another participant, which highlight the ways in which trust pervaded these relationships, and contributed to the sense of security:

...knowing they're gonna be there, like depending on someone, that you're not gonna have to keep checking behind you and making sure that they're gonna be there supporting you all the time. You can just trust that they're there and then you can kind of just go and dive into whatever you've been scared to...that they're gonna still be there and pick it up

and we'll try again...that's what let me kind of give myself that room to go there with my recovery.

The women's sense that their relationship with their partner was not contingent upon recovery from the ED appeared to contribute markedly to their feelings of safety and security in their relationships. Indeed, for these women, the sense of security relieved them of a sense of "pressure" or expectation to change, and the anxiety associated with perceiving such pressures. One woman recognized, that "as significant as [the ED] was in [her] life, it was never something that he was willing to part with [her] over." As previously noted, this sentiment was reflected in all of the participants' experiences, including the women whose relationships eventually ended, and the two women who attained recovery after their relationships had ended. Relatedly, several women observed that their partners were not afraid of, or overwhelmed by, the ED, which was viewed by the women as contributing to their partner's stability, consistency, and availability.

Participants' belief that their partners could ultimately tolerate and withstand the women's experiences and struggles with the ED further promoted the women's sense of security. In describing her experiences of this over time, one woman spoke of the trust and faith she had in her partner, in light of his consistency and availability. She shared that she "knew that he wasn't gonna go anywhere, and [she] knew that he wasn't scared or overwhelmed by [the ED]." Like many of the participants, particularly those in longer-term relationships, she reflected that the presence of these relational qualities, and the security they endowed, enabled her to risk experiencing the vulnerability necessary for recovery. Some participants noted however, their partner's "frustration" around the ED behaviors and difficulties of achieving change; these women's experiences highlight what appeared to be variability in partners' responses to the ED, and their ability to cope with and navigate the ED. It was noted by one participant that when her

partner struggled to understand her ED related behavior and voiced distress around it, she felt triggered (i.e., leading to thoughts, feelings, and behaviors that she was ultimately trying to change). Another woman commented that she viewed her partner's distress with compassion, and acknowledged it to be an understandable aspect of being witness to the ED and recovery process; she explained that by adopting this view of her partner's experiences, she was able to manage her own reactions and remind herself that he was grounded in a place of concern.

The women's experience of their partners as reliable, consistent, and available, across their recovery related needs and experiences, also contributed to a sense of unconditional support. This sense of unconditional support reinforced the participants' sense of safety and security in the relationship, and increased their trust in their partner and the strength of their relationship. One woman was emotionally moved as she reflected on this aspect of her experience:

...if I needed to ask for more help, he would just be there, and if I was struggling, he would be there, and he was just so steady. Like that's the one, he's always steady, not always, he has a lot of ups and downs of his own, but he's there for me in a way that I don't think I've ever experienced someone being available to me, I never had that growing up... I think I tried to push him away so many times and he's just always there and I'm like, oh my God, to have that, it shifted everything.

This woman's experience beautifully captures the value participants' placed upon partners' consistency, and the security it instilled. She recognized and appreciated her partner's own experiences and challenges, and the presence of struggles and disconnects in their relationship over time, and thus, felt deeply touched that in spite of this, he remained open and available as a grounding place and support to her. To this end, it appeared that for the majority of these

participants, steadiness and consistency were established over time, as the couples navigated the “ups and downs” of both partners, and the relationship itself.

Reflecting the experience of many women in the study, one participant described the importance of the security she experienced in her intimate relationship, with particular focus on the continuity it afforded throughout her recovery process, in relation to other supports:

...it was the primary grounding...like it was my home space, was with him, or where we were, and it was like the primary grounding, solid support. Where I would go out you know, to see a psychiatrist or I'd go out to the group therapy or I'd go out to my counsellor and process different pieces but he, and the home there with him, was like the, was the one constant. Um, yeah very constant, very steady and just al- always there during that time whereas you know, these other supports for little pieces, but this was just very grounding, it was very steady, it was this solid foundation of support.

Participants' sense of security in their relationship was intimately related to their sense of trust in their partner's capacity to support them unconditionally, including their partner's acceptance, non-judgment, compassion, availability, and consistency. Trust was in turn essential to the women's overall sense of safety, and thus, their ability to be vulnerable and open in their relationships and throughout their recovery.

### ***Sense of Mutual Commitment***

All of the women described a sense of shared commitment and investment, between them and their partner, to each other and the relationship and to recovery from the ED. The women described a *shared valuing of the relationship*, and an associated sense of unity around efforts to foster the relationship. The women also described a *joining in recovery* from the ED, a sense that both they and their partners were invested in the process. To this end, the participants' described



the experience of partnership – in both relationship and recovery. The women all described the *sense of motivation* this mutuality instilled, and emphasized the *sense of accountability* that took root within this shared investment in the relationship and recovery process.

***Shared valuing of the relationship.*** The women experienced a strong, mutual valuing of their intimate relationship. They experienced both themselves and their partners as being invested in each other, and in making the relationship prosper. As they described their commitment to the relationship, the women spoke of compromise and working together, being “open minded” and “flexible,” “being on the same page,” and needing to “shift perspectives” at times. To this end, the relationship was often experienced as a partnership, characterized by efforts to attend to, and respect, each partner’s needs. Several women acknowledged the ways in which the ED interfered with, or rendered more challenging, their efforts to be optimally present and available in the relationship, yet re-iterated their desire and efforts to do so. One woman commented, “your partner is there and living it with you, and if it’s going to work then there’s got to be some kind of give and take a little bit.” She acknowledged, “I need to be able to accept what he’s gonna say, and understand that he’s living with me, and it’s not always easy for him, but also, he needs to be mindful that [recovery is] not straight up hill, it’s definitely a rollercoaster.” Echoing the words of other participants, the following woman voiced her deep gratitude for her partner and the shared valuing of their relationship she experienced. In particular, she captures the sense of commitment experienced by the women in this study:

It’s like I have the root of this relationship that provides more happiness than anything could, and anything has, and that’s what matters. And I feel like we, I keep coming back to that with him, because that’s the focus. It’s just constantly making sure that [we’re] doing everything we can to make sure that we’re contributing to that...and that it’s not

just about me and what I'm doing, and how I can get worked up with my own stuff, but that we're really responsible to each other.

The following participant's words further capture this aspect of the women's experience, with particular attention to the intentionality of the women in addressing relational issues with their partners:

...it's been really amazing to be able to work through problems from a place of knowing that we're really in it together. That we're not separate and we're not isolated and that we just come together because it works or something, it's like, no this is us really moving together, and these feelings come up, and why are they coming up, because it's two of us, not just one.

Similarly, in speaking about her and her partner's shared commitment to their relationship, another woman emphasized her perception that her partner was consistently willing to work on issues that emerged within the context of the intimate relationship. As such, her experience of her partner as being invested in overcoming challenges strengthened her trust in his support. She shared a strong belief in his dedication to making their relationship as strong as it could be, which increased her confidence that they could sustain challenges and grow together:

I think it wasn't even as much advocating just for recovery but it was advocating for us... he was there for the long haul...he was willing to work on things, he was willing to be there through things...we were willing to put the effort and you know, he showed me that he was okay with going to counselling sessions with me. Like if things aren't working, he's willing to seek help, and so that meant that he was willing to work on this marriage...and make it not about him and not about me, but it's about us and working on things together.

Relatedly, several of the women shared their experiences of a bi-directional flow of support in the relationship, which further contributed to a sense of partnership and mutual investment in both their own and their partner's wellbeing. One woman shared that her experience of mutual commitment to the relationship reinforced her efforts to reciprocate in her relationship, demonstrate care for her partner, and share her appreciation for his support. For the following woman, the presence and recognition of her partner's life experiences served to decentralize the ED as the primary focus within the relationship, and uphold their relationship – its functioning and quality – as a priority:

...he didn't stop going through his own stuff either and he was open about when things, when he was struggling with stuff, and that was helpful too 'cause then it wasn't all about me and it wasn't all about my recovery and my process. It was still both of us in the relationship with one another...

The above sentiments were echoed by another participant, who felt strongly committed to contributing to the partnership that she and her husband had created, by endeavouring to provide support to her husband when needed. She shared, "we're here for each other, and it makes me try harder on the days when he's having difficult days. I really have to turn around in my head and say, 'okay he was here for me, I'm going to be here for that man.'" Relatedly, the following participant reflected on the ways in which being in a committed relationship shifted her focus from herself, towards the partnership. For this woman, her valuing of her intimate relationship led to growing awareness of how the ED interfered with her sense of connection in the relationship. She shared how upsetting it was for her to realize the negative relational consequences of the ED, and how much this reinforced her valuing of her partner and their relationship.

...it got me out of just focusing on myself. 'Cause that was definitely a default for me, just always going back to, 'what's wrong with me, what's wrong with my life, what's wrong with the way I'm functioning, and what's wrong with how I'm approaching things' and it was more about how can we be with one another, and the eating disorder was just totally causing us to be apart from one another.

The women described the ways in which their perception of their partner's commitment engendered a sense of hope about the future, and strengthened belief in the possibility of recovery. One woman explained that her relationship opened her eyes to the potential inherent in both her relationship and her life, and observed her growing willingness to approach and engage with that potential, versus remaining in the depths of the ED:

We both really felt right off the bat that we wanted to be together for a really long time and so, knowing that just made it more, I guess for him and for me, being that invested in the relationship...we were both so invested in each other...I think it kind of ties into what I was talking about, about not being able to think that I was ever gonna get out of [the ED] and so to now have something else in my life that could be wonderful, could be healthy, could be really positive, and allowing myself to move towards that.

For this woman, the value of being in a fulfilling relationship began to outweigh the value associated with the ED. Similarly, in speaking to her cultivation of a relationship with her partner, one woman reflected upon the ways in which being in an intimate relationship contrasted her experience in the ED. Specifically, she reflected that her rigid adherence to the ED restricted her lived experience, and juxtaposed this "stoic" and "puritanical" way of living with the energy and freedom of pursuing love and connection through her relationship:

...to make a choice to move towards is not an avoiding behaviour, right, like if you're moving towards, you're not avoiding, and that, I think, is quintessentially opposite as well...there's such a compulsion towards vitality...love is vital and if you're moving towards that, then you're moving towards a purpose again, that is far more important than any compulsion to be unwell.

To this end, the relationship appeared to afford a sense of purpose and meaning, greater than the ED. Indeed, several women highlighted the importance and meaning of building a life with their partner, and the ways in which this pursuit outweighed the ED in its significance. Of note however, the extent to which a shared commitment to, and vision for, the relationship characterized and permeated the women's experience varied somewhat among the women, between those who were still currently with their partner, and those whose relationship had ended. Specifically, while all the women experienced a shared valuing of their relationship, a focus on the future and an orientation towards long term hopes and visions for the relationship tended to be more apparent for women who remained with their partners over the long term. To this end, many of the women in longer term relationships and those still with their partner spoke of shared hopes, goals, and visions for their relationship and their life with their partner. This included, but was not limited to, a prioritizing of family, a desire for and commitment to children, and attaining an optimal quality of life. Notably, participants spoke about the ways in which plans for the future promoted more immediate efforts and changes with respect to their recovery from the ED. As one woman reflected:

...you also start to think about things in the future, like you think down the road and you're like, eventually if I want to have kids, then I can't be doing this to my body and

then that becomes not about me, that's about a baby and it's also about them, because they are the other person...

Similarly, another participant shared the belief that her and her partner's commitment to having a healthy family fuelled her recovery efforts, and helped her move beyond a particularly difficult time in her life and ED by providing a sense of purpose in her recovery. She explained that in truly reflecting upon the question, "what, really, do I want?" she realized, and became committed to, something more significant than the ED:

...I want another baby, and I mean he was supportive, and that's what our goal is, that's what we want, so you know, he was supportive in that, so I guess in a sense that was supporting my recovery.

Like many participants in the study, this woman felt that her and her partner's shared hopes for their future united them around common values, provided a sense of direction in recovery, and ultimately facilitated change efforts.

***Joining in recovery.*** In addition to a shared commitment to the relationship itself, all of the women experienced a mutual investment in the recovery process. To this end, they described a partnership, or joining, in recovery. They spoke of a unity, of "we," "us," and a "team" in the recovery journey, and the ways in which this promoted change. Reflecting the experience of all the women in the study, one woman commented, "you're just in it with somebody, and that's extremely helpful." Another participant described the supportive nature of this unity, including the sense of encouragement it afforded her:

...it felt more hopeful and it felt more supported, because all of a sudden it wasn't just me, you know, it was like, 'oh we're in this together,' and 'I'm gonna stand beside you

and I'm gonna still love you when you fall and when you get back up, and when you do well and when you do poorly,' and all that sort of stuff.

Another participant's words further illustrate this aspect of the women's experience, as she described what it was like for her to have her partner by her side through the various stages of the ED and recovery:

...it challenged me just to break out of the pattern that I was in and to kind of trust that if I did that there would be you know, a better opportunity or a better way of living or of accepting myself...and on days where I would slip up or days where I felt like maybe without him would've, I don't know if you want to call it relapse or, but relapse for much longer or, just been in a really bad place for a longer time, I had someone to help me...

As articulated above, of particular importance to the women was the sense that their partner would be by their side through both the successes and challenges of recovery. The women consistently acknowledged the efforts, work, and difficulties of recovering from their ED, and voiced appreciation for the presence of their partner. One woman was particularly moved as she spoke of what this commitment meant to her:

I really think it was a testament to how much he wanted you know, the relationship and wanted me and so, willing to go through like not only being in a relationship with someone with an eating disorder but willing to go through the recovery process...I think they're both very hard...just living with someone with an eating disorder is difficult but willing to go through that you know, the disappointments and the exciting parts of feeling better about myself or gaining weight or you know, being able to exercise again and not be triggered, things like that. Willing to go through that with me, believing that in the end I would be able to make it even though I didn't think at the time I would be.

The above sentiments are echoed by another participant, who experienced her partner's presence and commitment throughout all aspects of her recovery, as paramount to her experience of the relationship as a support:

...he's always gonna be by my side, he's supportive, he's there for the long haul, he's there through shit, he's there through the good times, he's just, he's there. And I mean I guess that's, I mean that's really all you can ask for, I mean that's exactly the example of an intimate relationship supporting recovery, just, he's been there.

For these women, a sense of partnership in recovery was particularly important in reducing feelings of isolation associated with their experience of the ED. The participants all shared the sentiments voiced by this woman, that "eating disorders are so isolating, and distancing," and involve "secrecy," yet with the relationship "it's not, I'm not alone." Another participant's words further illustrate the women's feelings that an experience of partnership in recovery decreased this sense of disconnection:

I wasn't going at it alone...[it's] such a lonely kind of disorder that you put yourself in, there's no social aspect to it...it's such a internal struggle but then to have someone that's now kind of in on it in some ways...

This woman speaks further about her experience of having her partner voice his investment in her recovery, and his desire to join with her in the journey, and observed the impact this had:

I had never really considered recovery before...it just felt like [the ED] was always gonna be with me and this was gonna be like my life for the rest of my life and so for someone to say, you know, 'you could be getting better, I want you to get better, this is how you can get better with me, I want to do this with you, I want to help you in this way'...it



pushed me to start going to different groups, it pushed me to talk about what I was talking about at therapy or different things like that.

Another woman shared that “you do take, I think, more risks when you have someone who’s supporting you and who believes in you, when you don’t really believe in yourself, then it gets a little bit easier every time.” To this end, another woman commented, “I think it’s a combination between [partners] providing that strength and kind of teaching you that you are strong.” Indeed, many women expressed growing awareness and appreciation of their capacities, and found their experience of their partners joining with them in recovery to be affirming and reinforcing of their efforts to make changes. For example, one woman commented that “to see that pride in someone that you care about so much, and that cares about you, and to see them be really excited for you and really cheering you on” when changes have been made, was significant.

For the women in this study the experience of joining in recovery manifested in a variety of different ways. In addition, the extent to which partners were directly involved in the women’s recovery efforts appeared to vary among the women, and appeared related to the women’s needs and preferences for support. To this end, the women’s partner’s orientation to, or stance towards, the women’s recovery efforts, and the women’s perception of their partner’s efforts to support them, appeared to be particularly important to the women’s overall experience of support. For example, in speaking to her partner’s orientation towards her recovery efforts and needs, one woman commented:

... he didn’t have any ideas about what was right or wrong in terms of it, he wasn’t criticizing me for what I was eating, what I wasn’t eating, my exercising...

As illustrated above, the women shared the belief that they were themselves largely empowered to guide their recovery process. This involved however, an experience of working with their

partner to determine the nature of support – to this end, they often spoke of a sense of collaboration with their partners. The following participant’s words capture the experience of several women, who experienced less direct involvement and feedback around the day-to-day steps and tasks of making changes to ED behaviors, yet felt profoundly supported and united with their partners in their journey:

...he never tried to direct me or say ‘what about trying this,’ it was always up to me to kind of find a way. He was more there to be like, kind of like I said, he was a cheerleader for whatever decision it was...if it seemed like it was a behaviour that was maybe gonna put me in a bit of a box again he would kind of, he would maybe point to that, but generally he really advocated for what I felt I needed to do and what strategies I needed to use...

Another woman shared that her partner never “gave [her] the key to recovery, he never told [her] ‘you need to take these steps, you need to do this, don’t do that,’” and she believed he wasn’t equipped to provide specific strategies. However, like many women in the study, she felt that his presence and availability were key in establishing a sense of unity.

The women in this study also shared that their partners validated and encouraged their efforts to make changes, and in many cases, “gently challenge[d]” them to attempt alternate behaviors or ways of coping, and to reflect on their experience. To this end, the women often spoke of their partner’s stance in providing support, sharing that their partner would “check-in,” share an observation, or appear “curious” about the women’s experiences. The following participant captured this latter dimension of the women’s experience, as she described the ways in which the ED and related issues were often broached in her relationship:

...he would check-in, he would ask me about [it], you know, see how I was doing and I felt like there was an openness to talk about it, and I think it caused me to be pushed out of my comfort zone...

These aspects of partner's joining in recovery are further illustrated by the following participant's experience:

...he would help me monitor my emotions in some ways, so if I was really upset he'd ask me what would I be doing that night to make sure that I wouldn't want to binge and purge or things like that, so yeah monitoring, I think, my affect in some ways...just being really in tune with how I was doing and being aware that often that would relate to my eating habits or to my disorder, and so really understanding that relation and then being able to help me with that.

Indeed, many women shared the perception that their partner became aware of factors related to the ED (e.g., vulnerabilities, patterns), and used this knowledge of the women and their experiences to inform the kind of support they might offer, and also, as illustrated above, when they might "check-in" with the women. The words of another participant capture this aspect of the women's experience:

...he really learned what my all-or-nothing thinking was, or he really learned what my triggers were, or he really learned my weaknesses or how I would react to certain things, and so he would be able to predict sometimes how I would respond to things and help me in those ways...

The women in the study emphasized their experience of emotional support within the context of their intimate relationship, however, many also described more tangible, behavioural, and practical support, and shared ways in which these kinds of support facilitated their recovery

efforts. One woman, whose partner was more actively involved in her recovery efforts, described her experience of her partner joining with her to promote changes to her eating, and voiced how meaningful this partnership in recovery was:

...he became an amazing support because he was probably the first person that I was ever that honest with right off the bat. And so when we'd go out for dinner, we would either go late [or] eat something beforehand. He would check-in and see how I was doing. We would check-in periodically throughout the night. It was extremely helpful because it's different than a friend. It's different than your parents 'cause they're not going to be there in those situations...it was always okay just to check-in, to set goals so if we got, if I got through that night and it was okay, we could leave at any time, we'd go snowboarding together the next day and do something fun. Like, not that I wasn't allowed to do that if I didn't get through the night but there was just incentive to do things...and I found that to be extremely helpful, but also there was no judgement if I didn't get through.

Another participant found her partner's presence to be particularly helpful, as a distraction, as she worked to manage urges to engage in ED behaviors. She described how instrumental and supportive this felt: "[him] just being there with me during that time, like I needed someone to just, you know, like kind of talk me through it or sit with me through it until the feelings passed, and he did," and "that's a huge way that he was there for me." Several other women also described their partner's efforts to suggest or participate in alternate ways of coping. One woman found her husband's support around their home, and teaming up for grocery shopping to be particularly helpful. Relatedly, many women appreciated their partner's flexibility around what kinds of foods would be available in the home, and many found that eating meals and/or engaging in post-meal distractions with their partner were supportive. One participant shared that

this joining around meals, including preparation, was particularly helpful in re-defining her relationship to food, meals, and eating; she shared that she and her partner, together, were able to find ways to make the process and time together enjoyable, which helped her construct new meanings around food related practices. Indeed, most women described the ways in which their intimate relationship helped them to normalize their relationship with food. For example, some women identified partner modeling of a more flexible relationship with food, and partner validation of their efforts to eat in healthful ways, as contributing factors; others spoke of giving themselves “permission” to eat within the safety of their relationship. Ultimately, participants all described the ways in which they began to challenge existing beliefs around eating and food, and experiment with new eating practices, within the context of their intimate relationship.

Several women also indicated that their partners encouraged them to pursue, accompanied them to, and/or participated in aspects of their treatment. For these women, their partner’s involvement in treatment was perceived as a reflection of their partner’s care, concern, and willingness to be an active partner in the recovery process. They also found it to be validating of their experience. For the women whose partners were not directly involved in their professional treatment, several noted that their partner expressed interest in their treatment experiences, and shared the belief that their partner would have been open to engaging in treatment, had this been desired. As illustrated here, one woman spoke to the significance of her partner’s involvement in her intensive treatment:

...it was nice because it was acknowledging what I was doing. You know, it’s all fine and dandy for me to go off for a month and you know, for him to see me occasionally, but to actually acknowledge what I was doing and to come and to try and be a part of it and try and you know, be part of my team.

Relatedly, a common and particularly salient example of partners joining in recovery was the women's experience of their partner's efforts to seek and obtain information and resources on EDs. The women frequently expressed sentiments such as, "he really wanted to learn how he could be a part of helping me get through this," "he actually went and sought out information," and he was "very open to wanting to learn more about it." The women shared that their partner's efforts in this regard created a deep sense of being valued and loved. Many women commented that these efforts enhanced their sense of trust and security in the relationship, as they reinforced their partner's commitment to them, their relationship, and their recovery. This woman's words reflect the experience of most participants in the study, of feeling very moved by, and grateful for, their partner's attempts to seek information and provide support:

...to have no resources or no idea of what to say or what to do, and to immediately be reaching out to anyone he can think that's gonna help him be able to help me was just like, I mean I was so, so lucky to have someone that, during that time in my life, 'cause he didn't have to do that...to really make those proactive steps was huge. And that really reaffirmed that it was something he truly cared about and that I could be open with him about, because he really was concerned, wanted to be there to help me move forward.

Importantly, the women consistently noted that it was their partner's *efforts* to support them that were most significant in contributing to their experience of their intimate relationship as a support throughout recovery. As previously illustrated, while participants experienced a number of tangible supports and variable degrees of active involvement from their partner, they voiced that their partner's efforts to support them were instrumental to their perception of support, as compared to the specific strategies partners employed or the outcome of their partner's efforts. This is illustrated here by one participant who acknowledged that although she didn't always

experience her partner's support attempts as helpful in the moment, the fact that he was trying to support her was ultimately facilitative:

...he was trying to think of ways that he could help, so sometimes it wouldn't even really feel like it was helping me feel better, but it was [helping], because I knew that he was doing it, [and] that made me feel better...so not feeling like he had to get it a hundred percent, but just that he was trying to, and that he wanted to, made me feel like I was worth that effort or worth trying...

That being said, several women shared the belief that their partners' efforts to educate themselves did indeed result in perceived improvements in partners' ability to provide informed, responsive, and effective support. For example, this woman found that her partner's active involvement in her treatment translated to their relationship in important ways:

...he went to a family group and I'm sure he probably felt pretty weird going but he went, so even from the beginning he kind of had a better understanding of what was going on, so he was better able to support me...he knows not to say things like that because he's actually taken the time to go and find out about these kind of things, and through like my treatment and things like that, he came to sessions with me and he, I guess put forth a bit of an effort to work on me so that it was working on our relationship.

Notably, a few participants acknowledged feeling a range of emotions in response to this sense of joining in recovery. For example, one participant shared that her partner's involvement in her ED and recovery initially felt "annoying" and "frustrating," given that she didn't feel ready to have someone so close to this aspect of her self and life. She observed however, that over time she did not experience her partner's efforts and growing knowledge of the ED as intrusive or pressure. Rather, she came to find that his involvement with resources and treatment

were largely facilitative, in that he was more effective in supporting her in ways that fit for her. Similarly, in speaking about the process of letting go of the ED, and moving out of isolation and into connection within the intimate relationship, one woman acknowledged the fear she felt. For this woman, to even consider the possibility of recovery was so foreign, and unsettling, yet, within the context of the relationship and her partner's belief and encouragement, it eventually became her reality:

...I did feel like he was threatening [the ED] for a while, and so I think that's also why I said freeing, because I was able to you know, unlock myself from that a little bit and allow myself [to consider change], because he also believed in me, that I could move towards recovery.

This woman was able to manage the fear associated with letting go of the ED, given her partner's affirmation of her ability to do so. To this end, while being in a partnership during recovery evoked anxiety for some women, this anxiety appeared to dissipate over time, and they all shared that their partner's efforts were ultimately conducive to change, given the goal of recovery. Overall, the women shared that they felt supported, yet not pressured, to change within the context of their intimate relationship.

***Sense of motivation and accountability.*** The women's sense of mutual commitment and investment in the relationship and recovery was experienced as motivating. Participants' experience of mutual investment strengthened their personal commitment to recovery, with recovery experienced as a pursuit for not only the women themselves, but for their partners, intimate relationships, and lives with their partners. In addition, the participants shared a sense of "accountability" that emerged within the context of their committed relationship, and the ways in which this facilitated their recovery efforts.



Many women in the study shared the sentiment that “when you’ve got somebody to share it with, and you’re sharing the future, then there’s a little bit more motivation to get on the path to recovery” and “I wanted to get better for me, but I also kind of wanted to get better for him.” Indeed, many women found their partners to be implicit reminders of why they wanted recovery, what they were “striving towards,” with mutual commitments instilling a sense of purpose and meaning in recovery. One woman acknowledged, “that’s why I wanted help, was for our relationship, and that relationship just grew more and more as I got healthier and healthier.” Similarly, the following woman shared that her relationship served as a consistent prompt for change, particularly when recovery felt more daunting:

...it gave me the motivation that I needed, the commitment that I maybe couldn’t find in myself at the time...and remind[ed] me why I was doing this and why I wanted to change...he was like my constant reminder of why I wanted to get better.

Likewise, this participant emphasized the value of her partner’s belief in her, and the ways in which this pushed her through difficult times and periods of lower motivation:

...in a lot of ways I feel like before I had any hope, I saw that he had hope in me, and so that would help me, because I would feel like even if I don’t feel like doing this right now I would, it sounds horrible, but like I would wanna do it for him.

Participants shared that they felt motivated to contribute to the wellbeing of the relationship, and identified commitment to recovery as a means of doing so. As illustrated here, this participant reflected that her valuing of her relationship challenged her to push herself in her recovery – to take risks and experiment with new behaviors:

...[your relationship is] something you think about when you’re having a bad day...I feel like it’s not just me, so now there’s just that want to make better choices and try different

things, and try to open up more and step outside of my comfort zone to do things that I know will help me, so that it helps us both, so that you know, you can kind of be a partner essentially.

Relatedly, many women shared that their partner and relationship provided them with something to “fight for.” They shared sentiments such as, “I just keep coming back to the fact that I had something that I was really engaged with, that I really wanted to fight for more than anything,” and “for once I had something to lose, and before that, I had nothing to lose, it didn’t matter.” Similarly, another participant commented:

...it gives you something to work for. You know like, him, our future, at that point our future kids, it’s our marriage, like all of that, it was you know, something to work for...why am I doing this – I’m doing it for our future.

In voicing care for their partners, most women in the study expressed concern about the consequences of the ED for their partners. They explained that they did not want to see their partner hurt in response to the ED and related struggles. This desire to prevent or minimize any harm or distress for their partners was experienced as further impetus for, and commitment to, change. One woman identified a turning point in her recovery as she recalled, “when I hurt somebody I loved as much as I was hurting myself – that’s when I said ‘enough.’” Another woman contrasted her experiences of being single and being in a committed intimate relationship, and observed, “before, when I was alone, I really didn’t feel like anyone cared or was impacted, and obviously I could see how much it impacted him.” She shared about how this heightened her efforts to make changes. Expressing the sentiments of the other participants, one woman reflected:

I don't want to make this other person sad, this person is very important to me, and I think that's what pushed [recovery] too, I think it's the love for somebody else and the fact that you care about their feelings just as much as they care about yours.

Relatedly, several women described an emergent sense of responsibility, stemming from their sense of mutual commitment; that is, they reflected that their partner's investment in them and the relationship fostered a sense of accountability. The women described a sense of accountability to their partner and the relationship, and therefore, to themselves and their change efforts (i.e., efforts, not necessarily outcomes). In the words of one woman:

...just considering how much effort he was putting into it, I know at times I felt guilty because I was like, well if I don't have this motivation or I don't you know, commit to really trying to recover, that's not fair to him.

Another woman shared her belief in personal responsibility for sustaining wellness:

...we both have committed to having a healthy relationship which means that you can't fall back into [ED behaviors] because the impact on your partner, [it's] way too much for you to do to somebody...there's an element of responsibility around your mental health that comes along when you have a relationship.

Similar sentiments were shared by another participant, who described her sense of responsibility to the health of her relationship. She observed that her valuing of her relationship, and her commitment to sustaining the wellbeing of the relationship, naturally extended to include attendance to her personal health. She described an instance when her partner raised and identified difficulties that were occurring within their relationship, which prompted her to reflect on the role of her ED in this disconnection. In reflecting on this experience, she shared the powerful impact this conversation had on her sense of responsibility for change and recovery:

...he was pointing out problems in our relationship, that we were struggling with at the time, and I found it really upsetting because I found that the worse, the more rigid I was with my eating, the more distance there was between he and I, and when he pointed that out, he just kind of put it out there, he just said like, that a few things seemed to really, they weren't functioning the way they used to in our relationship, and that landed with me in a way that I've never experienced before. And he didn't put it out to say 'you have to fix this' or 'you have to change,' but we have to figure something out. And I went, 'oh my God, like this isn't just about me'...it was about the two of us in relation to one another and what we meant to one another, and that that was kind of falling apart, I just didn't want that to happen, I didn't wanna lose him, and I didn't wanna lose him so that I could look a certain way and try to make myself feel better in that respect.

To this end, her sense of "responsibility" to the relationship "totally shifted [her] ability to look at what [she] was going through and to make a really, really big change." Specifically, in recognizing the impact of the ED on her relationship, she felt compelled to seek additional and more intensive treatment. This was true for other participants who also became more inclined to follow-up with professional supports or pursue intensive treatment, in light of their sense of motivation and accountability in the relationship. The push to address the ED was particularly true for one participant who experienced the loss of her intimate relationship as the ultimate driver of treatment, change, and eventual attainment of recovery. For this woman, the ending of her relationship prompted her to further question the presence and impact of the ED in her life, and deeply reflect on what she wanted for herself, her future, and her relationships.

Consequently, her commitment to pursue recovery and engage in professional treatment was

strengthened, and she remained motivated by the hope and encouragement for change that had been previously provided by her partner.

The majority of women described their sense of accountability around recovery in relation to their openness and honesty regarding the ED. That is, as the ED became known or visible within the relationship, and mutually identified as an issue to be addressed, many women felt that their agency and power to make recovery-related choices became more pronounced. Several women also acknowledged however, some anxiety associated with this. One woman recalled “a time where [she] felt threatened” by her partner’s awareness and involvement, and felt as though he was “intruding,” however, she found that these feelings passed, given her sense of safety and trust in the relationship. Another woman reflected her initial experience of accountability. She shared that aspects of it were “anxiety provoking,” yet it was also what she “needed, it was a bit of a push” to make changes, and was ultimately viewed as useful. She shared further about her experience:

...[recognizing] I’m not going to be able to fool him...that was pretty unnerving, but then at the same time, it’s like it depends on how you see recovery, because I mean, being held accountable in a certain extent...was helpful for me in recovery because I had to sit with those difficult emotions and I had to find other coping mechanisms...

The following participant viewed her experience of accountability in this regard as essential to her achievement of recovery. Like most women in the study, she shared the sense that her partner’s presence and involvement inhibited her engagement in the ED and likewise, challenged her to find alternate ways of coping:

...it held me accountable too, a lot of the time, which I think is kind of the biggest part in recovering from an eating disorder because that voice is always gonna be there and

having someone around you, you're held physically accountable to that, you can't sneak around 'cause they know. You've been transparent with them and they know...[this] was paramount in my recovery...being open with him and him knowing kind of where I was at in my recovery, it made me less able to sneak around, around him and that is so important to stopping the behaviours that I still wanted to do...him being around and me being so open with him about it and him caring really made me, you know, say no to those urges a lot, which was, I mean the only way I could really say that I got through those first few months.

These feelings around accountability were re-iterated by another woman, who commented, “that was the biggest crucial thing – is [my partner] supporting me, loving me, but not enabling me.” One woman shared that she did not want to “disappoint” her partner, and another acknowledged that feelings of guilt associated with disclosing ED behaviors to her partner served as a deterrent to engaging in the ED. To this end, many participants shared that being in an intimate relationship held them accountable with respect to specific ED behaviors, such as what they were eating or how much they were eating, viewed by one woman as “a little bit of social pressure.” The following participant’s experience illustrates this further. She noted the ways in which her partner acknowledged and named ED related behaviors, which furthered her self-reflection, self-awareness, and sense of accountability:

I was really accountable to what I was doing and if something seemed to, if I seemed kind of preoccupied with exercise or something when I came home, after I had wanted to make a change, he would kind of point it out and say, ‘oh it seems like you’re kind of wrapped up in that right now’ or ‘you’re really doing a lot of it, like are you, are you doing it and are you okay in it’ – check-in...

Relatedly, several women also emphasized the ways in which their partner's commitment to them and their recovery increased their sense of accountability to themselves. As voiced by one woman:

...sometimes I wouldn't even feel like being healthy or eating that day or you know, but because I almost had to report to him or because I knew that he wanted to know, it forced me to be more honest with myself as well.

Another woman shared the sense of ownership she felt over her recovery, differentiating her relationship to recovery as an adult in a partnership, from that of an adolescent for whom the primary relationship was with her parents. She commented that her "sense of responsibility and [her] sense of taking ownership for [her] actions was really different" at this point in her relationships and life. Several women described the ways in which their partners inspired them to live more congruently, for example, by identifying and addressing "dissonance" and discrepancies between core values, including relational values, and the ED practices. Indeed, for these women, this fostered a sense of accountability to themselves.

Overall, the participants described a range of perceived benefits emerging from their experience of mutual commitment and unity in their relationship and recovery. According to these women, not only did the shared commitment decrease their sense of isolation, offering encouragement and strength in recovery, it increased hope for the future, hope for recovery, and a belief that recovery was indeed possible and attainable. For the women in this study, the relationship served as a central motivating force, reminding and prompting them of why they wanted change and providing a sense of meaning and purpose around recovery.

### *Communication as Facilitative*

All of the participants felt that communication with their partner was a central component of their experience of their intimate relationship as supporting their recovery from an ED. The women perceived communication as an integral means of shifting from a sense of disconnection and ‘stuckness’ in one’s ED, recovery, and relationship, towards connection and change. To this end, while the nature of communication, including its content and process, varied among the women in the study, its critical role as a source of movement remained consistent. In general, the women found that being in an intimate relationship increased their communication about sensitive issues, including their emotional and ED related experiences, and thus, afforded them opportunities to develop and enhance communication skills and capacities. In addition, according to the participants, communication with their partners promoted the identification of, and attendance to, issues underlying the ED, which helped the women explore and shift perspectives, assumptions, and beliefs maintaining the ED.

All of the women shared that being in an intimate relationship promoted dialogue, and thus, engaged them in greater communication about personal and relational experiences than they had previously experienced. To this end, communication served as a means of decreasing feelings of disconnection and isolation associated with the women’s experience of the ED. For a few of the women, open and honest communication around their experiences was present from the outset of their relationship; however, for most of the women, opening up and engaging in conversation about sensitive issues developed and grew over time. As such, the women’s sense of safety and trust in their relationships remained foundational in creating a context in which they felt they could be sufficiently vulnerable to broach difficult issues. One woman identified



the struggle she experienced as she began to give voice to her ED related experiences within her intimate relationship:

I feel like [the ED] is something that is so internal that even learning how to talk about it with someone was hard for me, and explaining to someone why I was doing it...

Other women shared similar sentiments, commenting “it was a slow process...I had to share about how I felt and that’s really hard for me.” They described initial discomfort with discussing the ED and related issues, yet recognized that these feelings dissipated over time, and gave way to an appreciation of the benefits of naming and processing issues. Increase in comfort and willingness to share appeared to be further facilitated by partners’ encouragement of communication, which contributed to a relational climate that privileged and prioritized communication. One participant found her partner’s persistent invitation of self-expression and dialogue to be profoundly important in increasing her efforts to share how she was feeling, and also, her comfort in doing so:

...he’d always say to me, ‘let’s talk about it’...[and ask] ‘how are you feeling’...he’d always tell me, ‘next time you’re feeling like that, like don’t be afraid to come to me and talk to me up front about it, instead of you know, showing it through anger.’ He’s like, ‘you can always talk to me about it before it escalates into something bigger, like if you’re feeling down, tell me you’re feeling down...

The following participant’s experience illustrates this relational dynamic further. She described how challenging it was, initially, for her to engage with her partner around difficult issues, but noted that over time she became willing to push herself and enter into dialogue more readily:

...with a little bit of time, then we’re able to kind of work it out, and I would still walk away from the situation and not talk about it, just get over it, whereas he will encourage

that I talk about the situation so that we know what went on and where we're kind of going to go from there...

To this end, it appeared that these relationships also involved a process of navigating and negotiating each partner's communication needs and preferences, as the couples' learned to communicate together. In speaking to this process, one woman acknowledged, "now I do have to compromise, and I do have to do things that I'm not comfortable with, and that's a bit of a struggle." She shared however that her partner's "being mindful of the tim[ing], and opening [the dialogue] in a really gentle way" felt supportive and conducive to her ability to enter into difficult or sensitive conversations. Another woman felt as though she was afforded "the space to disclose [ED related issues] if [she] wanted to, or not," and found this helpful – reflecting yet again an absence of perceived pressure. Many women experienced their communication with their partners as respectful, and described feeling empowered in regards to the navigation and strengthening of communication in the relationship. For most women, communication was itself evolving, along with their capacity to engage with their partners in meaningful ways. Reflecting the experience of the other participants, this woman's words highlight the centrality of communication in the intimate relationship, and illustrate some of the ways in which it evolved over time, with negotiation of needs and growing capacities:

So, as we kind of grow together, I can tolerate a bit more of what he has to say and he can challenge a little bit more, and so I think that it just keeps the progress going, and that's sort of how we've avoided staying in one place and not really making any more progress or relapsing...it all goes back to the communication piece...it's still that safe enough place that you can go back to, and then talk about it and go from there. And I think that the communication piece is one of the biggest pieces.

Another woman emphasized the fluid nature of communication with her partner, and the sense of coming and moving together that resulted: “he was there with me and we just kept moving forward, acknowledging when things were going really well and touching base when they weren’t.” For this woman, “acknowledging what’s going on and finding a way through is so key and so fundamental to [them] being present with one another,” and therefore remained a central piece of the relationship and recovery process.

For the majority of participants, a key dimension of their experience of communication as facilitative of their recovery was their perceived strengthening of communication skills and capacity within the context of their intimate relationship. As previously illustrated, for some women this meant managing discomfort and approaching issues in new ways; for others, it included learning how to ask for and receive help within the context of their intimate relationship. One woman shared that her partner validated the appropriateness of asking for help, and she reflected that “a changing point” was when she began “to realize that it’s okay to ask someone else for help, and it’s okay to kind of let down those barriers.” For the women in this study, learning to express their needs rendered them better able to meet these needs, and obtain support from their partners that felt congruent with these needs.

In addition, many women described experiencing their partner as a model of alternate ways of relating to themselves and others. In this sense, the women felt that witnessing their partner’s way of relating, including both verbal and non-verbal communication, provided alternate examples of how they might approach and manage situations and experiences, which further contributed to their growing capacity for communication. For example, one participant commented, “I was always hard on myself, and food just ended up being the comfort in the end, and he helped me to express myself better.” By virtue of communication with her partner, this

woman described learning how to express herself in a manner more conducive to sustaining healthy interpersonal relationships:

...up until that point, I had never like, I didn't know what assertive was, I didn't know what it was like to just speak what you're thinking and not do it in an aggressive or passive aggressive way, I didn't know that...so, he taught me that too...

Another participant discussed her development of boundaries, and identified this as an important part of her emotional and relational wellbeing, including stress management:

...when I'm in relationship with him, it's mirrored to me that I can, that having self-respect and not getting super wrapped up in situations that maybe don't fit for me is really, really important, and I can function much better when I'm not getting so wrapped up in things that maybe don't align with me or work for me, or that I can say no, too.

Like many other participants, this woman observed that new skills were then translated beyond the intimate relationship, into other relationships and contexts, further strengthening her capacity to communicate and convey needs in relationship. As one woman noted, "I think it's been so helpful to start [communicating] in a safe place, and then be able to expand it to other parts of my life...now I can be more direct with my parents and I'm more honest with friends."

As a group, the women indicated that with the formation of new outlets for expression and growing capacity for open communication, reliance on the ED as a means of managing intra- and/or interpersonal issues lessened. To this end, many women shared that as they learnt and practiced methods of communicating in their relationship, the power, function, and need for the ED decreased. One woman observed:

I think that if anything, I've learned through this that my eating disorder is my coping mechanism for stress and for discomfort, and it's my voice. Because I have never been a

big talker, and when I don't want to talk or I don't know what to do, then I rely on it, but when you're in a situation where you have to talk, then the need for it is not so large.

Likewise, several women voiced that the very act of naming the ED and related issues with their partner loosened its hold, as captured here by this participant:

...[communication within the relationship] helped me to see that it was something that I could you know, externalize in some ways or talk about in some ways, that gave me control back. Whereas I had kept it so much in myself, not having someone that close to talk to about it...[the ED] was so powerful and so to have someone then that helped me, helped show me ways, helped in our communication, us talking about it, then it could be slowly broken down.

Another participant's words echo this sentiment:

...talking about it takes away the power that it has on you sometimes...I think that's huge, because so much of an eating disorder is secretive and so when you label it and you put it out there, then it makes it more real, and you're accountable.

Furthermore, open and honest communication appeared to promote the identification and exploration of issues underpinning the ED symptoms. The women reflected that addressing underlying issues positioned them, together with their partners, to access and respond more effectively to factors maintaining the ED. For example, virtually all the women in the study shared that giving voice to ED related thoughts helped challenge their legitimacy and generate new perspectives, unlocking rigid belief systems associated with the ED. This participant captured this aspect of the women's experience:

...I remember saying things out loud to him, being like, 'this is what I'm thinking,' and it would be a really bad thing about myself. And then as soon as I'd say it, I'd think about

it, and I'd be like, 'that sounds crazy,' because I know it's not true. But I had kept it in my head for so long, and I hadn't told anyone for so long, that I started to believe it...I remember even saying sometimes, like 'that was ridiculous,' I can't believe I thought that. And I think that's when I started to realize a couple things, and the more I started to talk about it, the more I started to realize that, 'oh, actually they're just negative thoughts in my head, and I'm the one who's being critical of myself, and they're not true.'

In addition, many women found that talking things through with their partners helped them identify connections and patterns between the ED and other aspects of their experience, such as their emotions and/or expectations of self, increasing self-awareness and insight. This woman's words illustrate the participants' experience of recognizing underlying issues, within the context of dialogue with their partner:

...he kind of checks-in and he's like, 'something else going on?' like what's going on here. And he provides a way for me to engage with it in a fun way versus a really like serious way, and he's not trying to make light of it, he's just trying to connect and being able to connect in that way has been really helpful. Yeah that it's not, I'm not gonna fall back into real trouble, it's just there's obviously something that's really, that's bugging me and 'what is it?' – okay, identify it and then I can move through it with him.

Although the content and processes of communication varied among the relationships, the women all described experiencing their partners as responsive to, and available for, communication, which contributed to the women's sense of being heard and validated. Indeed, the women in this study perceived their experience of being heard and validated by their partners as paramount to their experience of their intimate partner relationship as a support in their recovery from the ED. They were unanimous in describing their partners as available and willing

to listen, and often reflected upon the healing power of this support. This woman's words illustrate the participants' experience of their partners as present and responsive:

...honestly, the biggest thing is that I could speak, I could say what was going on for myself and he was really there to listen and he was there to respond through that whole process, like when I said, 'this isn't working and I need to make a change'...he was always there to really hear what I had to say and respond really openly to what I was going through.

In describing the ways in which her partner was "responsive to" her, another woman emphasized the importance of what she viewed as her partner's capacity to integrate feedback and adapt, and the ways in which this influenced her recovery process:

...he would take it in, like when I would share either 'this is helpful' or 'this isn't helpful' like he would actually hear that and respond to it in a way that was like, yeah he heard me, he actually heard, deeply heard me and is responding to me now based on you know, what I asked or what I shared, so he listened...if I felt that he really heard something and accepted it then I could let it go...

For this woman, feeling heard and validated was key to moving forward, and letting go. Another woman further illustrated the ways in which the perception of partner responsiveness affirmed and validated efforts to communicate support needs:

...I could say, 'no this is how I need you to support me' or 'this is how I want you to support me' and have him really genuinely listen and respect [that]...the process was more important than the content, I think, in those experiences...

In this regard, several women reinforced the notion that communication *processes* were in some instances more facilitative than the specific content of the conversation. For example, several

participants shared that, “what was more supportive was him listening, checking-in,” and many felt that it was “sometimes therapeutic to talk to someone even if they don’t tell you anything back, but you just hear yourself, and you can get some insight as to what’s going on.” Similarly, another participant found that by virtue of talking things through with her partner, she was afforded the space necessary to reflect on her experiences and develop new awareness and perspective:

I think half of it was just having someone that’s willing to listen and that truly cares about you, I think it’s less what someone’s gonna say to you and more just hearing yourself talk, and the things that will come out when you’re just you know, venting or you know, kind of like delving into that...

For the women in this study, the development of new thoughts, perspectives, and beliefs was also associated with an internalization of their partner’s views – views that were shared through open and honest communication. The women frequently described their experience of gradually internalizing the messages conveyed by their partner, including messages related to hope and belief around recovery; self-acceptance, -compassion, and –worth; and shape, weight, and body. For many women, this internalization served as an antidote to beliefs and assumptions driving the ED, such as “you’re not enough,” and was described as “freeing.” This woman described what it felt like to see “how much [her partner] believed in [her] and accepted [her] and liked [her],” and how profoundly this influenced her relationship to her self:

...at the time I didn’t like myself, I didn’t love myself, I didn’t think any of those things about myself, so he was really the starting point for that, and then I slowly became able to accept you know, first the fact that he could think those things about me, and then the fact that maybe I could start absorbing some of that, and think that about myself as well.



Overall, communication appeared to be an essential facilitative component of the participants' experience of their intimate partner relationship supporting their recovery from the ED. Trusting that they would be accepted and not judged by their partners, many women described their growing capacity to be increasingly honest, vulnerable, and open with their communication. It appeared that this not only positioned partners to better support the women, but also increased the women's insight and self-awareness, and disrupted the maintaining mechanisms of the ED.

### ***Intimacy***

All of the women in the study emphasized the unique nature of their intimate relationship, in relation to other relationships also experienced as supportive of their recovery. To this end, it was *differentiated from other supportive relationships*. For these women, the intimate partner relationship was experienced as a relationship within which they felt completely seen and known, in ways that were uniquely characteristic of a romantic relationship. It was characterized by emotional, physical, and sexual intimacy, and for several of the women, spiritual connection. In addition, the intimate relationship, by its very nature, was perceived by the women as being integral to the re-definition or *shifting of their relationship to their body*.

The women described experiences of emotional, physical, and sexual intimacy. They all spoke of a deep sense of connection characterized by a unique level of trust, closeness, and authenticity. In speaking to her felt sense of intimacy, one woman acknowledged, "it is hard to describe what it is but I think it's just the closeness of that person to you." Another woman reflected, "having an intimate relationship with someone is just different parts of you and different types of closeness." These sentiments were frequently echoed by other women in the study, who shared that "the level of intimacy is completely different" than in other relationships.

Similarly, another women commented, “it’s almost like that person is your other half, they know all of these things about you, you constantly talk every single day, and they get to know you on a deeper level than most other people.” The participants shared that the high degree of trust in their relationships supported them to be more vulnerable and authentic, and that in doing so they felt capable of being seen and known by their partners in ways that their other relationships could not provide. Feeling truly seen and known in such depth, and in turn, experiencing a sense of love and acceptance, appeared integral to the women’s development of self-acceptance; this was particularly true in regards to their sense of acceptance around their body.

***Shifting relationship to their body.*** The participants in this study all spoke about their experience of re-defining their relationship with their body within the context of the intimate partner relationship. The women felt that this process was influenced by the physical and sexual nature of their relationship with their partner, reception of partner affirmation around their body, and/or conversations about shape, weight, and appearance that occurred with their partner.

The women described their physical and sexual relationships with their partners, which they believed to be central to their experience of being fully seen, known, and loved. Many women shared that the experience of having their partner express and demonstrate sexual attraction and desire for them and their bodies was tremendously affirming, and initiated the process of re-considering their own relationship to their bodies. Participants frequently shared the sentiment that “when your partner is attracted to you and tells you that...there is something behind that, that helps [you] feel okay,” and “the intimate aspect of our relationship is what helped make me see my body as more positive, and I started to accept it more.” In describing her intimate relationship with her partner, one woman shared a sense of re-assurance afforded by the physical and sexual closeness experienced in her relationship:

...being intimate with someone...the sexual nature of our relationship, being able to be comfortable with someone when you're so exposed...to see him really, he was so attracted to me and I could, you can just tell when you're with someone that they wanna touch you and they want, the way they look at you and like, that's so comforting when you're just so terrible to yourself.

In addition, some women shared a sense of empowerment emerging from their sexual relationship and physical intimacy with their partner, as depicted by this participant:

...to get up and go to the bathroom naked, and walk across the room...that was empowering and it really like, it was another [experience] that kind of brought the idea to my head like, 'oh, I could actually like my body'...

Another woman spoke to the ways in which this intimacy “diminished the shaming” around her body that she had experienced previously. Reflecting the experience of all the participants in the study, she captures the healing power of feeling physically seen and fully accepted by her partner, and the ways in which this acceptance supported her in shifting her self-perceptions:

...I started to realize that I didn't feel as shameful about how I looked because I didn't feel any judgement...that was really, really important, that was constantly reinforced, like I never was judged for my body and how I looked. But I expected it in my head, and each time it just surprised me that he didn't say anything or like he completely appreciated me...I just started to be more loving and more caring about who I am and how I looked and I didn't judge myself as harshly...over time I was just more comfortable with how I looked and I didn't feel bad about myself.

Another woman shared that it was meaningful for her to experience her partner and his body from a place of acceptance, given the extent to which this contrasted her own, judgemental

experience of her body. Specifically, she described feelings of acceptance and non-judgment towards her partner's changing body over time, recognizing that she doesn't place value on his appearance. She voiced the belief that "if I know I can love a body that's you know, not ideal at all times, then I can start to transfer that state to my own body." Adopting this perspective helped shift her relationship to her own body. Importantly, all the women acknowledged that shifts in self-perception occurred gradually, over time, as reflected by this woman's experience:

...naturally, it's not like he swung me into a place where I was like, 'oh yeah, I'm totally happy with my body, awesome,' but it did help with having more instances of that, having more instances of feeling like I'm okay, rather than always feeling like I'm not okay...

The women in this study described a number of other ways, beyond their physical and sexual relationships with their partners, that supported them in shifting their relationship to their body. For some women, experiencing pregnancy and motherhood with their partners promoted shifts in their relationship to their body. One woman reflected that having a baby "was a huge healing process" for her, as it challenged her to view and experience her body in new ways. In addition, she found her partner's acceptance and consistent desire for physical attention throughout the process and body changes to be affirming. Similarly, another woman described her husband's consistent attraction to her, despite fluctuations in her weight over time and in relation to child bearing, and the re-assurance this afforded her:

...he was still attracted to me when I was at my highest weight and [I] felt disgusted with myself, he still wanted me...you know like, post-baby and that, it's like 'well you know, you could get back to your pre-pregnancy weight, or maybe you're just where you're supposed to be now, and he still loves you' ...it makes it easier to love yourself when your

body's changing and things aren't quite the same, and it's learning to find its set point...it's easier when there's somebody who still loves you. And they don't care if you gained weight or lost weight, they just love you and they're there for you.

Another woman found her partner's focus on the functional aspects and benefits of her body (i.e., what she could do if she maintained a healthy, versus very low, weight) to be particularly helpful in decreasing the value she placed on her appearance, shape, and weight. To this end, she felt encouraged and supported by her partner to pursue activities that honored, utilized, and required her body, such as sports and leisure activities that involved a physical component. She shared that she gradually began to appreciate different aspects of her physical self and the opportunities that physical strength and wellbeing afforded her.

For many women the shifting of their relationship to their body was facilitated by "open conversations about bodies" with their partners. One woman shared that this dialogue challenged assumptions about beauty and attraction, and supported shifts in the way she was experiencing herself:

...we've had lots of conversations about how I feel about my body...and just you know, having an ideal in my head...and then him to say you know, the opposite or to say that 'I love you the way that you are,' [helped] to break all that negative thinking about myself. Similarly, another woman shared that she and her partner would discuss beliefs about attraction, and that these conversations contributed to her growing sense of self-acceptance:

...[we] would have open conversations about that, and about how he would feel, and I don't know, they kind of know other guys and stuff so, sort of what that looks like to him, to help change my perspective on what would be attractive to a guy, and kind of help me be more okay with myself...to learn that it was okay if that wasn't me and that wasn't

ever going to be me, and that was very hard to learn but when you're with somebody who's kind of validating that a lot, it is quite helpful.

Another woman commented that receiving affirmative and appreciative feedback from her partner about her body was a “juxtaposition to...what [she] was telling [herself].” Several women noted that while these conversations also occurred in other relationships (e.g., with friends and family), the trust and honesty characteristic of their intimate partner relationship influenced the nature, and enhanced the perceived legitimacy or validity, of the dialogue. Most shared the sentiment that they “would trust [their partner's] opinion beyond anyone else's” and that this unique level of trust was foundational to their ability to consider, and gradually internalize, their partner's affirmative views about their appearance. Several women commented that in conversation with other women, re-assurances and affirmation of one's appearance and body would be commonplace and experienced as “social nicety.” One woman shared the belief that her family members were more inclined to respond affirmatively with respect to her body and appearance, versus authentically, in efforts to ensure her happiness, rendering their feedback less credible; in contrast, she observed that “because of his honesty then, [she] could trust him and then fight the whole image distortion.”

Of note, in speaking about the value of conversations with, and feedback from, partners about their bodies, one woman acknowledged what she perceived to be an expectation or message in recovery (e.g., in treatment) that one's focus be placed elsewhere, not on appearance. This woman shared however that being able to process and challenge her thoughts and feelings about her body within the safety of this particular relationship was reparative. She noted how helpful it was to “just be totally honest and have somebody that you trust respond, and not feel

judged like it was a bad thing to talk about or something, ‘cause it’s on your mind and you’ve got to get it off.”

Notably, several women found great safety in the relative absence of focus and feedback on their bodies within their intimate relationship. For these women, this absence stood in contrast to what they were accustomed to, and was therefore experienced as a relief. In general, they found that their partner would offer affirming comments when they were struggling, but otherwise, there was little attention to their appearance. For example, one woman observed:

I think that just made it really safe at home, that he wasn’t constantly saying, ‘oh you look great’ or when I was going through changes, he wasn’t even saying, ‘oh you look beautiful, I love your body,’ like there were times when he would if I was really struggling and I was like, ‘oh I’m having trouble with this, this feel awkward,’ he would usually say like, how much he did love my body and appreciated me...[that] he loved me in my body no matter how that was gonna look or present. I know that came up a few times and that was really helpful for me to have from him.

Another woman shared a similar experience with her partner:

...[he] just really made it apparent that, not that it didn’t matter what I looked like but how I was totally fine for him, so I think that really helped, that was probably a really big help for me in the times when the eating disorder would flare a little bit, and I would feel just really gross or awful in my body, he was supportive in that way of just saying encouraging or kind words, and then outside of those times, like outside of maybe critical flare-ups or just in our general day-to-day life, he was never one to comment on image or you know, dissatisfaction or anything like that.

For the women in this study, physical and sexual intimacy, and partner affirmation around their bodies, appeared to de-stabilize assumptions and beliefs about their body, and women's bodies in general, they felt had been contributing to difficulties with body image and the ED. In particular, the experience of having their bodies seen and appreciated by their partners supported the women's growing self-acceptance, and importantly, initiated the creation of new meanings around shape, weight, and appearance. The following participant illustrates this dimension of the women's experience, as she reflects upon her shifting relationship to her physical appearance in relation to her partner's expressed attraction:

...to me that was like, 'oh okay, I'm good enough or I'm sexy or I'm you know, he likes my curves, or he thinks that I'm attractive' and stuff like that, just the experience of it, of being comfortable around someone...and that sort of translated to the whole body, it wasn't just about weight.

This woman's experiences with her partner challenged a deeply engrained belief that thinness was essential to one's worth and desirability:

...it helped deconstruct that idea that I had, that my body doesn't look like this person's body and therefore it's not good. So, it was kind of like, 'no, yours can be loved too'...that was really ground-breaking for me 'cause I was like, 'what, people can have different, not even different tastes, people can like many different types,' whereas before it was just like, there's only one type...I started to begin to question my reality that I had constructed and started to kind of think like, 'oh maybe there are different ways here.'

Within the context of their intimate relationship, the women experienced a sense of normalization around their bodies, which many felt was missing in their family of origin and/or other relationships with men. The majority of the women commented that receiving affirmative



male feedback, specifically, challenged deeply embedded notions of female beauty and attraction, and helped them manage anxiety about their bodies. One woman commented, “I needed male approval and him giving me that and it being genuine, I think is a role that only he could’ve filled at that time.” Notably, the majority of the women blamed themselves, or held themselves responsible, for their body dissatisfaction, with little acknowledgment of the sociocultural factors and contexts driving their internalization of thin-beauty ideals. However, one participant situated herself within these broader contexts and dominant discourses, and described her consequent struggle to reconcile her relationships with her body and sexuality, and sexual intimacy with her partner:

...there were lots of really tender moments where he was really, really enjoying my body, and there’s some challenges with that, and I still have some anger around [it], but it’s made me face the fact that my body had always been an object of desire, and I was supposed to create a, or I had bought into the fact that I was supposed to make it into the object of desire. And so my eating disorder was, to a certain extent, an act of rebellion against that but it was also exactly investing in it too, right. The act of rebellion was me trying to disappear the body so that I could not have to contend with the object of desire thing, but then I was trying to be thin, which is what you’re supposed to be, so it was just this mind-numbing thing that I started to contend with when I was having sex with him, because I started to feel the resentments and I started to feel the pull towards enjoying...

***Differentiation from other supportive relationships.*** As illustrated above, the level and nature of intimacy in the intimate partner relationship distinguished it from other supportive relationships in the women’s lives. The women shared that they trusted their partner in ways they did not necessarily trust others, and linked this to their experience of feeling deeply seen and

known in this relationship. The women shared that they disclosed sensitive, intimate, personal experiences to their partners that they would not have shared with others, in particular, concerns about their bodies. One woman commented, “I think that’s the biggest thing about an intimate relationship, is that the conversations that him and I have are more than the conversations I’ve ever really had with anyone.” Many participants shared that “you’re able to be open in a different way” with your partner. Here are one woman’s efforts to capture the sense of unique intimacy experienced with her partner:

I think that it’s different with your friends or your family. They don’t make you feel safe the same way that someone you’re intimate with does. I don’t know if it’s safe physically or that comfort or just safe in a way that you feel like you can say anything to them or you can, you know, bear those ridiculous thoughts that you cringe to say, but that they’re just not gonna judge you on it. I think that was something that only he could’ve provided...not for lack of trying but I just think it’s just different.

Similarly, this woman re-iterated the feeling that her intimate partner relationship afforded her a different kind of security and availability, which was particularly facilitative to her recovery:

...you can be so close with your friends and your family but someone that you’re intimate with I think you have that extra openness with them, and that was just so nice...I could just constantly reach out to him if I needed it and I didn’t feel bad about it...especially since it’s such a long, long road for recovery, and it can be exhausting on the people around you. It’s exhausting when you’re sick, and then if you are like me and you need to be talking things out all the time to get it off your shoulders so that it doesn’t manifest in a different way...I mean it was incomparable, the support you have when you can phone them at three in the morning and say, ‘I feel fat’ and they’re not gonna be like, ‘don’t call

me anymore.’ You can’t necessarily do that to everyone else in your life but when they’re your person, you can do that, and that was huge.

In addition, on a practical level, the women felt that the sheer proximity and time spent with their partners was unique to their intimate relationship. As previously described, the women experienced their partners as a constant, steady presence, whereas other supportive persons were privy to limited aspects of their recovery process. Reflecting the experience of all the women in the study, this participant captured the value of her partner’s consistent presence throughout her recovery:

...this is the person that I see every day and that’s with me every day...he would definitely be the one, the most aware because he’s living with it on a daily basis, so again, this goes back to him just being there, he was just there day in and day out and was just such a tangible, solid, always there support.

The following participant’s experience further illustrates the extent to which partners were felt to be present and engaged throughout the multiple facets of the women’s recovery process:

I guess going back to being known, to feel like he was getting the whole picture and still supporting me, whereas maybe you know, the group that I was in, they knew one part of me and maybe you know, my sister knew one part of me or the online friends that I shared this with knew one part of me, but he knew the most of me and was the biggest support in that way...it was different because it was obviously more intense, we saw each other a lot more...

The women also spoke about the ways in which their intimate relationship afforded them an opportunity for “corrective emotional experience[s].” That is, most women shared a sense of being inextricably situated within their family’s history, and pre-existing emotional and

communication patterns and processes, which in several instances were viewed as being linked to the ED. One woman described this aspect of her experience, in relation to long held messages about food and eating that she had received from her family. She emphasized that her experiences with food and eating with her partner were so different from her prior experiences, and so normalizing to her, that they served to challenge her belief system and meanings around food:

...it contradicted that world view that I had that was like, you need to, you're eating too much, you have been eating too much, you need to stop eating...if you were eating less people would love you more, women should eat less, you should lose weight, all those sort of things, like it totally like contradicted that.

Another participant's words illustrate this further, namely, the sense that past experiences in family relationships may have inadvertently hindered movement forward in recovery:

...I think that I didn't have a history with him...with my Mom, she's very supportive and she was great but we had a lot of stuff we needed to work through. And so, it wasn't restful with my Mom. It was a lot of contending with old patterns, whereas I could just go and take a rest with him.

Relatedly, many women felt that their identity and relationships with their family, and in some cases with friends, were so closely tied to the ED that differentiation from this was challenging. For the participants in this study, experiences with partners were felt to afford new opportunities for relating, and healing. As one woman commented, "I hadn't known him before, so I was able to construct myself a little bit...I needed to change my patterns, [as] clearly some of them weren't working." Another woman's words illustrate this experience further:

...there's a lot of history there and sometimes I feel like [my friend] looks at the whole history versus just where I am right now, and sometimes that's used a bit against me, or I'm judged a bit for certain circumstances, and with him, I'm not. He's usually dealing with the here and now.

Overall, the participants experienced a unique sense of intimacy in their relationship with their partner, which distinguished this relationship from other supports, and contributed to the women's sense of healing and perceived movement in recovery.

### ***Sense of Identity Beyond the Eating Disorder***

All of the women experienced a sense of differentiation from the ED within the context of their intimate partner relationship, such that their sense of identity was not intrinsically linked to, or constituted by, the ED. To this end, the women felt seen by their partners beyond the ED, with the ED reflecting but one aspect of their experience. They shared that their partners and intimate relationships affirmed and encouraged their sense of self and development beyond the ED, including hopes, goals, and pursuits, which was facilitative of their recovery process.

The women consistently described the ways in which the ED was “externalized” by their partners, and the sense of space and separation from the ED that this created. Many women shared the sentiment that “to him, I was never associated with the eating disorder, we were always separate and it was just something I struggled with and something that could improve.” As illustrated by this participant, the women found that their partner's reinforcement of this separation was particularly validating and affirming, and an important reminder as they battled to let go of the ED:

...he made that very clear too, that he knew the disorder wasn't me...I referred to it as 'ED' and so he would always refer to it as that and would just be like, 'this is ED talking,

not you.’ And that’s another thing that I appreciated with him, is he didn’t really see [us as] the same people...I believed he knew that and that’s why he was such a good support, because I believed that he saw something in me that I didn’t see in myself.

These sentiments were echoed by another woman who commented that her partner “could see the person that [she] could become.” As illustrated above, for many women, their partner’s reflection and reinforcement of identity and capacity beyond the ED was a relatively new experience, and appeared to initiate the women’s contemplation of “possibilities” for self and development. Most shared that they had not previously realized or believed in this potential. Indeed, the experience of being distinguished from the ED created a sense of space for the women – offered pause – within which the potential for change and a life beyond the ED took root, as voiced by this participant:

I remember just crying one time and saying, ‘what am I going to do when I don’t have my disorder anymore’ and he just calmly, didn’t even think about it, was like ‘anything you want to.’ And I’ll always remember that ‘cause it just didn’t really occur to me that I can do whatever I want to, it was always, my entire life was ‘how am I ever going to beat this.’

For these women, experiencing themselves as separate from the ED planted the seed that they could move beyond, and exist without, the ED. One woman described her partner’s consistent distinction between her and her ED, which gradually fostered her own sense of separation from the ED. As was true for many of the women, being presented with an alternate reality supported her to gradually shift the way in which she related to the ED, and instilled feelings of hope and empowerment around change:

...those few years don't define me forever, whereas I felt they had, and that he continued to believe that that wasn't all of me, that that wasn't you know, who I had become forever and that that was just something that I was struggling with. So I guess I had really personified what was going on for me and he helped me remove [it]...helped me to see that it was something that I could you know, externalize in some ways or talk about in some ways that gave me back control.

Indeed, many women shared this experience, that is, the sense that their partners presented to them a different, independent image of themselves. One woman captured this through metaphor, as she shared her experience of her partner "being a mirror...making [her] think of the potential," of a life without the ED. She voiced the belief that her partner opened her eyes to the possibilities of her life beyond the ED, and that her intimate relationship provided her with "a picture of what [she] could become." She reflected upon the importance of her relationship to her personal growth:

...if we'd have a really wonderful date or a really wonderful evening, or a really nice walk or something, thinking of those examples in my head of like, 'oh I could be a really happy person, that could be our life all the time.' It wouldn't just be little slices of that, and then me going home and worrying about my weight all night, but that it could be my life.

To this end, several participants described the ways in which the intimate relationship itself, including their experience as a partner, supported the development of their sense of self beyond the ED. One woman felt particularly touched by the joys of intimacy and partnership; she shared that the happiness associated with these experiences called into question the meaning and place of her ED symptoms in relation to her values, identity, and life:

...you have someone that really loves you...does it really matter now that you lose another five pounds, or do you really care if your thighs touch or like you know, all of these things that you had felt were the most important things...in my eating disorder, it just felt like I would obsess about the silliest things, and I feel like a lot of times they were easy, it was almost easy to go into that way of thinking because I often felt like I had nothing good around me...

Another participant commented, “I think the relationship has its own identity and it’s a little bit less painful to start to explore the identity of the relationship than it is exploring your own identity.” This woman shared about her experiences of experimenting with new ways of being in the world, through art, creativity, play, and community, and the ways in which these pursuits with her partner helped her access and cultivate different parts of her self and identity, that had previously been inhibited by the ED:

...he exposed me to another way to be creative...so performance became interesting to me, and the supportive nature of it was that we started to be performers together. And it was a lot of fun, and eating disorders aren’t very fun. And I do think laughter and fun and creativity are huge healing components in letting go of the need for control and perfection...so we started to create a lifestyle [together]...

For this woman, another “big part of it was just starting to be seen as more than a body,” within the context of her intimate relationship and the life she and her partner were creating. This further contributed to her shifting sense of identity and ability to break away from the ED. Indeed, for most of the women, being in relationship and being a partner was inherently conducive to identifying with other dimensions of self. For another woman in the study, her identity as a mother proved central to letting go of the ED. For example, wanting “to be a good



role model” and have a “healthy family life,” and having these values reinforced by her husband, helped shift her away from the ED identity and further develop these aspects of herself and identity.

The participants in this study described the ways in which their intimate partner relationship provided a context within which they were able to explore different ways of being and relating. To this end, the women consistently expressed the feeling that their relationships enriched and enhanced their lives; they shared that the experience of isolation and in many cases, rigidity with the ED, was transformed into an experience of connection, engagement, and flexibility through new life and relational experiences. Indeed, several women felt that witnessing their partner’s engagement in life provided a window into alternate possibilities for being in the world, as illustrated by this participant:

I’ve seen bits and pieces of life, like he loves to have fun, he loves to be with his friends, and he just loves to live. And so, from where I’ve been, where I’ll stay inside, I’ll live in my box, and it’s safe and I just want to be there, to then see what it could actually be like. And it’s going to be really hard because I’m not always okay with it, but in the end, the things that you get to do [are] just so much more worth it. And I think that was a really big push.

This woman’s experience further illustrates the developmental nature of the participants’ experience, and the discomfort and uncertainty that many contended with as they explored different possibilities for being in the world. For many participants, this process involved a gradual shifting of their focus away from the ED and the comforts it may have afforded, and consideration of the value and desirability of other life pursuits. The women spoke about how their relationship and explorations drew them out of themselves, and the necessity of this for

growth to occur. To this end, one woman recognized, “if I wanted a voice in that identity, I needed to actually speak the voice instead of just shrinking back into invisib[ility] again.” The woman also shared the perceived value of having their partner’s support as they began to engage with life in new ways, as illustrated by this participant:

...before I was in a relationship I buried myself in work, that was all I ever did and I hid from the world. I never really knew how much fun you could have and I didn’t really know this peace outside of having an eating disorder. When you feel you’re a bit free from it, there is just this weight lifted off your shoulders and you just want to live again, but you have somebody right beside you that’s encouraging you through it all, and that’s a huge piece.

This participant described her experience further, highlighting the role her partner played in her exploration and experimentation with new behaviors and pursuits:

...he’ll encourage me to go do it, he’ll come if that would make it easier, he’ll support me in whatever I want to do and that’s pretty huge...it just helped me to see that there was more out there.

Like many of the women in the study, this participant shared that as she opened up to new experiences, she began to relate to herself and her potential differently. Moreover, her capacity to continue on the path of self development, and continue taking risks, was strengthened:

...you start to learn more about yourself because you have this opportunity to kind of be yourself, and talk about your fears and your dreams...things that I never really thought that I would do, I have done, and if they don’t go well then, they just didn’t go well, and you take the info and you learn and you go from there, rather than beating yourself up about it, being scared to try again, or anything like that.

Some women experienced their relationship as a “distraction” from their identification with the ED, ED behaviors, and associated distress, as voiced by this participant: “he helped distract me with new people, new scenarios, new situations, new ways of looking at life.”

Another participant shared how her relationship with her partner enabled her to develop “a healthier identity or a healthier idea of” herself and to “build patterns that were better for [her],” creating more and more distance from her ED practices, and moving her towards a greater sense of self as independent of the ED. She described this experience further:

...[the intimate relationship] was also a distraction in that it gave me some time to think about, like it almost pulled me into this great space that I could look back on the bad space that I had always kind of been in, and think about it from a healthier perspective, maybe a more objective perspective. So even though I didn’t really feel like I deserved this experience, like this really good experience, I was in it, and then I could kind of look at what I was doing you know, back at home or whatever and think like, ‘what am I doing,’ and it didn’t really seem as normal...it was really like him pulling me out of it, and so whenever we had these you know, social dates and stuff it was really, not only opening my eyes to our relationship, what it could be, but [to] a lot of other people, healthier interactions, that then challenged what I was doing.

In addition, the women experienced respect for and promotion of their autonomy in their relationships; they described feeling supported as individuals, within the context of the partnership. One woman described her experience of gradually incorporating new experiences into her life, and her partner’s support of this:

I started working, and then I started taking courses, there was just this kind of gradual development of going out into the world more. And that again, that was all good with him.

Relatedly, all of the participants shared that their sense of self and identity beyond the ED was further promoted by their partner's affirmation and support of their life goals. For example, most women experienced encouragement from their partners to pursue educational, career, or family-related goals, and felt supported emotionally and practically in doing so. The women described the confidence this inspired, and the belief in self it instilled. They shared about giving themselves permission to try new things, which was empowering. One woman felt that her partner "really celebrated" potential pursuits as she began to explore what she wanted for herself:

... he would come home sometimes and I'd have been doing something or looking at something and investigating it, and then we'd talk about it and he was always really there to say like, 'this is really amazing, this seems to bring out something in you that I haven't seen'...he really validated those things for me and I think I needed that, like I needed to hear like, oh you're seeing that this, yeah this does really make me feel great, and to be looking at these things and these options and even though I knew it felt good, it was really nice to have him there to kind of reflect off and be like, 'this is, this is awesome to see you looking at other things that can really fulfill you and that you can be passionate about,' and I ended up going back to school and he was really, really supportive of that and all the stuff that came with it.

The women found that as they opened up to the possibilities that were available to them, and moved towards more value-driven and congruent lives, the ED began to lose its significance. As one woman commented, "there's just more things to look forward to, there's more life to live

that I've never really felt before." Another participant found that as she started "to move [her] life forward," and put her "energy...in different directions," that "things [were] let go...[and] other things start[ed] to become more meaningful." One participant captured the experience of connecting to a sense of self and identity beyond the veil of the ED beautifully:

I think when you're in the disordered eating, if somebody sees you as perfect, you take satisfaction from that, and so it was a shift in perspective towards recognizing that authenticity was more of value than being viewed as okay...I think that was my shifting out of the eating disorder into a place where I wanted to be seen and wanted to have the space to be a complete person.

### ***Summary of Results***

All of the women in the current study described their intimate relationship as a site of change, that is, a context within which growth, healing, and a gradual letting go of the ED occurred. The relational climate described by the women appeared to afford them the relational, psychological, and emotional safety to be vulnerable, which was deemed necessary to taking the risks required for change. That is, the women emphasized the centrality of safety in promoting openness and willingness to experiment with new ways of relating (i.e., to self, partner, and others) and behaving, which they felt was key to developing alternate ways of coping and functioning, and thus, letting go of the ED. Indeed, the participants consistently spoke of their relationship as a safe space within which the mechanisms maintaining the ED were challenged and new ways of coping were developed. To this end, acceptance, non-judgment, and compassion emerged as significant relational elements of recovery, neutralizing feelings of shame that had been fueling avoidance and secrecy around the ED, and consequently, the women's sense of feeling "stuck."

The women were unanimous in their perception that their partner's way of "being" was another core aspect of their experience of support. The women's sense of their partner "being there" throughout their recovery was less related to specific events, and rather, emerged from an accumulation and convergence of moments, gestures, responses, and behaviors that were perceived by the women as being caring and facilitative, that is, congruent with their support needs. To this end, the women emphasized the centrality of their partner "being" versus "doing," and their partners efforts, describing their partner's presence and availability emotionally, physically, practically, and intimately as steady, consistent, and grounding. For participants in this study, these relational qualities, and the experiences they afforded, were essential in differentiating the intimate relationship from other supportive relationships. The intimate relationship possessed a unique intimacy, engendered through proximity, trust, and physical closeness.

While the women felt accepted in their intimate relationship, this experience was paralleled by a co-occurring promotion of change and recovery, by their partner. The women shared that their change efforts were consistently affirmed, validated, and encouraged by their partner, and that they experienced both practical or tangible, and emotional support from their partners. It appears that the congruence between support needs and experiences described by the participants was achieved in large part through open communication, which was cited by all women as integral in facilitating change in recovery. The women found their partners to be responsive and flexible, and described processes of navigating and negotiating relational and recovery related needs within the relationship. For these women, communication appeared to foster not only their relationship and experience of intimacy, but also, facilitated acquisition of methods of communication, self-awareness, and openness to change. The nature of conversations

with partners, including conversations about bodies and appearance, proved to be instrumental for most women. Relatedly, their experiences of physical intimacy were felt to be essential to re-defining their relationship to their body.

The experience of being in an intimate partner relationship, in which both partners valued and were committed to the health and future of the relationship, was healing for these women. The relationship afforded the women a window into their life and identity beyond the ED, instilling motivation and hope for change and recovery, and ultimately facilitating movement beyond the ED. Of particular significance to the women's experience of their intimate partner relationship as a support during recovery was the women's experience of a united effort, or partnership in recovery, which was experienced as motivating for these women.

Importantly, in describing their experience, all the women shared a deep sense of gratitude for their partners and the ways in which their partners had supported them throughout their recovery journey. The women spoke of their partners with profound respect, recognizing that navigating relational and recovery related processes was challenging, and that support attempts were not always perceived as "supportive," which reinforced their appreciation of their partner's commitment and consistency. As a group, the women shared resonant images of the ways in which their partners supported their recovery, and the grounding space they experienced as they navigated the journey of recovery, as illustrated in closing by this participant:

...it was just this sense of warmth and sense of genuine care for another human being, and that's all he showed me and that's been what I come back to, and that's what I knew could get me through – being able to come back to that.

## Chapter 5: Discussion

The current study employed a hermeneutic phenomenological method to explore the meaning of lived experience of intimate partner relationships in supporting adult women's recovery from an eating disorder. Hermeneutic phenomenology aims to achieve a deep, detailed, rich, and contextualized representation of lived experience, and privileges participant voices and meanings. As such, it is particularly well suited to inquiry in under-researched areas, such as intimate partner relationships and recovery from an ED.

The research question guiding this inquiry was: "*what is the meaning of lived experience of intimate partner relationships in supporting women's recovery from an eating disorder?*" Ten women meeting the study's inclusion criteria completed in-depth, qualitative interviews to explore this question. Interviews were transcribed and analyzed, and five common themes characterizing the women's lived experience of the phenomenon were identified: *Sense of Safety*, *Sense of Mutual Commitment*, *Communication as Facilitative*, *Intimacy*, and *Sense of Identity Beyond the Eating Disorder*. This chapter begins with a brief overview of the contextual considerations for interpreting the study's findings. Key findings are then discussed in relation to existing empirical and theoretical literature. Specifically, the ways in which the findings converge, diverge, and/or extend extant research are highlighted. I then discuss the implications of the study's sample, and in doing so, address additional contextual considerations for interpretation of the findings, and associated limitations. Finally, implications for clinical practice and research are discussed, including recommendations for future research. I then conclude the chapter with a brief reflection on conducting this research, and a re-statement of key findings.



### *Contextual Considerations*

The findings generated in a hermeneutic phenomenological study reflect one co-constructed interpretation of the phenomenon of interest, informed by the researcher's positionality and interpretation, and the participants' expression of their lived experiences. Although I have situated myself, with respect to my particular lens and context, to ensure transparency for the reader, my interpretation is also inherently influenced by my ability to see and grasp essential meanings, and to convey them in a rich and resonant text (van Manen, 1997b). Within the context of this methodology, it is acknowledged that alternate interpretations of the participants' experience are not only plausible, but expected. Further, the goal of hermeneutic phenomenology is not to generalize findings, but rather, to achieve transferability. These contextual considerations therefore aim to highlight issues relevant to the transferability of the findings.

Participation in the current study was completely voluntary and offered no compensation, and thus, women who self-selected into the study may reflect a particular subset of women who experienced their partner as significant to their recovery. To this end, although the women's experiences of an ED history were notably diverse (e.g., duration, severity), as were their intimate partner relationships (e.g., duration, co-habitation, current status, children), the group of participants also reflected significant areas of homogeneity. Specifically, all participants identified as Caucasian, with European heritage, as were all but two partners, and as heterosexual women with male partners. As a group, participants were highly educated and relatively young, with an average age of 29 at the time of the research interviews. Each woman had pursued post-secondary education, and at the time of the research, over half were pursuing or held a graduate degree. The implications of the sample's homogeneity with respect to demographic

characteristics and culture are discussed in a subsequent section of this chapter. At this point, it is important to note that despite efforts to recruit widely, the current findings reflect the experience of the ten heterosexual women who met the study's inclusion criteria and volunteered to participate in the research, and may not necessarily reflect the experience of all adult women who feel their intimate partner relationship was a support during their recovery from an ED.

### ***Significant Findings and Theoretical Implications***

Current findings affirm that for some women, intimate partners play an indispensable role in the achievement of recovery (Hsu et al., 1992; Tozzi et al., 2003). Participants in the current study deemed their partners to be “pivotal” in supporting them to initiate change, and one of the “cornerstones” of recovery. Indeed, the women in this study shared that partners “played a huge part” in their recovery, and some women questioned whether they would have recovered without their intimate partner relationship. For the women in this study, the experience of having their intimate partner relationship support their recovery from an ED was significantly influenced by the safe *relational climate* with their partners, including their sense of acceptance and validation; their experience of intimacy; and their experience of open communication. In addition, the experience of a *partnership*, including a sense of mutuality and joining, emerged as a key component of these women's experience of support in their recovery. Importantly, these relational qualities and experiences appeared to promote the women's motivation to make changes to their ED and related behaviors, and their development beyond the ED. Taken together, these key findings bear significant implications for our understanding of the ways in which the intimate partner relationship may facilitate change, healing, and recovery from an ED, an area that has to date received scant attention both empirically and clinically. They are discussed below within the context of extant empirical and theoretical literatures focused on

recovery from an ED. Research and literature on motivation, communication, and coping and social support, are also considered, with a focus on the ways in which the current findings contribute to, and extend, existing knowledge. The findings are then considered within the broader context of Relational-Cultural Theory (RCT), with particular attention to the ways in which the results may inform the application of this framework within the area of adult women and recovery from an ED.

### ***Relational Climate***

***Acceptance and validation.*** The relational qualities of acceptance and validation permeated the women's lived experience of support, and were fundamental to their experience of safety in their relationship. The women described feeling fully accepted for who they were, including their experience of living with an ED. Relatedly, they found their partner's acceptance and appreciation of their appearance and body to be particularly normalizing, and ultimately, a central component of their growing ability to challenge and shift assumptions and beliefs maintaining body dissatisfaction and ED behaviors. The women's experience of being accepted was coupled with their experience of validation, in that they felt their partners consistently validated who they were, beyond the ED. Importantly, the women's sense of being accepted and validated by their partners appeared foundational to the women's capacity to risk vulnerability in their relationships and experiment with new behaviors and ways of coping – essential to the process of change.

The women's sense of acceptance and validation, coupled with non-judgment and compassion, appeared to have a powerful effect on their experiences of secrecy, isolation, and shame – common and highly detrimental aspects of the experience of living with an ED, that often serve to maintain symptoms (Pettersen, Rosenvinge, & Ytterhus, 2008). Being fully seen

and known, and feeling accepted by their partners, appeared to decrease the women's sense of secrecy around the ED, and in turn, reduce their sense of isolation – of being alone with the ED and associated thoughts, feelings, and behaviors, and inauthentic in their relationships. For these women, being accepted for who they were, including their struggle with the ED and the ways in which it impacted their relationships with self and partner, led the feelings of shame to “shrink a little bit,” “strip away,” and “be broken up.” As the ED was acknowledged within the relationship, and the women continued to feel valued, the meanings they had previously attributed to their experience of living with an ED were challenged, and associated feelings of shame lessened. This gradual transformation in relationship to self, facilitated in large part by partner acceptance, was extremely important to the women's growth – in both the relationship and recovery.

The identification of these relational qualities as supportive for women in intimate relationships is particularly relevant to our current understanding of support, both within the partner relationship, and potentially, other close relationships, given that many women with an ED report dissatisfaction with the support they receive from others (e.g., Rorty et al., 1999; Tiller et al., 1997). That said, findings have been mixed (Leonidas & dos Santos, 2014), and one study has shown that women are satisfied with the support they receive from their partner, specifically (Marcos & Cantero, 2009). Models of support have focused on stance and delivery (Brown & Geller, 2006; Treasure, Smith, & Crane, 2007), and collaborative support has been deemed most helpful (Brown & Geller). According to Brown and Geller's model, collaborative support consists of “encouraging” support attempts, which imply some degree of expectation of change, and “cautious/concerned” support attempts, which are associated with less expectation for change (p. 223). Findings from the current study suggest that both encouraging and

cautious/concerned support may be particularly helpful within the context of adult intimate partner relationships, as they are congruent with participants' appreciation of autonomy, empowerment, and agency in their change efforts. In particular, for the women in this study, their sense of acceptance appeared to be highly related to the absence of expectation around change, reinforcing the notion that a focus on the ED and/or behavioral change may not be optimally supportive for some women, within the context of their partner relationship. To this end, the current study's focus on support within the context of recovery efforts is a valuable contribution to the existing literature, in which the link between social support and change efforts has not been thoroughly investigated.

It is also worth noting that validation has also been included in models of support for individuals with an ED (Gusella & Connors, 2014), and research has shown that a lack of validation may hinder recovery (Linville et al., 2012). The conveyance of acceptance and compassion appear to have received less attention within the support literature (Linville et al.; Marcos & Cantero, 2009). Indeed, the construct of compassion has just recently been applied in the area of EDs, and appears to be a promising area of intervention (Kelly, Carter, Borairi, 2014). Specifically, Kelly and colleagues (2014) found that increases in self-compassion were associated with decreases in shame, and that reductions in shame were associated with more rapid decline in ED symptoms. Given the pervasiveness of secrecy and shame for women with an ED, and their negative impact on ED symptoms (Kelly et al., 2014; Pettersen et al., 2008; Skarderud, 2007), the current finding regarding compassion as an ingredient of support is significant. Specifically, the finding that women found their partner's expression of compassion as not only supportive, but as facilitative of their own development of self-acceptance, further

supports the relevance of this construct for women with an ED, in particular, within the context of support offered during recovery – a link that has yet to be made in the literature.

Of particular importance to the women's experience of support and recovery was their experience of partner acceptance and appreciation around their appearance and body. The women commented on their experiences of physical and sexual intimacy with their partners, highlighting the ways in which this aspect of the intimate relationship may be facilitative of recovery. Specifically, experiencing acceptance and normalization with respect to their bodies supported the women in re-constructing perceptions of, and relationship to, their bodies. The women spoke of the ways in which their partner's affirmation of, and attraction to, their bodies, and open "conversations about bodies," were helpful in challenging deeply held and culturally reinforced notions and ideals of beauty, that had played a role in maintaining body dissatisfaction, negative thoughts and feelings about self, and ED-related behaviors.

The literature on intimacy in the area of EDs is extremely limited, and tends to portray intimacy as an area of difficulty for couples for whom one partner is living with an ED (see Van den Broucke et al., 1995c). The current findings that physical and sexual intimacy, including communication about the body, may be empowering and contribute to women's healing not only diverge from this longstanding assumption (van den Broucke et al.), but offer a significant contribution to extant research by illuminating another perspective on intimacy in the area of EDs. The perspective that intimacy not only exists for couples for whom one partner is living with an ED, but may be positively related to recovery, has received virtually no attention in the literature (Newton et al., 2005a, 2005b, 2006). This omission may be understood in a number of ways, particularly, within the context of documented relational challenges for women with an ED (Arcelus et al., 2013; Arcelus et al., 2012), and potentially, in relation to the histories of

sexual abuse and trauma reported by women with an ED (Wooley, 1994). This lack of attention must also be considered within the context of the physical and physiological symptoms associated with some ED presentations, including low weight and starvation, and high rates of depression, each of which negatively impact sexual functioning (Pinheiro et al., 2010). Extant literature on physical and sexual intimacy in the area of EDs remains focused on problematic aspects of sexual functioning for women with an ED (Pinheiro et al., 2010; Rothschild, Fagan, Woodall, & Andersen, 1991), and very little research has explored women's subjective experience of sexual intimacy (Newton et al., 2006; Schembri & Evans, 2008).

Arguably, for participants in the current study, the sense of being accepted by their partners, and the feelings of safety this instilled, was integral in cultivating physical intimacy. One might further speculate that the participants' ability to discuss their thoughts and feelings about their bodies with their partners, and receive affirming feedback, played a role in both the couples' experience of intimacy and the women's recovery. Indeed, Newton and colleagues (2006) found that acceptance, trust, and feeling "known" were conducive to emotional closeness, and in turn, open communication in intimate partner relationships for women with AN (p. 46). Clinical work in the area of couples, sexuality, and EDs has also affirmed the general assertion that intimate partners may play a role in shifting women's relationship to their bodies, in part through communication (Young, 2014). This seems highly warranted given that women's experiences of self-consciousness during sexual intimacy have been associated with higher levels of ED symptoms (Schembri & Evans, 2008). For the women in this study, both the process and outcome of dialogue were helpful. That is, by virtue of engaging in conversations about these issues, feelings of safety were reinforced, and trust and emotional intimacy enhanced. In

addition, the reception of affirmative and normalizing feedback from partners supported gradual shifts in women's self-perceptions, and decreased feelings of shame around their bodies.

Although women's experience of addressing body image concerns with their intimate partner within the context of recovery from an ED does not appear to have been addressed in the empirical ED literature, body image and romantic relationships have been explored, both empirically and theoretically, in non-clinical populations (Evans & Stukas, 2007; Morrison, Doss, & Perez, 2009; Weller & Dziegielewski, 2004). While caution is certainly due in generalizing from this body of work, this literature affirms that partner feedback about shape and weight is related to women's body and relationship satisfaction, respectively (Evans & Stukas), with affirmative feedback and support from partners being inversely related to body image disturbance (Weller & Dziegielewski). In addition, Morrison and colleagues (2009) reported that male partners' desire for change in their female partner's body was related to both women's drive for thinness, and their relationship satisfaction, offering further support for the influence of partner perceptions on women's experience, and thus, the potential role of conversations about bodies in women's recovery process.

While positive and normalizing affirmations around appearance, shape, and weight were experienced as supportive in the current study, participants' valuing of their male partners' perceptions, attraction, and "approval" around their appearance, shape, and weight is itself noteworthy, given its illustration of the extent to which socio-cultural standards of beauty and experiences of sexual objectification may be internalized by women (Fredrickson & Roberts, 1997). For these participants, self-worth and -esteem were linked to appearance, with body image strongly influenced by socio-culturally defined beauty ideals. Some women located the development of their beliefs about appearance, shape, and weight within their family of origin,



while others identified the general culture of body dissatisfaction among women. However, only one participant named the oppressive socio-cultural context driving women to experience their body as an “object of desire.” As such, while the self-objectification expressed by participants underscores the pervasiveness of, and extent to which women may internalize, socio-culturally defined beauty ideals, standards, and expectations (Fitzsimmons-Craft, 2011; Moradi, Dirks, & Matteson, 2005), the women’s ability to gradually challenge these perspectives through partner feedback, suggests that the intimate relationships of adult women in recovery from an ED could play an important role in increasing women’s resistance to culturally reinforced messages about female appearance. Indeed, while many women in the current study found their partner’s expressed attraction to their bodies to be highly valued, despite validation and affirmation of other sources of self-worth, this feedback was experienced by the women as an important component of their process of shifting self-perception and relationship to, and reducing feelings of shame around, their body. Consistent with objectification theory (Fredrickson & Roberts), it is possible that, as these women began to question and dispute dominant messages about appearance and the female body, that self-objectification and associated feelings of body shame decreased, ultimately leading to shifts in ED symptoms (Moradi et al., 2005). Indeed, body shame has been shown to mediate the link between internalization of beauty ideals and ED symptoms (Moradi et al.), reinforcing the significance of the current finding that body shame may be addressed and reduced within the context of supportive intimate partner relationships. While this does not address the broader, contextual issues of unhealthy cultural norms and values, it suggests the power and role of some intimate relationships in challenging the internalization of these dominant messages, and supporting women’s re-construction of body

image and ideals, which is understandably a difficult task of recovery (Bardone-Cone, et al., 2010a).

In addition to feeling accepted by their partners, women in the current study consistently felt validated for who they were beyond the ED symptoms – and arguably, beyond their appearance, shape, and weight – lending further support to the aforementioned notion that these relationships may have supported reductions in women’s self-objectification. To this end, participants felt that their partners consistently viewed them as separate from the ED. For some women, contemplation of themselves and their life without the ED were foreign, and thus, having their partner reflect these possibilities was a powerful message to receive. Indeed, research has shown that some women feel they have no “reference to a life as a recovered person” (Pettersen, Thune-Larsen, Wynn, & Rosenvinge, 2013, p. 95), and thus, despite its importance to recovery, connecting with that potential and alternate ways of identifying and relating in the world can be incredibly challenging. For participants in the current study, the perception that their partner “externalized” the ED and focused on their individuality and valued life pursuits, opened a window into – or “mirrored” – possibilities of what could be in a life without the ED. To this end, the women’s sense of being seen and validated beyond the ED appeared to broaden their way of thinking about themselves and their lives. With this, the women described feeling increasingly hopeful about change and recovery. In fact, not only did this validation appear to promote cognitive shifts, altering their perspectives and assumptions about their identity and potential, it seems to have also led to behavioral change. Many women described increasing willingness to engage in new experiences, explore interests, pursue goals, and ultimately challenge themselves to move outside of what was known with the ED. Importantly, they shared that they felt supported by their partners to do so, and that their efforts – in regards to decreasing

ED behaviors and exploring and experimenting with other life pursuits – were consistently validated by their partners, further reinforcing and encouraging their growth. The women shared that they felt supported by their partners to develop themselves in meaningful ways, consistent with their higher values, and were thus increasingly able to connect to a sense of purpose more powerful than the ED. Indeed, it seemed of great value to these women to have someone they trusted and loved by their side through this process. Support appears to be particularly important to this aspect of recovery, as research has shown that for some women the task of developing one's identity beyond the ED can be “a long and difficult process filled with much sadness and uncertainty” (Pettersen et al., 2013, p. 95). For the women in this study however, despite the anxiety and challenges associated with letting go of the ED, their experiences were characterized by hope.

The notion that both recovery and the maintenance of change involve self-development is widely documented in empirical research (e.g., Bardone-Cone et al., 2010b; Cockell et al., 2004; D'Abundo & Chally, 2004; Lamoureux & Bottorf, 2005; Pettersen et al., 2013; Weaver et al., 2005). Bardone-Cone and colleagues (2010b) found that women who had attained recovery reported greater self-esteem, self-efficacy, and self-directedness as compared to those who were still struggling with the ED. Lamoureux and Bottorf (2005) conceptualized the recovery process for women with AN as “becoming the real me” (p. 183). Similarly, in another qualitative study of recovery, Weaver and colleagues (2005) conceptualized the process of recovering from an ED as a gradual shifting from “not knowing myself,” which was related to greater engagement with the ED, to “finding me,” which included a process of “encountering self” (p. 192) and importantly, establishing “identities based on self, not AN or other's expectations” (p. 196). Peters and Fallon (1994) concluded that “recovery in the most fundamental sense is a process of

human development and identity formation” (p. 353). As a whole, the recovery related literature highlights the process of personal growth that occurs during recovery and its impact on the women’s sense of self, life pursuits, and ED behaviors. Although studies to date have in large part conceptualized self-development as an autonomous process (e.g., Weaver et al., 2005), current findings suggest that self-development may occur within, and be facilitated by, supportive intimate partner relationships. In fact, the intimate relationship may be uniquely valuable in promoting this aspect of women’s recovery, as research suggests that it can be difficult for women to disentangle themselves from the ED identity in the eyes of family and friends who have witnessed a long struggle with the disorder (Pettersen et al., 2013), an experience echoed by women in the current study.

Relatedly, the women’s sense of being accepted and validated by their partners appeared to decrease their anxiety about change. Participants consistently shared that a perceived absence of pressure or expectation to change paradoxically increased their capacity to consider and actually make changes to their behavior. Feeling as though they could simply “be” within their relationship was extremely powerful. It created a sense of “space” – a sense of relief from perceived pressure to be different – within which contemplation of change became more tenable. This finding further highlights the ways in which the relational climate itself was facilitative of change for these women. As previously noted, it emphasizes the salience of partner acceptance within a context and circumstances that would understandably pull towards the encouragement of change. As reflected in the results however, this is not to say that women did not feel supported, and indeed, encouraged, to change their ED behaviors, but their experience of their partners promoting change occurred within the broader context of acceptance. This climate appeared to create a “holding space” within which the women could settle into their current

experience, making change feel less daunting; that is, the women felt more empowered to approach the possibility of making changes to their ED behaviors, and supported by their partners in doing so, when there was no expectation that they do so. As discussed earlier, this finding is largely consistent with models of social support (Brown & Geller, 2006), and psychoeducation and skill-building for “carers” of individuals living with an ED (Treasure et al., 2007a, p. 24), which caution against directive, or demanding, support attempts (Brown & Geller; Treasure et al.).

Taken together, the women’s experiences of acceptance and validation contributed to shifts in their relationship to themselves, increasing the extent to which they were able to see themselves and their lives beyond the ED, and begin to embrace the possibility of change and recovery. The women described a process of internalizing their partner’s views and messages; their openness to hearing and believing such views was due to the high level of trust and intimacy in the relationship, and honest communication about sensitive issues, which distinguished the intimate relationship from other supports. Overall, the safe relational climate appeared integral in facilitating behavioral change for these women, and thus, supporting their process of gradually letting go of the ED.

***Open communication.*** In discussing the relational climate and conditions that were conducive to change for these women, it is important to highlight the open and honest communication that was cited by all participants as being facilitative of their recovery. This is particularly relevant given that, to date, the ED literature has espoused the view that communication in the intimate relationship is generally problematic or deficient (see Van den Broucke et al., 1995a, 1995b). Studies on interpersonal functioning, while not focused on communication in the intimate partner relationship specifically, also support the notion that

women living with an ED struggle with certain aspects of communication, namely, assertiveness (Hartmann, Zeeck, & Barrett, 2010), expression of negative feelings (Geller, Cockell, & Goldner, 2000), and interpersonal distrust (Arcelus et al., 2013). In addition, there are numerous models of interpersonal maintaining factors of EDs (e.g., Ansell, Grilo, & White, 2012; Arcelus et al., 2013; Goddard et al., 2013). Current findings offer a different perspective however, and illustrate some of the ways in which interpersonal functioning and communication may be developed and strengthened within the intimate relationships of women with an ED, and in fact, facilitative of recovery for some. Notably, the aforementioned literature relies in large part on a post-positivist paradigm of inquiry, namely, cross-sectional designs. This results in a de-contextualized picture of women's relationships. It also precludes examination and understanding of the developmental nature of communication processes within relationship, as described by the women in the current study. As such, methodological distinctions likely account, in part, for the current study's generation of novel findings regarding women's experiences of communication.

In the current study, open communication appeared to emerge, develop, and strengthen in response to the women's sense of safety in the relationship – that is, within the context of an accepting, non-judgmental, and trusting relationship. The majority of women described an increasing willingness and ability, over time, to self-disclose to their partner. Some participants described an initial apprehension about discussing sensitive ED related issues with their partner, and identified their tendency to withdraw or avoid communication in the earlier stages of their relationship. Importantly, these women noted the development of communication skills and capacities that occurred within the context of the intimate relationship, which subsequently lessened discomfort with, and increased engagement in, dialogue. These experiences reinforce

the nature of communication as a process that is mutually influenced by both partners in the relationship. For example, women shared that they experienced their partners as open to, and encouraging of, communication. Partner availability for conversation was seen by the women to further promote disclosure and discussion of sensitive issues related to the ED, their bodies, and their intimate relationship. To this end, the *couples'* capacity to engage in open and honest communication further contributed to the women's decreasing sense of isolation and shame, development of communication skills, and enhanced overall relational functioning – each of which being related to the women's recovery process. Indeed, the centrality of relational climate to open communication has been documented in earlier work on intimacy and romantic relationships in the area of EDs (Newton et al., 2005a; 2006), further supporting the current assertion that in order to understand women's relational experiences, including communication, it is imperative that they be situated within relevant contexts and considered over time.

### ***Partnership***

The study's finding that women experienced their intimate relationship as a partnership, characterized by a sense of mutuality and joining around recovery, challenges notions of recovery as an independent, intra-psychoic process and reinforces the notion that it occurs within, and is influenced by, relational contexts (Weaver et al., 2005). The women in this study experienced a sense of mutual investment in both their relationship and recovery, and identified their partners as members of their "team." This finding is a significant and unique contribution to the literature, and it enhances existing understanding of adult women's experience of their intimate partner relationship as a support during recovery from an ED in a number of ways; these implications are summarized below, and subsequently discussed in further detail.

Broadly speaking, the participants' experience of a partnership further elucidates the process of shifting from a sense of isolation and disconnection with the ED, to a place of connection in relationship. While this process has been documented in the recovery-related research (Petters & Fallon, 1994) and proposed in the theoretical writings of RCT (Miller & Stiver, 1997; Tantillo, 2000), the depth of our understanding regarding this experience remains limited, and the specific ways this manifests within the intimate relationship have not been addressed to date. In addition, the near absence of research on the intimate partner relationship during recovery has implicitly reinforced reliance on family-based models of understanding and working with partner experiences, negating the unique supportive elements and needs inherent to this particular relationship. When considered within the context of extant literature on spouses as "care providers," the finding that adult women experience their relationship as a partnership in recovery highlights the limitations of existing conceptual frameworks in the area of EDs and social supports. Moreover, it suggests that developmentally informed theoretical models and applied approaches could enhance couples' experience of navigating and attaining recovery. Finally, this finding highlights and further explicates the motivational elements of committed intimate partner relationships, by depicting the ways in which committed relationships may actually reduce the importance of the ED, heighten higher values, and cultivate sense of meaning and purpose, thus, promoting change. This is highly relevant given the significant and pervasive issue of low readiness and motivation for change in the area of EDs (Vitousek et al., 1998; Waller, 2012).

***From isolation to connection.*** As previously discussed, the women in this study consistently described experiencing isolation, secrecy, and disconnection associated with their experience of the ED. They contrasted this experience with being in a committed intimate



relationship, which appeared to offer them unique opportunities for emotional and physical closeness; for these participants, this closeness was in and of itself conducive to growth and healing. While the notion of re-connection in recovery is largely consistent with the relational experiences described in empirically derived theories of recovery (e.g., Peters & Fallon, 1994; Weaver et al., 2005), the finding that women experienced a sense of partnership and joining, specifically, extends our understanding of the role of the intimate relationship in recovery. Participants in Peters and Fallon's (1994) study on recovery described movement from "alienation to connection" (p. 345) as healing occurred. For those women, this movement involved less secrecy; open conversations about the ED; development of interpersonal boundaries, communication skills, and identities; and re-negotiation of sexual intimacy and relationships. These experiences are highly consistent with those described by women in the current study. However, in the current study, the intimate partner relationship itself was integral in facilitating these change processes. Specifically, the safe relational climate appeared to provide a context within which women felt increasingly capable of pursuing these tasks, and the sense of partnership and connection they experienced illustrate some of the mechanisms of change.

In another comprehensive study of recovery, Weaver, Wuest, and Ciliska (2005) generated a model of recovery from an ED as a process of "self-development" (p. 188) – an "individual journey" (p. 191) situated within social contexts, that is, influenced by cultural and developmental expectations. Once again, although current findings are congruent with the recovery related experiences depicted by these researchers (e.g., learning to challenge messages about shape, weight, and body; learning to utilize support), there are a number of noteworthy distinctions regarding the process as conceptualized by Weaver and colleagues. Foremost, the

current study demonstrates that the “individual” process identified by Weaver et al., may be better conceptualized as a relational process for some women. Several studies locate relational re-connection as an *outcome* of individual change (D’Abundo & Chally, 2004; Weaver et al.; Woodside et al., 2000), whereas current findings suggest that connection in relationship is both a precursor to change (e.g., safety as foundation; motivational in nature) and a healing element in and of itself (e.g., feeling accepted and cared for). To this end, current findings both reinforce and extend Weaver et al.’s assertion that recovery must be situated within social contexts – that is, that recovery tasks occur through “interactions within social structure and not as individual intrapsychic processes,” and thus, may only be evaluated “when context is taken into account” (p. 202). That being said, research such as Weaver et al.’s, which identifies external influences and situates women *in relation to* these influences, continues to implicitly privilege intra-psychic processes. Current findings augment the theoretical stance that recovery must be situated within relational contexts by illustrating women’s experience of recovery *within* such a context, specifically, through the experience of partnership, mutuality, and joining, and associated experiences of intimacy and open communication. Participants in the current study described negotiating and navigating recovery related tasks within the safety of their intimate relationship, which included the experience of unified efforts around behavior change, the development of shared meaning and purpose in creating a life without the ED, and mutually influenced processes of communication. It is also important to note that the women’s sense of partnership did not exist to the exclusion of autonomy and independence, and the women often described feeling empowered in their recovery journey and development of identity beyond the ED.

***Mutuality and joining.*** As previously discussed, women in the current study described a sense of partnership, mutuality, and joining with their partners, rendering this relationship a

unique vehicle for change. The women's sense that their partners were working with them, based on their needs at the time, appeared paramount in the women's perception of support. In fact, many women in the current study found that their partner's efforts to provide support were more salient, influential, and valued than the content or focus of the actual support, irrespective of immediate outcome or impact. That being said, they shared that their sense of partnership afforded tangible and emotional support in pursuing the tasks of recovery, and reinforced their sense of a mutual commitment in the relationship and hope for recovery. Joining in recovery was manifest in a variety of ways for these women – for many, unity was experienced through their partner's efforts to collaborate around the identification and implementation of alternate coping strategies, and/or engagement in more general life pursuits. Additionally, for all the women, their sense of support was strongly tied to their perception of their partner's consistent emotional availability.

To this end, the women's experience of partnership in their intimate relationship highlights a core distinction between the role of partners and other supports during recovery, and importantly, provides an alternate framework for conceptualizing the couples' experience of navigating the ED and recovery process. That is, conceptualizing the recovery process not only as a relational process, but a dyadic process, offers opportunities to optimize strengths and resources within the intimate relationship – notably absent in existing literature and practice to date. Participants consistently differentiated their relationship with their intimate partner from their relationships with other supports in their lives, be it professional or personal, such as family and friends. In addition to the notion of partnering and joining in recovery, and associated sense of mutual investment in both the relationship and recovery – each of which appeared unique to the intimate relationship – these relationships were distinguished by virtue of the level and nature

of intimacy and trust, emotional and physical closeness, and overall sense of safety in the intimate partner relationship. The women also noted opportunities they were afforded with their partner to re-construct identity and remove themselves from histories of living with and negotiating the ED within the family context.

Literature in the area of EDs reflects a range of theoretical constructs to depict women's experience of navigating the interpersonal dimensions of the ED and recovery. Lacking however, is a framework for understanding adult women's experiences of coping with the ED and negotiating recovery tasks within relationship. For example, research has addressed concepts such as social support (e.g., Marcos & Cantero, 2009), coping (e.g., Fitzsimmons & Bardone-Cone, 2010), interpersonal maintaining factors (e.g., Goddard et al., 2013), and "carer" experiences (e.g., Perkins et al., 2004, p. 256). Taken together, the literature highlight various dimensions of social support, women's individual efforts to cope, and interpersonal issues and processes associated with supporting someone living with an ED. Unfortunately, this work sheds little light on the nature of support experiences for/within intimate partner relationships during recovery.

It has been argued in the field of health research more broadly that, "to understand fully the relationship between stress and health or mental health, we need to examine coping as it occurs within the context of significant relationships" (Kayser et al., 2007, p. 404), such as the intimate partner relationship. This assertion is certainly supported by the current findings. That said, "coping as a couple phenomenon" (Kayser et al., p. 405), or dyadic coping, has not emerged for consideration within the ED literature. This absence may be attributed, in part, to the dominant paradigms guiding inquiry and understanding of the aforementioned phenomena and processes in the field of EDs, in addition to the field's emphasis on problematic aspects of the

intimate partner relationship (see Arcelus et al., 2012). Yet, if one adopts the perspective that (a) the ED involves stressors for an individual and/or couple (e.g., Huke & Slade, 2006), and (b) recovery from an ED is a process involving the development of alternate ways of coping (e.g., Fitzsimmons & Bardone-Cone, 2010; Pettersen et al., 2013), for each of which there is an abundance of evidence, the concept of dyadic coping seems particularly suited to understanding women's experience of recovery within the context of an intimate relationship.

Indeed, turning to some of the research on dyadic coping, there is evidence of congruence between the experiences of the women in this study, and couples coping with other health concerns. For example, participants in the current study described a mutual investment in, and valuing of, the relationship. Their use of "we" language highlighted the extent to which recovery efforts were perceived as a joint pursuit bearing implications for both partners. In addition, their emphasis on communication processes as facilitative underscored the importance of open dialogue to both recovery, and relational functioning. Existing literature shows that attending to one's relationship and approaching issues as "we" issues have been deemed important to overall relational wellbeing (Acitelli & Badr, 2005; Kayser et al., 2007), and "joint" efforts at problem solving and "mutual commitment" have been linked to better relationship functioning (see Traa, De Vries, Bodenmann, & Den Oudsten, 2014, p. 9). Indeed, generally speaking, perceived mutuality of commitment is thought to be relevant to the overall quality of romantic relationships (see Weigel, 2010).

In their study on couples coping with cancer, Kayser and colleagues (2007) described a pattern of "mutual responsiveness" (p. 409) occurring in some couples. This manner of coping was characterized by the relational qualities of authenticity (e.g., honesty around communication), mutuality (e.g., empathic responding between partners; conceptualizing the

experience as a “shared experience”), and relationship awareness (e.g., attending to the wellbeing of the relationship) (p. 410). These authors commented that “partners did not always respond perfectly with the support they desired from each other, but their authenticity and mutuality allowed them to make the necessary changes to cope more effectively as a couple” (p. 414), alluding to a responsiveness and flexibility in navigating needs similar to that described by participants in the current study. For the couples in Kayser et al.’s study, the aforementioned processes were associated with “relational coping that included the participation of both partners together” (p. 414), paralleling the unity and joining depicted in the current study. Although health related outcomes were not addressed by Kayser et al., they observed that relational coping was associated with both individual and relational growth, and a more positive orientation to the cancer experience.

Findings from the current study suggest that similar relational practices occur in some couples for whom one partner is living with an ED, and thus, suggest this model of understanding couples’ experiences may be theoretically and clinically relevant in the field of EDs. Certainly, adopting such a perspective would result in innovative lines of research in the area of EDs, and mark a departure from the dominant family-based models of relational functioning and support seen in ED literature and treatment (Files et al., 2014; Treasure et al., 2007a). Despite being well intentioned in their efforts, existing models position loved ones as “care givers” and “coaches” in relation to the individual with the ED, implying a hierarchical relationship, reinforcing focus on the ED identity, and arguably, disempowering adult women. While some of the practices are certainly appropriate in parent-child relationships (i.e., for whom they were originally developed), they are both theoretically and practically limited for adults in recovery. As evidenced by the current findings, the women’s experiences of support were

predicated on feelings of acceptance and validation of self beyond the ED, absence of expectation and pressure to change, and partnership and mutuality, each of which is in many ways theoretically incongruent with the aforementioned models. This suggests that developmentally informed models and approaches for working with women and their partners are needed, and that the literature on dyadic coping may be an appropriate direction for further pursuit.

***Motivational elements.*** Finally, the finding that women experienced their intimate partner relationships as inherently motivating offers a significant, and unique, contribution to the extensive literature on motivation for change in the area of EDs (e.g., Treasure & Schmidt, 2001; Vansteenkiste, Soenens, & Vandereycken, 2005; Vitousek et al., 1998; Waller, 2012). It appears that current findings are the first to highlight motivational issues within the intimate partner relationship, specifically, establishing initial, empirically informed understanding of this aspect of women's recovery. Indeed, the motivational features of intimate partner support are particularly relevant to the recovery-related research given the well-documented challenges of change (Vitousek et al.) and the often enduring nature of EDs (Herzog et al., 1999).

Participants in the current study were unanimous in citing their intimate partner relationship as a source of motivation in recovery. In fact, motivational elements permeated numerous aspects of the women's relationships. For example, feeling accepted by their partners paradoxically enhanced the women's inclination towards, and capacity to approach, behavior change. Open communication and validation of self beyond the ED both reinforced skills and capacity for change. Importantly, the experience of partnership and mutuality provided the women with important sources of meaning and purpose in recovery, fostering both hope and motivation for change. This latter finding is particularly important, as it suggests that motivation

to recover may be cultivated by mutual valuing of one's intimate relationship and shared goals with one's partner. According to the women in this study, these relational experiences helped them see beyond the ED, into possibilities for the future. Several women commented that the ED began to lose its significance in relation to shared values and goals, which helped generate a sense of purpose in recovery. Others commented that their relationship prompted them to live in a more congruent manner, highlighting the dissonance between their values and the ED behaviors, and that identification of these discrepancies fostered a desire for change. Indeed, this process has been identified as a task in recovery (Cockell, Geller, & Linden, 2003; Treasure & Schmidt, 2001).

For the women in this study, the intimate partner relationship appeared to reflect or "mirror" life's possibilities beyond what was afforded with the ED. To this end, the women encountered inner hopes for family, strong relationships, enhanced quality of life, and diversity of experience, which in many ways, felt incompatible with the ED. Hence, the consequences of the ED began to emerge within the context of their intimate partner relationship, and participants observed that they began to realize the extent to which the ED was limiting their personal and relational growth, wellbeing, and engagement in life.

These findings are consistent with the literature on motivation, which asserts that women's identification with the functional benefits of the ED is linked to lower readiness and motivation for change (Vitousek et al., 1998), whereas greater perception of the consequences or costs of the ED is associated with increases in motivation to change (Cockell et al., 2003). Research has also shown that "focusing on meaningful aspects of life" supports recovery, which includes "focusing on higher values," "personal development," and altering one's lifestyle (e.g., finding employment, increasing leisure, pursuing education) (Cockell et al., 2004, p. 530).



Current findings position the intimate partner relationship as a key support in this process of development, and confirm that a broadening of perspective, engagement with life activities, and fostering of identity beyond the ED may promote and sustain change.

Relatedly, the current findings strongly suggest that aspects of the intimate partner relationship may increase the perceived *importance* of change, and enhance *confidence* in one's ability to make desired changes, both salient aspects of motivation (Miller & Rollnick, 2002; Treasure & Schmidt, 2001). Participants often commented that they felt as though they had something to "fight for" given their intimate relationship, heightening the stakes of recovery. To this end, mutual valuing of, and investment in, the relationship and shared goals were particularly motivating for these women. In addition, the women frequently commented that they felt safe to experiment with new behaviors (and supported in doing so), and as they did, felt a growing sense of confidence in self and their ability to make changes. Indeed, sense of self-efficacy is thought to promote readiness for change (Treasure & Schmidt). These experiences are also consistent with research linking increased self-esteem, self-efficacy, and self-directedness to recovery (Bardone-Cone et al., 2010b).

The findings also support the notion that, for some women, being in an intimate relationship can elicit a sense of accountability, and consequently, support the identification and practice of alternate coping strategies. Notably, the women's experience of accountability was situated within an accepting relational context; that is, the women consistently shared that they did not feel pressured to change, did not feel that there was an expectation they change, nor was their relationship contingent upon change, which appeared to afford the women a sense of empowerment in their change efforts, and likely contributed to their experiences of accountability as supportive versus threatening or intrusive. Furthermore, the women's sense of

accountability appeared to be related to their sense of mutual valuing of the relationship and concern for their partner, versus anticipation of externally imposed consequences. Taken together, these findings lend support to the application of Self-Determination Theory (SDT; Deci & Ryan, 2008) in the area of EDs (see Vansteenkiste et al., 2005). SDT attends to the social contexts and conditions influencing motivation, and thus, is particularly well suited to understanding motivational elements in the intimate partner relationships of women in recovery from an ED. SDT argues that extrinsic motivation can be equally as important as intrinsic motivation, and places emphasis on the importance of internal locus of causality, personal values, and autonomous motivation, to the quality of motivation and outcomes (Deci & Ryan; Vansteenkiste et al.). Indeed, the current findings support the notion that women's valuing of their intimate relationship, and its cultivation of empowerment and autonomy around change efforts, were particularly salient to the women's experience of motivation, and arguably, their recovery.

Overall, the participants' experiences highlight the relational dimensions of readiness and motivation to reduce ED behaviors, and therefore reinforce the importance of situating women's recovery within relational contexts. Indeed, the study's findings capture the relational qualities and climate deemed to be conducive to experimenting with behavioral change and movement in recovery, and suggest that the relationship itself may be a vehicle for change for some women, as espoused by Relational-Cultural Theory.

### ***Relational-Cultural Theory***

To conclude this section on theoretical implications, I now turn to Relational-Cultural Theory (RCT) and comment on the implications of the current findings for this theory of women's wellbeing and development (Miller & Stiver, 1997), and its applications in the area of

EDs (e.g., Tantillo, 2000; Tantillo & Sanftner, 2010). RCT asserts the importance of close relationships to women's growth (Miller & Stiver), including their recovery from an ED (Tantillo; Tantillo & Sanftner). Broadly speaking, RCT's conceptualizations of psychological distress and wellbeing are grounded in processes of connection and disconnection in relationship. Theoretically, unmet needs and relational disconnection are associated with psychological distress, including ED symptoms. To this end, ED symptoms are thought to then develop and satisfy otherwise unmet interpersonal needs; paradoxically, the ED therefore functions to sustain relational connection, allowing a woman to remain in her relationship despite the relational disconnection (see Geller et al., 2000; Miller & Stiver; Tantillo). It follows that increased connection in relationship, including mutual empathy and empowerment, fosters wellbeing and growth, hence RCT's position that recovery from an ED may occur within the context of mutually empathic and empowering relationships (Tantillo; Tantillo & Sanftner).

As illustrated throughout this chapter, findings from this study elucidate the ways in which growth and healing may manifest within a specific relational context. Participants in the current study described movement from isolation, disconnection, avoidance, secrecy, and rigidity with the ED, towards connection, openness, and flexibility within their intimate partner relationship. To this end, several of the women contrasted being in relationship versus being in the ED – that is, connection versus disconnection – associating their recovery with the former. For several women, the ED was experienced as a source of disconnection in their relationship, detracting from, and at times compromising, the women's sense of intimacy with their partner, which is consistent with previous research on intimacy and romantic relationships for women with an ED (Newton et al., 2005a). In keeping with RCT's theories of psychological distress and wellbeing, this suggests that as these women worked towards recovery, the intra- and inter-

personal benefits of the ED may have lessened, with authenticity being most highly valued; indeed, the women in the study shared that over time, and in relation to their intimate partner relationship, the ED began to lose its significance and power.

To this end, it appears that high levels of safety and intimacy in these relationships, coupled with the women's/couples' development of communication capacities, decreased the presence of relational disconnections and facilitated connection, healing, and recovery. As such, it seems probable that the relational climate fostered in these relationships enabled the women/couples to maintain connection with their partners in healthful ways, and as noted by the women, reduce their reliance on the ED as a means of coping and communicating. Indeed, participants observed that as their communication with partners increased and developed, they gradually turned to or relied on the ED less. This aligns with research informed by RCT that found higher perceived mutuality in one's intimate relationship is associated with less self-silencing and interpersonal distrust for women with disordered eating (Wechsler et al., 2006), and lends support to RCT's overarching claim that recovery from an ED is associated with relational connection.

Particularly relevant to the application of RCT within the area of women's recovery from an ED is the current study's findings regarding partnership, mutuality, and joining in the intimate relationship. Participants emphasized their experience of a mutual valuing of the relationship and joint commitment to recovery, both reflecting relational characteristics and processes generally consistent with dimensions of RCT's central construct of "perceived mutuality" in close relationships (Genero et al., 1992). Within the RCT literature, mutual interactions have been described as exchanges characterized by "openness to influence, emotional availability, and a constantly changing pattern of responding to and affecting the other's state" (Jordan, 1991, p.

82). Jordan (1991) has proposed a “model of mutual intersubjectivity” that emphasizes a shared investment in both the relationship and the wellbeing of the other (p. 83), much like the process described by women in the current study.

Participants in the current study shared a number of specific experiences that map onto existing conceptualizations of mutually empathic and empowering relationships, thought by RCT to promote growth and recovery from an ED, and thus, lending support to the generalizability and relevance of this construct in the area of EDs. The women emphasized the centrality of a safe, accepting, and non-judgmental relational climate, which was foundational to relational connection and recovery efforts. The women located ongoing, open communication as central to both individual and relational functioning, and to decreasing the hold of the ED. The women highlighted their perception that both they and their partner sought to be responsive and flexible with respect to both recovery and relational needs, speaking to the ways in which needs were negotiated and navigated within the partnership. In addition, many women described feeling empowered in their recovery, consistent with RCT’s notion that autonomy and connection co-exist within relationship. In fact, findings suggest that this co-occurrence may be particularly relevant to women’s recovery process, in that, with the absence of perceived pressure to change and cultivation of one’s identity beyond the ED, the women began to contemplate and experiment with change.

Taken together, the above experiences map onto the six core elements of mutuality as conceptualized and operationalized by Genero and colleagues (1992): empathy, engagement, authenticity, zest, diversity, and empowerment (p. 38). This is relevant given that Genero and colleagues’ (1992) measure of mutuality has been adapted and employed in the area of EDs, in the absence of validity evidence with this group (e.g., Sanftner et al., 2004). In brief, women in

the current study experienced empathy and engagement within their relationships, which supported the cultivation of authenticity and intimacy, and aided communication.

Communication itself captures the quality of “diversity,” as conceptualized by RCT to consist of “expressing and working through different perspectives and feelings.” The women’s experience of motivation, including their openness to consider new possibilities for self, is congruent with “zest,” which refers to the “energy releasing quality of relationships,” and thus, a mechanism of growth (p. 39). Interestingly, compassion was quite prominent in these women’s relationships, and was understood by the women as being related to their partner’s difficulty understanding the ED, yet, ability to convey understanding and concern around the suffering caused by the ED. While not emphasized in RCT, compassion appears to be particularly relevant to the experience of connection and growth for women with an ED.

It must also be noted however, that despite these areas of convergence between the study’s findings and RCT’s tenets, the findings are limited in the extent to which they inform certain aspects of RCT, specifically, those that address issues of culture and diversity, and the ways in which oppression and marginalization affect relational experiences (Comstock et al., 2008; West, 2005). Arguably, numerous cultures and sub-cultures are represented amongst the women who participated in this study; for example, different religious and spiritual orientations, and Indigenous and Eastern healing practices, were all cited by participants as being part of their experiences. In addition, the women were involved in different communities, through academics, sport, and art. Adopting the view that each individual has multiple intersecting identities (Hays, 2008), there is certainly diversity amongst the experiences and relationships captured in this research. Importantly however, acknowledging the socio-economic advantages and privileges of the predominantly Caucasian and presently able-bodied group of participants, in heterosexual

relationships, the extent to which findings speak to a range of diversity factors, minority identities, and experiences of oppression and marginalization, and the ways in which they may influence women's experiences, is significantly limited. Specifically, the ways in which the aforementioned intersecting aspects of identity and experience may influence ED and recovery-related experiences, and importantly, experiences of connection and disconnection in relationship, require further investigation, as discussed below. The experiences of the women, and their partners, in the current study reflect the influences of North American culture, including media and the beauty ideals portrayed and perpetuated in this media and associated discourses, and norms regarding heterosexual intimate relationships and gender roles. It is therefore unknown to what extent findings fit for women and partners of other cultural backgrounds, experiences, and identities, for whom norms, messages, and discourses may differ (e.g., in their emphasis on gender roles, appearance, relational functioning).

As such, taken together, findings offer support for the application of RCT as a framework for understanding adult women's recovery from an ED within the context of intimate partner relationships, however, remain limited in the extent to which they address the applicability of all aspects of this theory. This issue is addressed further directly below, within the context of the implications of the sample.

### ***Implications of the Sample***

The aims of a hermeneutic phenomenological study are to recruit participants who have shared a common experience, in order to depict that experience in detail (Langdridge, 2007). In adopting this method, the aim is to achieve transferability, not generalizability of the findings. With these methodological considerations in mind, I now return to the contextual considerations

for interpreting the study's findings, with specific focus on the implications of the sample and associated limitations.

As previously stated, the participants in the current study consisted of heterosexual women in heterosexual relationships. As such, it remains unclear to what extent the current findings may resonate with women of sexual minority orientations and/or gender identities, and same sex relationships. For example, participants valued their male partner's affirmative feedback about their appearance, shape, and weight, and viewed this to be central to the re-negotiation of their relationship to their bodies. It remains to be seen whether, and how, physical and sexual intimacy may influence the experiences and ED symptoms of women in same sex relationships. Arguably, given that socio-cultural messages and ideals regarding shape, weight, and appearance differ for men and women, and thus, may affect men and women (and their experiences of intimacy) in different ways, body related issues and conversations during recovery may manifest in alternate ways for women in same sex relationships. Questions remain regarding the extent to which shape, weight, and appearance are addressed within the relational context for women in same sex relationships, and again, the ways in which this may influence experiences of support and recovery. To this end, given that some research suggests differences in symptom presentation among women of various sexual minority identities (Bankoff & Pantalone, 2014; Polimeni, Austin, & Kavanagh, 2009), it is not clear to what extent the relational qualities and support experiences described in the current study may be applicable for these individuals as they engage in recovery from an ED.

All but one woman in the study identified as Caucasian, of European heritage, and all but two partners were Caucasian, of European heritage, limiting the extent to which findings may be transferable to women and their partners of other racial and ethnic identities. For example,



research suggests differences in symptom presentation for women of ethnic minority identities (Naidoo, Geller, & Zelichowska, 2011; Podar & Allick, 2009), and thus, it is possible that their specific support needs and preferences throughout recovery may therefore differ. Additionally, as previously noted within the context of RCT, given the study participants' social locations and positions within dominant/majority cultural contexts, which inevitably shaped their experiences and relationships (Comstock et al., 2008), caution is required in extending current findings to women of sexual and ethnic minority identity(ies).

In addition, the women in this study were all highly educated, with many holding or pursuing graduate degrees. The majority of participants had pursued education in the area of social sciences and at the time of the interviews many were working in occupations associated with health and mental health services, suggesting a high level of knowledge around interpersonal processes and communication. Participants' education and work experience may have influenced their interpersonal functioning and intimate relationships. This background may have also influenced the women's interest and willingness to participate in the study, and their ability to reflect on and articulate their experiences. It appeared that participants were all relatively skilled at identifying, accessing, and navigating professional supports and treatment, as all of the women had been involved with professional mental health and/or ED services to varying degrees prior to entering their intimate relationship. As such, the women's socio-economic advantages, and the resources afforded to them by virtue of this status, including their ability to access supports, may have influenced their support needs and experiences with their partners.

To this end, it remains unclear whether findings would resonate for women with less education and/or access to professional resources, as these aspects of the participants' experience

may have influenced their relationships and course of recovery. This is particularly true given that individuals of racial and ethnic minority identity tend to seek and access less treatment than do individuals identifying as Caucasian (Marques et al., 2011; Naidoo et al., 2011). This is relevant in light of the finding that women in the current study described their efforts to identify and articulate their support needs to their partners, which likely influenced their experience of *joining in recovery*, and it seems arguable that the participants' awareness around their needs, and their growing capacity to communicate them, were in part influenced by treatment experiences. It is also possible that the women in this study's perceived access to opportunities, such as career and education pursuits, which proved important to their *development of their identity and life beyond the ED*, was related to their higher socio-economic status. Therefore, the process of self-development and the sense of hope the women voiced may have manifested differently or been less prevalent for women holding less privilege.

Finally, considering a developmental perspective, it must be noted that all of the participants in the current study began experiencing ED symptoms during their adolescence, and were engaged in the recovery process during their twenties; all but one woman indicated that recovery was attained during her twenties (i.e., one woman achieved recovery in her early thirties). As such, it is possible that the experiences of the women in the current study reflect relational and recovery-related needs and processes unique to this particular developmental period. There is a growing body of literature that not only suggests an increasing prevalence of EDs in mid-life women (e.g., 40-65; Cumella & Kally, 2008), but that specific developmental transitions (e.g., loss or change in relationships with partners and children), experiences (e.g., menopause and associated changes in one's body), and events (e.g., later pregnancy), coupled with dominant socio-cultural messages and expectations about aging, appearance, shape, and

weight, may play a role in the onset and course of the ED (Brandsma, 2007). To this end, the extent to which women in mid-life may relate to the supportive and facilitative relational experiences described by the relatively younger group of women in the current study, remains to be seen.

Importantly, there was significant heterogeneity among the study participants with respect to their ED presentation and course, and their intimate partner relationships. Specifically, the women described diverse experiences with respect to their ED, including duration of the ED, symptom presentation and severity, levels of readiness and motivation for change, perceived stage of recovery, time since recovery, and extent of involvement in professional treatment. To this end, the participants appeared largely representative of treatment seeking populations.

For this group of participants, the course of their ED symptoms varied (i.e., two to fifteen years), as did self-reported symptom severity and readiness and motivation to change their ED behaviors. This variability is particularly notable, given the similarities in what was perceived by the women as being supportive and facilitative of their recovery. That is, it suggests that the experiences of support described by the women in the current study may indeed be representative for women with varying levels of symptoms severity and readiness and motivation, at different stages of recovery.

In addition, although some women self-identified as having been in recovery much longer than others (i.e., range of one to ten years), there did not appear to be marked differences in the women's lived experiences or their ability to recall and describe these experiences. This may reflect the subjective nature of the recovery process, namely, the perceived course of one's recovery and when/whether one identifies as having attained recovery (i.e., versus working on

recovery, being in recovery) (Root, 1990), which highlights the approximate nature of the durations cited by participants.

In addition, although the women in the study all described heterosexual relationships, there was considerable variability among these relationships, including duration of the relationship, marital status, current status of the relationship, children in the relationship, and whether or not the women lived with their partners during their recovery process. With respect to duration of the relationship, the only notable difference among the participants' experiences was that women in longer-term relationships tended to share more hopes for the future *with their partners*, as motivating forces. Other supportive and facilitative aspects of their intimate relationships appeared quite similar, overall. The study's inclusion of women in dating relationships is also noteworthy, as it contrasts much of the existing research on intimate partner relationships that focuses on married women who are living with their partner (e.g., Van den Broucke & Vandereycken, 1988), and thus, this inclusion strengthens the transferability of findings.

Finally, at the time of the research interviews, five of the ten participants were still with their partners, and for the other half, their intimate relationship had ended. Of those whose relationship had ended, three women identified as having recovered prior to the ending of the relationship, and two identified as having recovered after the relationship ended. Interestingly, there appeared to be few differences between the groups in their experience. Readers are cautioned to keep these limitations in mind when considering implications for practice. The implications of participant characteristics are addressed further within the context of future research.

### ***Implications for Practice***

Consistent with a counselling psychology perspective, the findings affirm the importance of contextualizing women's ED and recovery experiences, and attending to relational processes, in order to deepen understanding and develop comprehensive conceptualizations of clients' distress and strengths (see Berman & James, 2012). Relatedly, the findings affirm that adopting a non-pathologizing lens regarding couples' functioning in the area of EDs may afford practitioners greater opportunity to identify and optimize resources within the intimate relationship, and thus, support couples to mobilize capacities in the interest of change (see Kashubeck-West & Mintz, 2001). Consistent with RCT, it is argued herein that by situating recovery as an individual process we may inadvertently reinforce the focus on individually based treatments and approaches, obscuring the multiple contexts and cultures influencing women's experiences of the ED and relationships; furthermore, we are at risk of denying women and their partners important resources and couples' focused care when indicated. To this end, findings from the current study present a range of implications for clinical practice, including implications for both individual and couples' counselling, and the provision of resources for partners. These practice implications are each discussed within the broader context of specialized treatment in the field of EDs, an overview of which is provided to help situate the current findings.

### ***Treatment of Eating Disorders***

To date, individual approaches to therapy remain a focus in the treatment of adult EDs (Wilson, 2005), as very little research exists on the involvement of partners in treatment (Bulik et al., 2012; Gorin et al., 2003). Existing research reflects efforts to assess the effects of partner inclusion in an ED prevention program (Ramirez, Perez, & Taylor, 2012) and group CBT (Gorin et al.), respectively. Partners have also been included in family-based interventions, however

these approaches are grounded in, and generalized from, literature on family relationships and functioning (e.g., parent-child relationships), rather than knowledge of the adult intimate partner relationship specifically (Treasure et al., 2007a; Treasure et al., 2007b). Drawing upon some of the same theoretical principles regarding interpersonal maintaining factors and the involvement of close others in recovery (see Treasure et al., 2007a), researchers have recently developed and evaluated a tailored treatment for adults with AN, which includes attention to close relationships, namely, the ways in which close others respond to the individual with the ED (Schmidt et al., 2013). In addition, growing awareness and appreciation of the role of partners in recovery has resulted in the development of a couples' focused CBT for AN [i.e., Uniting Couples in the Treatment of AN (UCAN)] which is currently being evaluated (Bulik et al., 2012; Bulik et al., 2011). Despite the relative absence of consistent partner involvement in adult treatment to date, it seems the field may be shifting in this direction, which could lead to the establishment of further interventions and support for women and their partners (e.g., Bulik et al., 2011).

***Individual counselling.*** Counselling Psychologists need not practice in specialized treatment settings to work with women living with an ED, and thus, consideration of the ways in which current findings apply to individual counselling practice in general is warranted (Kashubeck-West & Mintz, 2001). First and foremost, findings suggest that counsellors ought to assess the client's relational context, including immediate supports and whether or not the woman is in an intimate relationship. While the collection of this information typically occurs within the context of history and current psychosocial functioning, counsellors may be less inclined to inquire specifically about the intimate partner relationship, given that it has not been fully acknowledged or appreciated as a factor in women's recovery, and consequently, this

consideration remains largely absent in the treatment of adult EDs (Bulik et al., 2011; Wilson, 2005).

The current findings suggest that understanding the nature and quality of the intimate partner relationship may support both case conceptualization and intervention. Specifically, the findings suggest the following areas for assessment: whether the woman has disclosed her ED to her partner, or whether her partner is aware of the ED; if the partner is aware of the ED, what was/is his or her response to learning this information; the extent to which there is communication about the ED, and the nature (i.e., both content and process) and perceived quality of this communication; and the woman's experience of emotional, physical, and sexual intimacy with her partner. In addition, gaining a sense of the woman's perspective on the quality of her relationship and its potential role in her ED and recovery (e.g., supportive, hindering; in what ways might it exert such influences) are strongly recommended. Ensuring a comprehensive assessment of this particular relational context would not only generate useful clinical information, it would make explicit the ways in which the ED may be relationally located, and therefore support the client in contextualizing her experience. This is particularly relevant given the general tendency towards intra-psycho factors in many evidence-supported interventions for EDs (Wilson, 2005). Assessment of this nature would also lay the foundation for future treatment directions, such as partner involvement in counselling, couples' focused counselling, and/or provision of resources for the partner, as indicated and desired by the client.

The findings also suggest several areas for intervention with women in recovery, who are in an intimate partner relationship. Specifically, individual counselling may be a place for all women (i.e., those who identify their partner as a support and those who may not have this experience) to safely explore aspects of their intimate relationship shown here to influence

experiences of support and facilitate recovery. To this end, counsellors are encouraged to consider exploration of relationship quality and climate, including the extent to which women feel acceptance, non-judgment, and validation in their intimate relationship; communication processes (e.g., areas of strength, areas of difficulty); experiences of intimacy; and women's perceptions of their partner's efforts and capacity to provide support. The current findings also indicate that discussing the extent to which the ED is a focus in the intimate relationship could be useful. Specifically, exploration of this aspect of the couple's experience could enhance opportunities for both joining in recovery (e.g., when and how might partners be a resource in supporting behavioral change), and, supporting development beyond the ED (e.g., how can couples orient themselves to the ED such that there is encouragement and space for growth and identity beyond the ED).

It is also advised that counsellors attend to, and explore, potential barriers to connection in relationship. While this was not a focus in the current study, and thus, findings do not speak to this directly, addressing the challenges of connection and sources of disconnection appear warranted. Relational disconnections and connections occur in all relationships, including the counselling relationship, and thus, establishing a safe, trusting, and validating therapeutic relationship may afford clients a space within which to explore these aspects of their experience, learning and translating awareness and skills to other relationships. It also affords counsellors an opportunity to validate personal (e.g., trauma, attachment), systemic (e.g., limited access to resources), and cultural (e.g., experiences of discrimination) sources of disconnection, and barriers to connection, in efforts to foster supportive relationships in recovery.

Finally, it is also notable that women in the current study found their experience of compassion on behalf of their partners to be particularly helpful in increasing feelings of self-



acceptance and decreasing feelings of shame around the ED. Compassion has begun to receive some attention in the area of EDs, namely, the role of self-compassion in decreasing shame (Kelly et al., 2014), and a compassion-focused therapy has recently been developed specifically for EDs (Goss & Allan, 2014). The findings lend support to the utility of this concept and approaches; specifically, the findings suggest that exploring and enhancing self-compassion, which would include identifying and addressing barriers to self-compassion, could be beneficial for adult women in their recovery from an ED.

***Couples' focused approaches.*** Findings from the current study may inform the development and tailoring of couples' focused approaches to counselling, and ED treatment (e.g., Bulik et al., 2011), for adult women and their intimate partners. The current findings are particularly valuable to this area of practice, given the paucity of research to date, and consequently, the near absence of women's voices informing couples' focused interventions.

Extending the areas of assessment and intervention outlined above, which are equally relevant within the couples' counselling context, counsellors working with the dyad have the opportunity to elicit the perspectives of both partners on these aspects of relational climate, quality, and functioning. Based on initial and ongoing assessment, and in consideration of any contraindications to pursuing couples' work<sup>25</sup>, counsellors can work collaboratively with their clients<sup>26</sup> to determine areas of intervention.

---

<sup>25</sup> Although extensive discussion of ethical issues in couples' counselling is beyond the scope of this work, it is acknowledged that a couples' approach may not be suitable for some couples, such as those in which there is current abuse.

<sup>26</sup> It must be noted that there are various approaches to couples' based therapy when one partner presents with a mental health concern (see Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Determining the "client" will therefore depend on the approach adopted by the counsellor and couple, and the agreed upon goals of the counselling process (i.e., the couple as client, or, the woman seeking ED treatment as the client).

The current findings emphasize the importance of the couples' orientation to the ED, and highlight three key areas for intervention: relational climate, communication, and intimacy. Specifically, with respect to the couples' orientation to the ED, participants indicated that an externalization of the ED and validation of their identities beyond the ED, were particularly supportive of recovery. Furthermore, the women experienced a sense of partnership and unity in their recovery as being facilitative of change efforts, when coupled with an absence of perceived pressure to change. That is, while women found that it was supportive to experience recovery as a joint endeavor with their partners, they also valued being validated and encouraged in their pursuits beyond the ED. Counsellors are therefore encouraged to support couples in finding a balance with respect to the extent to which the ED is a focus in the relationship. To this end, counsellors should explore with the couple the ways in which they may work together, as a "team" in recovery, to effectively navigate the woman's support needs and hopes for behavior change. However, these efforts to join in recovery ought to occur concurrently with efforts to ensure encouragement of the woman's self-development beyond the ED, and thus, a focus on more than symptom reduction, as this balance within the relationship appears to be essential.

In addition, the findings suggest that interventions aimed at enhancing the relational climate and conditions of the intimate partner relationship are a fundamental component to working with couples in recovery. Supporting couples to enhance communication offers one means of cultivating a relational climate characterized by acceptance, non-judgment, and compassion, deemed by the women in this study as being key to facilitating healing. Specifically, within the safety of the therapeutic relationship, women and their partners can be supported to develop, strengthen, and practice communication strategies. For example, findings suggest that it may be helpful for women to practice expressing thoughts and feelings, and articulating support

needs to their partner, and also, for couples to practice negotiating each partner's needs, with respect to both communication and the relationship.

For participants in the current study, communication was also linked to their experiences of intimacy, another key ingredient in their experiences of support. In light of the role of intimacy in supporting women's process of re-defining their relationship to their body, counsellors are strongly encouraged to address the couples' experiences of emotional, physical, and sexual intimacy, including strengths and challenges, and relational experiences that may promote and/or hinder intimacy. To this end, supporting the couples to engage in dialogue around intimacy needs and concerns may be particularly helpful. As acknowledged by one of the participants, in reference to the utility of sharing appearance-related concerns with her partner, women may interpret general messages that seeking re-assurance around one's body, or sustaining a focus on shape and weight as factors influencing self-esteem, to suggest that any conversation about shape and weight is problematic. However, current findings suggest that within the context of a trusting intimate relationship, such conversations may indeed be helpful – namely, normalizing and affirming. As such, couples may be supported in counselling to negotiate this dialogue, including underlying needs and intentions, to ensure couples' refrain from reinforcing a value and focus on appearance, and rather, increase women's self-acceptance, ability to challenge socio-cultural norms, and overall resistance to the internalization of ideals and objectification.

I now turn to couples' focused approaches to specialized ED treatment, namely, the *Uniting Couples in the Treatment of Anorexia Nervosa* (UCAN) treatment model (Bulik et al., 2011), and the ways in which current findings may inform this developing line of work in the field. Notably, given this study's inclusion of women with a history of BN and EDNOS, and the

absence of marked differences amongst the women's experiences, findings suggest that aspects of UCAN may be generalizable to women with other symptom presentations.

Overall, findings from the current study are largely congruent with aspects of this cognitive-behavioral approach to working with couples in which one partner has an ED. For example, participants' experience of a partnership in recovery is consistent with the UCAN therapeutic aims of helping "the couple work together as an effective team to approach an eating disorder" (Bulik et al., 2011, p. 23) and maintaining equality within the relationship (Bulik et al., 2012). In addition, current findings support UCAN therapeutic aims of psychoeducation and communication enhancement, including dialogue about body image (Bulik et al., 2011). Indeed, for participants in the current study, these were both paramount in supporting change.

It is important to acknowledge that Bulik and colleagues identify their UCAN approach as a "couple-based intervention," distinguishing it from a "couple therapy" (Bulik et al., 2012, p. 4). Given that empirical evaluation of this approach is reportedly underway (Bulik et al.), it remains to be seen whether focus on the relationship more generally, or aspects thereof (e.g., trust, communication, intimacy), may also be beneficial for individuals with an ED and their partner, prior to, as an alternate to, or concurrent with focused ED treatment.

An important consideration for counsellors working with couples is that the process and attainment of recovery bring with them numerous changes to both individual and relational functioning, which in themselves, appear to hold implications for the intimate partner relationship. Specifically, several women in the current study shared that their intimate relationships ended following their achievement of recovery. While these women acknowledged other factors associated with the ending of their relationship, they observed the ways in which their recovery process impacted their separation. They commented that aspects of their intimate

relationship that had been instrumental in supporting their recovery ultimately became less conducive to optimal relational functioning as their identities, pursuits, and needs shifted. This finding suggests that counsellors must remain mindful of the many ways in which recovery may impact the intimate relationship, and support couples in navigating these changes and any associated losses.

Finally, although the current study focused on supportive intimate relationships, limiting the transferability of findings to less supportive or challenging intimate relationships, it seems reasonable to consider the ways in which the findings may in fact apply to intimate relationships that have not been explicitly identified as supportive and/or possess challenges that may be related to the ED. That is, with the aim of enhancing the supportive qualities and overall functioning of intimate relationships in the interest of recovery, the relational experiences and processes discussed above may still serve as targets of intervention with these couples. While the women in the current study described incredibly healthy, supportive relationships, they also acknowledged the many challenges and stressors associated with being in relationship and negotiating recovery with their partner. Importantly, improvements in relational functioning including communication and intimacy, were cited as gradual, and supportive elements developed, evolved, and shifted over time. This suggests that many couples' could be supported to develop growth enhancing relational practices to facilitate recovery. Indeed, as previously mentioned, there was significant heterogeneity in the relational features of the women in this study (e.g., duration of relationship, co-habitation, children), lending further support to this proposition. As such, given that many women living with an ED do indeed experience difficulties in their intimate partner relationship (Arcelus et al., 2012), and could arguably benefit

from support in this domain (Bulik et al., 2012), it seems warranted for counsellors to consider working with most couples to enhance the supportive relational elements outlined herein.

***Resources for partners.*** For the most part, participants in the current study felt that their partners were not afraid or overwhelmed by the ED, and were typically able to manage their own emotional reactions to both the ED and the women's struggles. This was felt by the women to contribute to their partner's availability as a support, a key facilitative component of the intimate relationship. Yet, this may not be the case in many women's intimate relationships. As such, supporting partners to manage feelings of anxiety, frustration, or powerlessness associated with the ED and the challenges of recovery may enhance their ability to remain present, and also, hopeful and encouraging of recovery. To this end, individual counselling may help partners navigate both personal and relational needs throughout the recovery process, such that they can maintain their own wellbeing and be optimally present for their partners. Potential benefits to counselling for partners are therefore twofold: (a) individual counselling may provide partners with much needed support in managing the distress associated with caring for someone living with an ED, which has been widely documented in the literature (e.g., Huke & Slade, 2006; Leichner et al., 1985; Perkins et al., 2004); and (b) individual counselling may increase partners' ability to tolerate their own distress, in the interest of remaining a steady and consistent support to their partner, which appears to be instrumental in creating a climate conducive to change. As noted by one participant, her partner's difficulty in managing his distress associated with the ED and challenges of the recovery process was at times detrimental to her change efforts. As such, this recommendation is not only implied by current findings, it is strongly supported by the literature, which has shown that high expressed emotion plays a role in the maintenance of the ED (see Treasure et al., 2007a), and support provider distress is associated with more directive

support attempts (i.e., stance and delivery), which are in turn associated with lower support satisfaction (Geller et al., 2010b).

Relatedly, the study findings also suggest that ensuring the availability and accessibility of resources and psychoeducational information for partners could be important. Participants in the current study described their partner's efforts to obtain information, learn about, and understand the ED as inherently supportive, and meaningful, as it was perceived as a demonstration of commitment, care, and concern. Research supports the notion that partner openness to, and interest in, learning about the ED promote closeness in the intimate relationship, despite the recognition that partners may not grasp the experience of living with an ED (Newton et al., 2006). Furthermore, the provision of information to partners appears to be particularly important given that research has shown that lack of information is associated with distress (Graap et al., 2008; Huke & Slade, 2006). Finally, while the literature affirms that partners are motivated to offer support, they often experience confusion and difficulty in determining how to best do so, and in understanding the ED (Bulik et al., 2012; Huke & Slade).

While women in the current study valued their partner's efforts to obtain information to support their recovery, several also acknowledged that their partner's (perceived) actual level of knowledge appeared to translate into responsive and flexible support. This finding offers further support for the provision of resources to partners, namely psychoeducation and skill-building, which have been espoused as key component of treatments aiming to include "care providers," that is, family, spouses, and friends (Gusella & Connors, 2014; Treasure et al., 2007a; Uehara, Kawashima, Goto, Tasaki, & Someya, 2001). However, findings from the current study suggest that psychoeducation and skill-building interventions could be enhanced by tailoring them to the

needs and nature of the adult intimate relationship, and thus, ensuring they are developmentally informed.

Participants in the current study consistently differentiated the intimate relationship from other supportive relationships, by virtue of trust, physical and sexual intimacy, and mutual commitment to the relationship and recovery. They commented that family relationships, despite best intentions, rendered separation from the ED identity and related patterns challenging, given history, which is consistent with research on adults in recovery (Pettersen et al., 2013). As such, psychoeducation for partners may benefit from inclusion of issues unique to the intimate partner relationship, such as the impact of ED symptoms on physical and sexual intimacy, and the role of intimacy and conversations about the body in recovery (Young, 2014), both deemed relevant to recovery by the women in this study. In addition, given that the promotion of an egalitarian relationship, in which women feel empowered – not expected or pressured – to make changes, was experienced by participants as supportive, findings suggest that the positioning of partners as “care providers,” guides, and “coaches” in recovery, the stance adopted in current family-informed models (Files et al., 2014; Treasure et al., 2007a), could undermine the unique value, capacities, and role of the intimate partner relationship as a support for adult women during recovery.

### ***Implications for Research***

The current study is the first known empirical exploration of intimate partner relationships supporting recovery from an ED for adult women. While findings have deepened our understanding of the supportive nature of this specific relationship, further research in the area of intimate partner relationships and EDs, particularly with diverse groups of women and their partners, is sorely needed.



***Directions for future research.*** Given the body of literature that has implicated partners in recovery from an ED, the paucity of focused research in this area, and the development of couples' focused approaches to treatment, further research on women's experiences of their intimate partner relationships during recovery is certainly indicated. In particular, in light of the presence of relational challenges for many women living with an ED (Arcelus et al., 2013; Arcelus et al., 2012), it would be beneficial to extend the current findings by exploring intimate partner relationships in greater depth for women who identify relational difficulties as a barrier to recovery. In addition, studies exploring couples' experiences, and also, partners' experiences, are both recommended. Finally, further research informed by an RCT framework appears warranted.

Counselling psychology and RCT share a non-pathologizing, strengths-based, developmental, and contextual view of women's experiences (Comstock et al., 2008; Duffey & Somody, 2011), and thus research grounded in an RCT perspective would supplement existing literature that has tended towards de-contextualized, problem-focused approaches to understanding relational functioning in the area of EDs (Arcelus et al., 2013; Arcelus et al., 2012). Given the implications of the study's sample, namely, limitations to the transferability of the findings, a primary recommendation for future research in this area is for researchers to include and explore the experiences of women occupying diverse social locations, women of minority identities, and women at various developmental stages of life. To this end, increasing understanding of the intimate partner relationships of women of racial and ethnic minority identities, women of minority sexual orientations, and women in mid-life is needed. Indeed, we know very little about the ways in which women's cultural backgrounds inform and shape their relational experiences during recovery, or the meanings they ascribe to these experiences. While qualitative methodologies are certainly congruent with the aim of privileging and giving voice to

the lived experiences and meanings of these groups of women, quantitative methods would also afford valuable knowledge. One possible approach to inquiry, informed by RCT, would be investigation of women's experiences of perceived mutuality in their relationships, using a measure developed for use with individuals living with an ED, the *Connection-Disconnection Scale* (CDS; Tantillo & Sanftner, 2010). Employing this measure would afford investigators the opportunity to examine the ways in which intersecting aspects of identity influence experiences of connection and disconnection in relationship, and the ways in which these relational experiences impact ED symptoms and related outcomes<sup>27</sup>.

In addition to attending to cultural and diversity related issues in this area of research, studies exploring women and their partner's experiences of joining in recovery would greatly enhance understanding of *couples' experiences*. To this end, research on dyadic coping (see Traa et al., 2014) and couples' identity (see Badr, Acitelli, & Talor, 2007) could increase our understanding of the experience of partnership in recovery, and further elucidate the interpersonal dimensions of couples' experiences of navigating the process of recovery. Importantly, studies of this nature would generate valuable knowledge about supportive, hindering, and challenging experiences and processes in recovery, from the couples' perspective. Pursuing this line of inquiry in the area of EDs may also broaden our conceptual lens by affording links to other bodies of related literature. Methodologies that include both partners, such as *Action Project Method*, a qualitative method developed by Young and colleagues in the field of Counselling Psychology are particularly well suited to this line of inquiry. Specifically, these methods could increase our knowledge of the ways in which couples' navigate their

---

<sup>27</sup> Although the measure is theoretically grounded in RCT, and thus, attends to the ways in which culture influences relational connection and disconnection, it was developed and validated with a predominantly European American sample (Tantillo & Sanftner, 2010).

relationship and recovery from the ED *together*, including similarities and differences in their process, the meanings they attribute to their experiences, and their goals (Young, Valach, & Domene, 2005), which have been implicated in outcomes in the dyadic coping literature (e.g., Kayser et al., 2007).

Quantitative methodologies are also recommended to further examine relational and ED characteristics, and their associations with recovery-related outcomes. Specifically, participants in the current study described personal and relational changes over time (e.g., learning to assert support needs, increasing comfort with self-expression, establishment of trust), within the context of their intimate partner relationship, suggesting that longitudinal designs may be particularly suited to expanding our knowledge regarding both developmental and relational dimensions of recovery. Importantly, research that includes assessment of women's symptom severity, concurrent mental health concerns, involvement in treatment, and readiness and motivation to make changes to their ED would increase understanding of how these variables influence women's experiences of support with their partner. For example, it is noteworthy that for women in longer-term relationships, who remained with their partner at the time of the research interview, shared goals and visions for the future were more prominent in their experience of support. To this end, duration of relationship may play a role in support experience. In addition, while co-habitation did not appear to differentiate women's experiences in the current study, research suggests that it may influence women's change process (Bussolotti et al., 2002) and partners' experiences (Huke & Slade, 2006). Finally, the women in the current study were all engaged in recovery efforts at the time of their relationship, and thus, motivated to varying degrees to let go of the ED. However, given the novel finding that the intimate relationship was inherently motivating, further exploration of readiness and motivation for

change within the couples' context seems highly warranted. Specifically, studies examining associations among relational qualities (e.g., acceptance, validation, compassion) and experiences (e.g., communication, intimacy), symptom severity, and readiness and motivation for change, are recommended in order to enhance our understanding of the motivational elements of this relationship. To date, no known research has addressed motivation within the context of the intimate partner relationships of adult women in recovery from an ED.

According to participants in the current study, their partners were highly effective in providing support, which included communicating openly and affirmatively, and managing their own feelings around the ED in order to stay present. To date, virtually no research has examined partners' experience of supporting their loved one through treatment and recovery experiences, and it remains unclear to what extent current findings may reflect the experience of other partners, or what may have influenced these partners' ability to provide such consistent support (e.g., previous experience with eating disorders). The limited body of literature on partner experiences suggests that partners experience significant distress (Huke & Slade, 2006; Leichner et al., 1985), yet little else is known about their lived experiences or needs. In order to best support partners, and subsequently, optimize the facilitative elements of the intimate relationship during treatment and recovery, greater understanding of partners' experience is required. Given the under-researched nature of this area, qualitative methodologies appear well suited to expanding our knowledge.

Further understanding of partners' and couples' experiences could also optimize the nature, focus, and content of supports, resources, and interventions for partners and couples, including psychoeducation, skill-building, and couples' based approaches to treatment. As previously discussed, interventions for spouses rely almost exclusively on research conducted

with parents of children and adolescents (e.g., Gusella & Connors, 2014; Uehara et al., 2001). Participants in the current study consistently noted the difference between their experiences of support in their intimate relationship, and their experiences of support in other close relationships, highlighting the unique nature of support afforded with partners. As such, in addition to the aforementioned recommendations regarding research on couples' and partners' experiences, further investigation of similarities and differences in support experiences across adult women's relationships would be particularly useful and aid in the tailoring of interventions.

***Dissemination plans.*** Findings will be widely disseminated across local, national, and international forums to ensure optimal impact of study findings within academic and clinical contexts. To date, a critique of the literature informing the study has been presented at a national conference (Jones & Zelichowska, 2014), with the aims of increasing attention and dialogue around the role of partners in recovery. Complete findings will be presented at conferences and prepared for publication in a manuscript, with the aims of reaching the broader ED research community. Findings will also be shared with local stakeholders, including regional and provincial ED programs, with particular focus on implications for treatment and program planning. Efforts are currently underway to increase family and partner involvement in adult ED treatment (Files et al., 2014), and thus, these findings are both timely and highly relevant within this context. Importantly, presentation of findings within organizational contexts will be linked to the institutional and program goals, priorities, and mandates, in order to increase likelihood that they are translated into, and able to inform practice. Finally, with the aims of reaching practitioners, women, and their supports, a summary of the study and findings will be presented electronically in professional association newsletters (e.g., Eating Disorder Association of

Canada) and via online forums (e.g., Looking Glass website, British Columbia ED Center for Excellence website) within the ED community.

Of note, study participants were consulted regarding the above stated dissemination plans, and invited to provide requests or state preferences for the ways in which findings were disseminated and made available to various stakeholders. All of the women in the study expressed agreement around, and satisfaction with, the dissemination plans presented herein, and some re-iterated the utility of presentation within social media forums, such that findings are accessible to partners. One participant also suggested presenting the findings more widely (e.g., in the area of women's health), given the perceived relevance of the partner relationship to women's overall wellbeing. This suggestion will be considered if an appropriate forum presents itself, but my focus will be on circulating the findings as per the above stated plans.

### ***Conclusion***

As I set out on this research journey, I was motivated to increase understanding of the relational dimensions of women's experience of recovery from an ED. Recognizing the challenges of recovery, the often enduring nature of EDs, and the role that relationships play in the course of the ED, I felt deeply committed to the research question and the ways in which this particular study could advance our knowledge. I was genuinely surprised at the lack of attention given to the intimate partner relationships of women living with an ED, and across the literature, the virtual omission of the ways in which this relationship may influence change. In conducting this research, I hoped to elucidate women's lived experiences, and the meanings they attributed to these experiences, to broaden existing literature and challenge the field to consider alternate perspectives on women's intimate relationships and the potential resources therein. Particularly important to me was creating space for the women's perspectives, within a field and area of

research that has not always done so. As the research progressed, I was truly touched by the women's interest and commitment in sharing their stories and making known the ways in which their partners and relationships had positively impacted their lives. The women expressed such gratitude for their partner's support, and I in turn felt gratitude for bearing witness to their stories, and the intimate details of their relationships and experiences with the ED.

In conclusion to this research process and the findings that emerged, it seems fitting to restate that this hermeneutic phenomenological study offers a unique contribution to the empirical and theoretical literatures, and presents significant implications for both practice and future research. Adopting a strengths-based approach, congruent with a Counselling Psychology perspective, this study illuminates the nature of adult women's experience of their intimate partner relationship supporting their recovery from an ED, an area that has to date received virtually no attention. As a whole, findings highlight the significance of a safe relational climate as being fundamental to women's healing process, and capture some of the relational dynamics experienced as facilitative of change and recovery. Namely, for these women, a sense of partnership in both relationship and recovery, and accompanying sense of mutual commitment, enhanced their motivation for change and supported their development of self beyond the ED. These processes were further promoted by open, ongoing communication and experiences of emotional and physical intimacy with partners. Practitioners and researchers are strongly encouraged to consider, and further explore, the potential role of intimate partners in supporting women in the journey of recovery. As illustrated here by one participant, intimate partner relationships may offer women a unique sense of safety, grounding, and closeness as they engage in the process of letting go of the ED, and move from a place of disconnection to connection and meaning, with self, others, and life.

...we were driving over the mountains and it felt like [choked up/tears] I was gonna be okay. And I think that's just what he does for me, is, you know, he drives me nuts and stuff...just like any other relationship, but I always know it's going to be okay...I guess at the end of the day, I think there's a period in our lives where we have to contend with the fact that life's not always easy but it's worth it...and I think he makes it worth it.



## References

- Acitelli, L.K., & Badr, H.J. (2005). My illness or our illness? Attending to the relationship when one partner is ill. In T.A. Revenson, K. Kayser, & G. Bodenmann (Eds.), *Emerging Perspectives on Couples' Coping with Stress* (pp. 121-136). Washington, DC: American Psychological Association. doi: 10.1037/11031-006.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, text revision (4th ed.). Washington, DC: Author.
- Ansell, E.B., Grilo, C.M., & White, M.A. (2012). Examining the interpersonal model of binge eating and loss of control over eating in women. *International Journal of Eating Disorders*, 45, 43-50. doi: 10.1002/eat.20897.
- Anells, M. (1996). Hermeneutic phenomenology: philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, 23, 705-713.
- Arcelus, J., Haslam, M., Farrow, C., & Meyer, C. (2013). The role of interpersonal functioning in the maintenance of eating psychopathology: A systematic review and testable model. *Clinical Psychology Review*, 33, 156-167. <http://dx.doi.org/10.1016/j.cpr.2012.10.009>.
- Arcelus, J., Yates, A., & Whiteley, R. (2012). Romantic relationships, clinical and sub-clinical eating disorders: A review of the literature. *Sexual and Relationship Therapy*, 27(2), 147-161.
- Badr, H., Acitelli, L.K., & Carmack Taylor, C.L. (2007). Does couple identity mediate the stress experienced by caregiving spouses? *Psychology and Health*, 22(2), 211-229. doi: 10.1080/14768320600843077.

- Bachner-Melman, R., Zohar, A. H., & Ebstein, R.P. (2006). An examination of cognitive versus behavioral components of recovery from anorexia nervosa. *The Journal of Nervous and Mental Disease*, 194(9), 697-703.
- Bankoff, S.M., & Pantalone, D.W. (2014). Patterns of disordered eating behavior in women by sexual orientation: A review of the literature. *Eating Disorders*, 22, 261-274. doi: 10.1080/10640266.2014.890458.
- Bardone-Cone, A.M., Harney, M.B., Maldonado, C.R., Lawson, M.A., Robinson, D.P., Smith, R., et al. (2010a). Defining recovery from an eating disorder: Conceptualization, validation, and examination of psychosocial functioning and psychiatric comorbidity. *Behaviour Research and Therapy*, 48, 194-202. doi:10.1016/j.brat.2009.11.001
- Bardone-Cone, A.M., Schaefer, L.M., Maldonado, C.R., Fitzsimmons, E.E., Harney, M.B., Lawson, M.A., et al. (2010b). Aspects of self-concept and eating disorder recovery: What does the sense of self look like when an individual recovers from an eating disorder? *Journal of Social and Clinical Psychology*, 29(7), 821-846.
- Baucom, D.H., Shoham, V., Mueser, K.T., Daiuto, A.D., & Stickle, T.R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology*, 66(1), 53-88.
- Beck, D., Casper, R., & Andersen, A. (1996). Truly late onset of eating disorders: A study of 11 cases averaging 60 years of age at presentation. *International Journal of Eating Disorders*, 20(4), 389-395.
- Belle, D. (1987). Gender differences in the social moderators of stress. In R.C. Barnett, L. Biener, & G.K. Baruch (Eds.), *Gender and Stress* (pp. 257-277). New York, NY: The Free Press.

- Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In P. Benner (Ed.), *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness* (pp. 99-127). Thousand Oaks, CA: Sage Publications, Inc.
- Berkman, N.D., Lohr, K.N., & Bulik, C.M. (2007). Outcomes of eating disorders: A systematic review of the literature. *International Journal of Eating Disorders*, 40(4), 293-309. doi: 10.1002/eat.20369.
- Berman, M.I., & James, L.C. (2012). Counseling health psychology. In E.M. Altmaier & J.C. Hansen (Eds.), *The Oxford Handbook of Counseling Psychology* (pp. 723-751). New York, NY: Oxford University Press.
- Binford, R.B., Mussell, M.P., Crosby, R.D., Peterson, C.B., Crow, S.J., & Mitchell, J.E. (2005). *Journal of Consulting and Clinical Psychology*, 73(6), 1089-1096. doi: 10.1037/0022-006X.73.6.1089.
- Bjork, T., & Ahlstrom, G. (2008). The patient's perception of having recovered from an eating disorder. *Health Care for Women International*, 29, 926-944. doi: 10.1080/07399330802269543.
- Bloks, H., Van Furth, E.F., Callewaert, I., & Hoek, H.W. (2004). Coping strategies and recovery in patients with a severe eating disorder. *Eating Disorders*, 12, 157-169. doi: 10.1080/10640260490445131.
- Bodell, L.P., Smith, A.R., Holm-Denoma, J.M., Gordon, K.H., & Joiner, T.E. (2011). The impact of perceived social support and negative life events on bulimic symptoms. *Eating Behaviors*, 12, 44-48. doi: 10.1016/j.eatbeh.2010.11.002.

- Borland, K. (1991). "That's not what I said": Interpretive conflict in oral narrative research. In S.B. Gluck & D. Patai (Eds.), *Women's Words: The Feminist Practice of Oral History* (pp. 63-75). New York: Routledge.
- Brandsma, L. (2007). Eating disorders across the lifespan. *Journal of Women & Aging, 19*, 155-172. doi: 10.1300/J074v19n01\_10.
- Brown, K.E., & Geller, J. (2006). Supporting friends and family members with eating disorders: Discrepancies between intentions and reality. *Eating Disorders, 14*, 215-228. doi: 10.1080/10640260600638915.
- Bulik, C.M., Baucom, D.H., & Kirby, J.S. (2012). Treating anorexia nervosa in the couple context. *Journal of Cognitive Psychotherapy, 26*(1), 19-33. doi: 10.1891/0889-8391.26.1.19.
- Bulik, C.M., Baucom, D.H., Kirby, J.S., & Pisetsky, E. (2011). Uniting couples (in the treatment of) anorexia nervosa (UCAN). *International Journal of Eating Disorders, 44*, 19-28. doi: 10.1002/eat.20790.
- Bussolotti, D., Fernandez-Aranda, F., Solano, R., Jimenez-Murcia, S., Turon, V., & Vallejo, J. (2002). Marital status and eating disorders: An analysis of its relevance. *Journal of Psychosomatic Research, 53*, 1139-1145.
- Campbell, M. (2009). Drop-out from treatment for the eating disorders: A problem for clinicians and researchers. *European Eating Disorders Review, 17*, 239-242. doi: 10.1002/erv.934.
- Canadian Psychological Association. (2000). *Canadian Code of Ethics for Psychologists* (3rd ed.). Ottawa, ON: Canadian Psychological Association.
- Champlin, B.E. (2009). Being there for another with a serious mental illness. *Qualitative Health Research, 19*(11), 1525-1535. DOI: 10.1177/1049732309349934.

- Creswell, J.W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks, CA: Sage Publications.
- Creswell, J.W., Hanson, W.E., Plano Clark, V.L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseling Psychologist*, 35(2), 236-264. DOI: 10.1177/0011000006287390.
- Cockell, S. J., Geller, J., & Linden, W. (2003). Decisional balance in anorexia nervosa: Capitalizing on ambivalence. *European Eating Disorders Review*, 11, 75-89.
- Cockell, S. J., Zaitsoff, S. L., & Geller, J. (2004). Maintaining change following eating disorder treatment. *Professional Psychology: Research and Practice*, 35(5), 527-534.
- Comstock, D.L., Hammer, T.R., Strentzsch, J., Cannon, K., Parsons, J., & Salazar, Gustavo II. (2008). Relational-Cultural Theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling and Development*, 86(3), 279-287.
- Corrigan, P.W., & Phelan, S.M. (2004). Social support and recovery in people with serious mental illnesses. *Community Mental Health Journal*, 40(6), 513-523.
- Cumella, E.J., & Kally, Z. (2008). Profile of 50 women with mid-life onset eating disorders. *Eating Disorders*, 16, 193-203. doi: 10.1080/10640260802016670.
- D'Abundo, M., & Chally, P. (2004). Struggling with recovery: Participant perspectives on battling an eating disorder. *Qualitative Health Research*, 14(8), 1094-1106. DOI: 10.1177/1049732304267753.
- Dalle Grave, R. (2011). Eating disorders: Progress and challenges. *European Journal of Internal Medicine*, 22, 153-160. doi: 10.1016/j.ejim.2010.12.010.

- Danermark, B., Ekstrom, M., Jakobsen, L., & Karlsson, J.C. (2002). *Explaining Society: Critical Realism in the Social Sciences*. New York, NY: Routledge.
- Deakin, H., & Wakefield, K. (2013). SKYPE interviewing: Reflections of two PhD researchers. *Qualitative Research*, 1-14. doi: 10.1177/1468794113488126.
- Deci, E.L., & Ryan, R.M. (2008). Self-Determination Theory: A macrotheory of human motivation, development, and health. *Canadian Psychology*, 49(3), 182-185. doi: 10.1037/a0012801.
- Denzin, N.K., & Lincoln, Y.S. (2005). Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed., pp. 1-32). Thousand Oaks, CA: Sage Publications, Inc.
- Dimitropoulos, G., Carter, J., Schachter, R., & Woodside, D.B. (2008). Predictors of family functioning in carers of individuals with anorexia nervosa. *International Journal of Eating Disorders*, 41, 739-747. doi: 10.1002/eat.20562.
- Dimitropoulos, G., Lackstrom, J., & Woodside, B. (2007). Couples with eating disorders: A review of the literature. In S. Wonderlich, J.E. Mitchell, M. de Zwaan, & H. Steiger (Eds.), *Annual Review of Eating Disorders* (pp. 15-22). Oxford, UK: Radcliffe Publishing Ltd.
- Duffey, T., & Somody, C. (2011). The role of Relational-Cultural Theory in mental health counseling. *Journal of Mental Health Counseling*, 33(3), 223-242.
- Earle, V. (2010). Phenomenology as research method or substantive metaphysics? An overview of phenomenology's uses in nursing. *Nursing Philosophy*, 11, 286-296.

- Evans, L. & Stukas, A.A. (2007). Self-verification by women and responses of their partners around issues of appearance and weight: "Do I look fat in this?" *Journal of Social and Clinical Psychology*, 26(10), 1163-1188.
- Federici, A., & Kaplan A.S. (2008). The patient's account of relapse and recovery in anorexia nervosa: A qualitative study. *European Eating Disorders Review*, 16, 1-10. doi: 10.1002/erv.813.
- Files, N., Gusella, J., Connors, L.L., Nash, P., Marchand, P., Orr, E., et al. (2014, October). "For the first time in a long time I feel hopeful": Facilitator experiences and participant outcomes following a 2-day EFFT workshop for caregivers. Workshop presented at the Eating Disorders Association of Canada Conference, Vancouver, BC.
- Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research*, 2(2), 209-230.
- Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice*, 1, 6-25.
- Fitzsimmons-Craft, E. (2011). Social psychological theories of disordered eating in college women: Review and integration. *Clinical Psychology Review*, 31, 1224-1237. doi: 10.1016/j.cpr.2011.07.011.
- Fitzsimmons, E.E., & Bardone-Cone, A.M. (2010). Differences in coping across stages of recovery from an eating disorder. *International Journal of Eating Disorders*, 43, 689-693. doi: 10.1002/eat.20781.
- Fredrickson, B.L., & Roberts, T. (1997). Objectification Theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly*, 21, 173-206.

Gadamer, H-G. (2004). *Truth and Method* (2nd ed., Rev. ed). New York, NY: Continuum.

(Original work published 1975).

Garrett, C. J. (1997). Recovery from anorexia nervosa: A sociological perspective. *International Journal of Eating Disorders*, 21, 261-272.

Geanellos, R. (1998a). Hermeneutic philosophy. Part I: Implications of its use as methodology in interpretive nursing research. *Nursing Inquiry*, 5, 154-163.

Geanellos, R. (1998b). Hermeneutic philosophy. Part II: A nursing research example of the hermeneutic imperative to address forestructures/pre-understandings. *Nursing Inquiry*, 5, 238-247.

Geller, J., Cockell, S.J., & Goldner, E.M. (2000). Inhibited expression of negative emotions and interpersonal orientation in Anorexia Nervosa. *International Journal of Eating Disorders*, 28, 8-19.

Geller, J., Jones, M.I., Zelichowska, J., Dunn, E.C., Srikameswaran, S., & Lockhart, A. (2010a, October). *Barriers to collaborative social support styles: Investigating the discrepancy between beliefs and behaviors*. Poster presented at the Eating Disorder Research Society Conference, October 7-9<sup>th</sup>, 2010, Cambridge, USA.

Geller, J., Zelichowska, J., Jones, M.I., Srikameswaran, S., Dunn, E.C., & Brown, K.E. (2010b, October). *Determinants of social support satisfaction in the Eating Disorders*. Poster presented at the Eating Disorder Research Society Conference, October 7-9<sup>th</sup>, 2010, Cambridge, USA.

Genero, N. P., Miller, J. B., Surrey, J., & Baldwin, L. M. (1992). Measuring perceived mutuality in close relationships: Validation of the Mutual Psychological Development Questionnaire. *Journal of Family Psychology*, 6(1), 36-48.



- Goddard, E., Salerno, L., Hibbs, R., Raenker, S., Naumann, U., Arcelus, J., et al. (2013). Empirical examination of the interpersonal maintenance model of anorexia nervosa. *International Journal of Eating Disorders*, 46, 867-874. doi: 10.1002/eat.22172.
- Gorin, A.A., Le Grange, D., & Stone, A.A. (2003). Effectiveness of spouse involvement in cognitive behavioral therapy for binge eating disorder. *International Journal of Eating Disorders*, 33, 421-433. doi: 10.1002/eat.10152.
- Goss, K., & Allan, S. (2014). The development and application of compassion-focused therapy for eating disorders (CFT-E). *British Journal of Clinical Psychology*, 53, 62-77. doi: 10.1111/bjc.12039.
- Graap, H., Bleich, S., Herbst, F., Trostmann, Y., Wancata, J., & de Zwaan, M. (2008). The needs of carers of patients with anorexia and bulimia nervosa. *European Eating Disorders Review*, 16, 21-29.
- Grilo, C.M., Pagano, M.E., Stout, R.L., Markowitz, J.C., Ansell, E.B., Pinto, A., et al. (2012). Stressful life events predict eating disorder relapse following remission: Six-year prospective outcomes. *International Journal of Eating Disorders*, 45(2), 185-192. doi: 10.1002/eat.20909.
- Grissett, N.I., & Norvell, N.K. (1992). Perceived social support, social skills, and quality of relationships in bulimic women. *Journal of Consulting and Clinical Psychology*, 60(2), 293-299.
- Guba, E.G., & Lincoln, Y.S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed., pp. 191-215). Thousand Oaks, CA: Sage Publications, Inc.

- Gusella, J., & Connors, L.L. (2014, October). *Pilot of an Emotion-Focused Family Therapy (EFFT) carer workshop for parents of adolescents with an eating disorder*. Poster session presented at the Eating Disorder Association of Canada Conference, Vancouver, BC.
- Halse, C., & Honey, A. (2005). Unraveling ethics: Illuminating the moral dilemmas of research ethics. *Signs: Journal of Women in Culture and Society*, 30(4), 2141-2162.
- Hanna, P. (2012). Using internet technologies (such as Skype) as a research medium: A research note. *Qualitative Research*, 12(2), 239-242. doi: 10.1177/1468794111426607.
- Hartmann, A., Zeeck, A., & Barrett, M.S. (2010). Interpersonal problems in eating disorders. *International Journal of Eating Disorders*, 43(7), 619-627. DOI: 10.1002/eat.20747.
- Haverkamp, B.E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counseling Psychology*, 52(2), 146-155. DOI: 10.1037/0022-0167.52.2.146.
- Haverkamp, B.E., & Young, R.A. (2007). Paradigms, purpose, and the role of the literature: Formulating a rationale for qualitative investigations. *The Counseling Psychologist*, 35(2), 265-294. DOI: 10.1177/0011000006292597.
- Hays, P.A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2<sup>nd</sup> ed.). Washington, DC: American Psychological Association.
- Hein, S.F., & Austin, W.J. (2001). Empirical and hermeneutic approaches to phenomenological research in psychology: A comparison. *Psychological Methods*, 6(1), 3-17. doi: 10.1037//1082-989X.6.1.3.
- Herzog, D. B., Dorer, D. J., Keel, P. K., Selwyn, S. E., Ekeblad, E. R., Flores, A. T., et al. (1999). Recovery and relapse in anorexia and bulimia nervosa: A 7.5-year follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38, 829-837.

- Herzog, D.B., Keller, M.B., Lavori, P.W., & Ott, I.L. (1987). Social impairment in bulimia. *International Journal of Eating Disorders*, 6(6), 741-747.
- Highet, N., Thompson, M., & King, R.M. (2005). The experience of living with a person with an eating disorder: The impact on the carers. *Eating Disorders*, 13, 327-344. doi: 10.1080/10640260591005227.
- Holt, A. (2010). Using the telephone for narrative interviewing: A research note. *Qualitative Research*, 10(1), 113-121. doi: 10.1177/1468794109348686.
- House, J.S., Umberson, D., & Landis, K.R. (1988). Structures and processes of social support. *Annual Review of Sociology*, 14, 293-318.
- Hsu, L. K. G., Crisp, A. H., & Callender, J. S. (1992). Recovery in Anorexia Nervosa: The patient's perspective. *International Journal of Eating Disorders*, 11(4), 341-350.
- Huke, K., & Slade, P. (2006). An exploratory investigation of the experiences of partners living with people who have bulimia nervosa. *European Eating Disorders Review*, 14, 436-447. doi: 10.1002/erv.744.
- Jacobson, R., & Robins, C.J. (1989). Social dependency and social support in bulimic and nonbulimic women. *International Journal of Eating Disorders*, 8(6), 665-670.
- Jones, M.I. (2011, April). *Exploring recovery from an eating disorder within a relational context*. Talk presented at the inaugural University of British Columbia Counselling Psychology Research Conference, Vancouver, BC.
- Jones, M.I., & Pye, K.M. (2012, October). *Navigating the complex ethical dimensions of qualitative health research as an early career researcher and mental health practitioner: Conversations with women living with an eating disorder*. Talk presented at the Qualitative Health Research Conference, Montreal, QC. \*Talk presented by Pye, K.M.

- Jones, M.I., Pye, K.M., & Palandra, A.L. (2014, June). *Research conversations: Identifying and addressing the ethical dimensions of conducting qualitative research with women living with an eating disorder*. Poster session presented at the annual Canadian Psychological Association (CPA) Convention, Vancouver, BC.
- Jones, M.I., & Zelichowska, J. (2014, June). *Understanding the role of intimate partner relationships in recovery from an eating disorder: A critique of the literature and recommendations for future directions*. Poster session presented at the annual Canadian Psychological Association (CPA) Convention, Vancouver, BC.
- Jordan, J.V. (1991). The meaning of mutuality. In J.V. Jordan, A.G. Kaplan, J.B. Miller, I.P. Stiver, & J.L. Surrey (Eds.), *Women's Growth in Connection: Writings from the Stone Center* (pp. 81-96). New York, NY: The Guilford Press.
- Jordan, J.V. (2011). Psychotherapy research centers and groups: The Stone Center and Relational-Cultural Theory. In J.C. Norcross, G.R. VandenBos, & D.K. Freedheim (Eds.), *History of Psychotherapy: Continuity and Change* (pp. 357-362). Washington, DC: American Psychological Association.
- Jordan, J.V., Kaplan, A.G., Miller, J.B., Stiver, I.P., & Surrey, J.L. (1991). *Women's Growth in Connection: Writings from the Stone Center*. New York, NY: The Guilford Press.
- Kashubeck-West, S., & Mintz, L.B. (2001). Eating disorders in women: Etiology, assessment, and treatment. *The Counseling Psychologist*, 29(5), 627-634. doi: 10.1177/0011000001295001.
- Kayser, K., Watson, L.E., & Andrade, J.T. (2007). Cancer as a "we-disease": Examining the process of coping from a relational perspective. *Families, Systems, & Health*, 25(4), 404-418. doi: 10.1037/1091-7527.25.4.404.

- Keel, P.K., & Brown, T.A. (2010). Update on course and outcome in eating disorders. *International Journal of Eating Disorders*, 43(3), 195-204.
- Keel, P.K., Brown, T.A., Holland, L.A., & Bodell, L.P. (2012). Empirical classification of Eating Disorders. *Annual Review of Clinical Psychology*, 8, 381-404. doi: 10.1146/annurev-clinpsy-032511-143111.
- Keel, P.K., Dorer, D.J., Franko, D.L., Jackson, S.C., & Herzog, D.B. (2005). Postremission predictors of relapse in women with eating disorders. *American Journal of Psychiatry*, 162(12), 2263-2268.
- Kelly, A.C., Carter, J.C., & Borairi, S. (2014). Are improvements in shame and self-compassion early in eating disorders treatment associated with better patient outcomes? *International Journal of Eating Disorders*, 47(1), 54-64. doi: 10.1002/eat.22196.
- Keski-Rahkonen, A., & Tozzi, F. (2005). The process of recovery in eating disorder sufferers' own words: An internet-based study. *International Journal of Eating Disorders*, 37, S80-S86. doi: 10.1002/eat.20123.
- Kessler, R.C., Price, R.H., & Wortman, C.B. (1985). Social factors in psychopathology: Stress, social support, and coping processes. *Annual Review of Psychology*, 36, 531-572.
- Kiriike, N., Nagata, T., Matsunaga, H., Tobitani, W., & Nishiura, T. (1996). Married patients with eating disorders in Japan. *Acta Psychiatrica Scandinavica*, 94, 428-432.
- Klump, K.L., Bulik, C.M., Kaye, W.H., Treasure, J., & Tyson, E. (2009). Academy for Eating Disorders position paper: Eating disorders are serious mental illnesses. *International Journal of Eating Disorders*, 42(2), 97-103. doi: 10.1002/eat.20589.
- Kordy, H., Kramer, B., Palmer, R.L., Papezova, H., Pellet, J., Richard, M. et al. (2002). Remission, recovery, relapse, and recurrence in eating disorders: Conceptualization and

- illustration of a validation strategy. *Journal of Clinical Psychology*, 58(7), 833-846. doi: 10.1002/jclp.2013.
- Kvale, S., & Brinkman, S. (2009). *InterViews: Learning the craft of qualitative research interviewing* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Lamoureux, M.M.H., & Bottorff, J.L. (2005). "Becoming the real me": Recovering from anorexia nervosa. *Health Care for Women International*, 26, 170-188. doi: 10.1080/07399330590905602.
- Langdrige, D. (2007). *Phenomenological Psychology: Theory, Research and Method*. Harlow, Essex: Pearson Education Limited, Prentice Hall.
- Lapadat, J.C., & Lindsay, A.C. (1999). Transcription in research and practice: From standardization of technique to interpretive positionings. *Qualitative Inquiry*, 5(1), 64-86. doi: 10.1177/107780049900500104.
- Leichner, P.P., Harper, D.W., & Johnston, D.M. (1985). Adjunctive group support for spouses of women with anorexia nervosa and/or bulimia. *International Journal of Eating Disorders*, 227-235.
- Leonidas, C., & dos Santos, M.A. (2014). Social support networks and eating disorders: an integrative review of the literature. *Neuropsychiatric Disease and Treatment*, 10, 914-927.
- LeVasseur, J.J. (2003). The problem of bracketing in phenomenology. *Qualitative Health Research*, 13(3), 408-420.
- Linville, D., Brown, T., Sturm, K., & McDougal, T. (2012). Eating disorders and social support: Perspectives of recovered individuals. *Eating Disorders*, 20, 216-231. doi: 10.1080/10640266.2012.668480.

- Liu, A.L. (Ed.). (2011). *Restoring our bodies, reclaiming our lives: Guidance and reflections on recovery from eating disorders*. Boston, MA: Trumpeter Books.
- Lopez, K.A., & Willis, D.G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, 14(5), 726-735.
- Lowe, B., Zipfel, S., Buchholz, C., Dupont, Y., Reas, D.L., & Herzog, W. (2001). Long-term outcome of anorexia nervosa in a prospective 21-year follow-up study. *Psychological Medicine*, 31, 881-890.
- Marcos, Y.Q., & Cantero, M.C.T. (2009). Assessment of social support dimensions in patients with eating disorders. *The Spanish Journal of Psychology*, 12(1), 226-235.
- Martin, J., Padierna, A., Aguirre, U., Quintana, J.M., Las Hayas, C., & Munoz, P. (2011). Quality of life among caregivers of patients with eating disorders. *Quality of Life Research*, 20, 1359-1369. doi: 10.1007/s11136-011-9873-z.
- Martin, J., & Sugarman, J. (1999). *The Psychology of Human Possibility and Constraint*. Albany, NY: State University of New York Press.
- Martin, J., & Sugarman, J. (2000). Between the modern and the postmodern: The possibility of self and progressive understanding in psychology. *American Psychologist*, 55(4), 397-406.
- Martin, J., & Sugarman, J. (2001). Interpreting human kinds: Beginnings of a hermeneutic psychology. *Theory & Psychology*, 11(2), 193-207.
- Marques, L., Alegria, M., Becker, A.E., Chen, C., Fang, A., Chosak, A., et al. (2011). Comparative prevalence, correlates of impairment, and service utilization for eating disorders across US ethnic groups: Implications for reducing ethnic disparities in health

- care access for eating disorders. *International Journal of Eating Disorders*, 44(5), 412-420. doi: 10.1002/eat.20787.
- Matusek, J.A., & Knudson, R.M. (2009). Rethinking recovery from eating disorders: Spiritual and political dimensions. *Qualitative Health Research*, 19(5), 697-707. DOI: 10.1177/1049732309334077.
- Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*, 2<sup>nd</sup> Edn. NewYork: The Guilford Press.
- Mintz, L.B., Hamilton, E., Bledman, R.A., & Franko, D.L. (2008). Preventing eating and weight-related disorders: Toward an integrated best practices approach. In S.D. Brown & R.W. Lent (Eds.), *Handbook of Counseling Psychology* (4th ed., pp. 570-587). Hoboken, NJ: John Wiley & Sons, Inc.
- Moradi, B., Dirks, D., & Matteson, A.V. (2005). Roles of sexual objectification experiences and internalization of standards of beauty in eating disorder symptomatology: A test and extension of objectification theory. *Journal of Counseling Psychology*, 52(3), 420-428. doi: 10.1037/0022-0167.52.3.420.
- Morrison, K.R., Doss, B.D., & Perez, M. (2009). Body image and disordered eating in romantic relationships. *Journal of Social and Clinical Psychology*, 28(3), 281-306.
- Morrow, S.L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52(2), 250-260. DOI: 10.1037/0022-0167.52.2.250.
- Morrow, S.L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, 35, 209-235. doi: 10.1177/0011000006286990.



- Naidoo, S., Zelichowska, J., & Geller, J. (2011). *A Canadian perspective on cross-cultural differences in eating disorders*. Poster session presented at the annual meeting of the Society for the Study of Psychiatry and Culture, Seattle, WA.
- Newton, M., Boblin, S., Brown, B., & Ciliska, D. (2005a). 'An engagement-distancing flux': Bringing a voice to experiences with romantic relationships for women with anorexia nervosa. *European Eating Disorders Review*, 13, 317-329. doi: 10.1002/erv.656.
- Newton, M., Boblin, S., Brown, B., & Ciliska, D. (2005b). Romantic relationships for women with anorexia nervosa: An integrative literature review. *Eating & Weight Disorders*, 10, 139-153.
- Newton, M., Boblin, S., Brown, B., & Ciliska, D. (2006). Understanding intimacy for women with anorexia nervosa: A phenomenological approach. *European Eating Disorders Review*, 14, 43-53. doi: 10.1002/erv.669.
- Noordenbos, G. (2011a). When have eating disordered patients recovered and what do the DSM-IV criteria tell about recovery? *Eating Disorders*, 19, 234-245. doi: 10.1080/10640266.2011.564979.
- Noordenbos, G. (2011b). Which criteria for recovery are relevant according to eating disorder patients and therapists? *Eating Disorders*, 19, 441-451. doi: 10.1080/10640266.2011.618738.
- Noordenbos, G., & Seubring, A. (2006). Criteria for recovery from eating disorders according to patients and therapists. *Eating Disorders: The Journal of Treatment and Prevention*, 14, 41-54. doi: 10.1080/10640260500296756.

- Packer, M.J., & Addison, R.B. (1989a). Evaluating an interpretive account. In M.J. Packer & R.B. Addison (Eds.), *Entering the Circle: Hermeneutic Investigation in Psychology* (pp. 275-292). Albany, NY: State University of New York Press.
- Packer, M.J., & Addison, R.B. (1989b). Introduction. In M.J. Packer & R.B. Addison (Eds.), *Entering the Circle: Hermeneutic Investigation in Psychology* (pp. 13-36). Albany, NY: State University of New York Press.
- Palmer, R.S., & Daniluk, J.C. (2007). The perceived role of others in facilitating or impeding healing from substance abuse. *Canadian Journal of Counselling*, 41(4), 199-212.
- Perkins, S., Winn, S., Murray, J., Murphy, R., & Schmidt, U. (2004). Qualitative study of the experience of caring for a person with bulimia nervosa. Part 1: The emotional impact of caring. *International Journal of Eating Disorders*, 36, 256-268. doi: 10.1002/eat.20067.
- Peters, L., & Fallon, P. (1994). The journey of recovery: Dimensions of change. In P. Fallon, M.A. Katzman, & S.C. Wooley (Eds.), *Feminist Perspectives on Eating Disorders* (pp. 339-354). New York, NY: The Guilford Press.
- Pettersen, G., & Rosenvinge, J.H. (2002). Improvement and recovery from eating disorders: A patient perspective. *Eating Disorders*, 10(1), 61-71.
- Pettersen, G., Rosenvinge, J.H., & Ytterhus, B. (2008). The “double life” of bulimia: Patients’ experiences in daily life interactions. *Eating Disorders*, 16, 204-211. doi: 10.1080/10640260802016696.
- Pettersen, G., Thune-Larsen, K., Wynn, R., & Rosenvinge, J.H. (2013). Eating disorders: challenges in the later phases of the recovery process. *Scandinavian Journal of Caring Sciences*, 27, 92-98. doi: 10.1111/j.1471-6712.2012.01006.x.

- Pinheiro, A.P., Raney, T.J., Thornton, L.M., Fichter, M.M., Berrettini, W.H., Goldman, D., et al. (2010). Sexual functioning in women with eating disorders. *International Journal of Eating Disorders*, 43(2), 123-129. doi: 10.1002/eat.20671.
- Podar, I., & Allik, J. (2009). A cross-cultural comparison of the Eating Disorder Inventory. *International Journal of Eating Disorders*, 42(4), 346-355. doi: 10.1002/eat.20616.
- Polivy, J., & Herman, C.P. (2002). Causes of eating disorders. *Annual Review of Psychology*, 53, 187-213.
- Polimeni, A., Austin, S.B., & Kavanagh, A.M. (2009). Sexual orientation and weight, body image, and weight control practices among young Australian women. *Journal of Women's Health*, 18(3), 355-362. doi: 10.1089/jwh.2007.0765.
- Polkinghorne, D.E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, 52(2), 137-145. doi: 10.1037/0022-0167.52.2.137.
- Ponterotto, J.G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126-136. DOI: 10.1037/0022-0167.52.2.126.
- Raenker, S., Hibbs, R., Goddard, E., Naumann, U., Arcelus, J., Ayton, A., et al. (2013). Caregiving and coping in carers of people with anorexia nervosa admitted for intensive hospital care. *International Journal of Eating Disorders*, 46(4), 346-354. doi: 10.1002/eat.22068.
- Ramirez, A.L., Perez, M., & Taylor, A. (2012). Preliminary examination of a couple-based eating disorder prevention program. *Body Image*, 9, 324-333.
- Rieger, E., Van Buren, D.J., Bishop, M., Tanofsky-Kraff, M., Welch, R., & Wilfley, D.E. (2010). An eating disorder-specific model of interpersonal psychotherapy (IPT-ED): Causal

- pathways and treatment implications. *Clinical Psychology Review*, 30, 400-410. doi: 10.1016/j.cpr.2010.02.001.
- Rothschild, B.S., Fagan, P.J., Woodall, C., & Andersen, A.E. (1991). Sexual functioning of female eating-disordered patients. *International Journal of Eating Disorders*, 10(4), 389-394.
- Ro, O., Martinsen, E.W., Hoffart, A., Sexton, H., & Rosenvinge, J.H. (2005). Adults with chronic eating disorders: Two-year follow-up after inpatient treatment. *European Eating Disorders Review*, 13, 255-263. doi: 10.1002/erv.651.
- Root, M.P.P. (1990). Recovery and relapse in former bulimics. *Psychotherapy*, 27(3), 397-403.
- Rorty, M., Yager, J., Buckwalter, J.G., & Rossotto, E. (1999). Social support, social adjustment, and recovery status in bulimia nervosa. *International Journal of Eating Disorders*, 26, 1-12.
- Rorty, M., Yager, J., & Rossotto, E. (1993). Why and how do women recover from bulimia nervosa? The subjective appraisals of forty women recovered for a year or more. *International Journal of Eating Disorders*, 14(3), 249-260.
- Sanders, C. (2003). Application of Colaizzi's method: Interpretation of an auditable decision trail by a novice researcher. *Contemporary Nurse*, 14, 292-302.
- Sanftner, J.L., Cameron, R.P., Tantillo, M., Heigel, C.P., Martin, D.M., Sippel-Silowash, J.A., et al. (2006). Mutuality as an aspect of family functioning in predicting eating disorder symptoms in college women. *Journal of College Student Psychotherapy*, 21(2), 41-66.
- Sanftner, J.L., Ryan, W. J., & Pierce, P. (2009). Application of a relational model to understanding body image in college women and men. *Journal of College Student Psychotherapy*, 23, 262-280. doi: 10.1080/87568220903167182.

- Sanftner, J.L., Tantillo, M., & Seidlitz, L. (2004). A pilot investigation of the relation of perceived mutuality to eating disorders in women. *Women & Health, 39*(1), 85-100.
- Sarason, I.G., & Sarason, B.R. (2009). Social support: Mapping the construct. *Journal of Social and Personal Relationships, 26*(1), 113-120. doi: 10.1177/0265407509105526.
- Schembri, C., & Evans, L. (2008). Adverse relationship processes: The attempts of women with bulimia nervosa symptoms to fit the perceived ideal of intimate partners. *European Eating Disorders Review, 16*, 59-66. doi: 10.1002/erv.797.
- Schmidt, U., Renwick, B., Lose, A., Kenyon, M., DeJong, H., Broadbent, H., Loomes, R., et al. (2013). The MOSAIC study – comparison of the Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA) with Specialist Supportive Clinical Management (SSCM) in outpatients with anorexia nervosa or eating disorder not otherwise specified, anorexia nervosa type: study protocol for a randomized controlled trial. *Trials, 14*, 160. Retrieved October 12, 2014 from <http://www.trialsjournal.com/content/14/1/160>.
- Sims-Schouten, W., Riley, S.C.E., & Willig, C. (2007). Critical realism in discourse analysis: A presentation of a systematic method of analysis using women's talk of motherhood, childcare, and female employment as an example. *Theory & Psychology, 17*(1), 101-124.
- Skarderud, F. (2007). Shame and pride in anorexia nervosa: A qualitative descriptive study. *European Eating Disorders Review, 15*, 81-97. doi: 10.1002/erv.774.
- Smith, J.A. (2004). Reflecting on the development of interpretive phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*, 39-54.

- Spivack, A., & Willig, C. (2010). 'There is a battle within yourself': Exploring the experience of a split sense of self among inpatients with eating disorders. *Counselling Psychology Review*, 25(4), 7-18.
- Tantillo, M. (2000). Short-term relational group therapy for women with bulimia nervosa. *Eating Disorders: The Journal of Treatment and Prevention*, 8, 99-121.
- Tantillo, M., & Sanftner, J. L. (2003). The relationship between perceived mutuality and bulimic symptoms, depression, and therapeutic change in group. *Eating Behaviors: An International Journal*, 3, 349-364.
- Tantillo, M., & Sanftner, J. (2010). Measuring perceived mutuality in women with eating disorders: The development of the Connection-Disconnection Scale. *Journal of Nursing Measurement*, 18(2), 100-119. doi: 10.1891/1061-3749.18.2.100.
- Thoits, P.A. (1995). Stress, coping, and social support processes: Where are we? What next? *Journal of Health and Social Behavior* (Extra Issue), 53-79.
- Thompson, A.R., & Russo, K. (2012). Ethical dilemmas for clinical psychologists in conducting qualitative research. *Qualitative Research in Psychology*, 9, 32-46. doi: 10.1080/14780887.2012.630636.
- Tiller, J.M., Sloane, G., Schmidt, U., Troop, N., Power, M., & Treasure, J.L. (1997). Social support in patients with anorexia nervosa and bulimia nervosa. *International Journal of Eating Disorders*, 21(1), 31-38.
- Tozzi, F., Sullivan, P.F., Fear, J.L., McKenzie, J., & Bulik, C.M. (2003). Causes and recovery in anorexia nervosa: The patient's perspective. *International Journal of Eating Disorders*, 33, 143-154.

- Traa, M.J., De Vries, J., Bodenmann, G., & Den Ouden, B.L. (2014). Dyadic coping and relationship functioning in couples coping with cancer: A systematic review. *British Journal of Health Psychology*, 1-39. doi: 10.1111/bjhp.12094.
- Tracy, S.J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10), 837-851.
- Treasure, J., Murphy, T., Szumukler, G., Todd, G., Gavan, K., & Joyce, J. (2001). The experience of caregiving for severe mental illness: A comparison between anorexia nervosa and psychosis. *Social Psychiatry and Psychiatric Epidemiology*, 36, 343-347.
- Treasure, J. & Schmidt, U. (2001). Ready, willing and able to change: Motivational aspects of the assessment and treatment of eating disorders. *European Eating Disorders Review*, 9(1), 4-18.
- Treasure, J., Sepulveda, A.R., Whitaker, W., Lopez, C., Todd, G., & Whitney, J. (2007a). Collaborative care between professionals and non-professionals in the management of eating disorders: A description of workshops focussed on interpersonal maintaining factors. *European Eating Disorders Review*, 15, 24-34.
- Treasure, J., Smith, G., & Crane, A. (2007b). *Skills-based learning for caring for a loved one with an eating disorder: The New Maudsley Method*. New York, NY: Routledge.
- Uehara, T., Kawashima, Y., Goto, M., Tasaki, S., & Someya, T. (2001). Psychoeducation for the families of patients with eating disorders and changes in expressed emotion: A preliminary study. *Comprehensive Psychiatry*, 42(2), 132-138. doi: 10.1053/comp.2001.21215.
- Umberson, D., Crosnoe, R., & Reczek, C. (2010). Social relationships and health behavior across the life course. *Annual Review of Sociology*, 36, 139-157.

- Van Buren, D.J., & Williamson, D.A. (1988). Marital relationships and conflict resolution skills of buimics. *International Journal of Eating Disorders*, 7(6), 735-741.
- Van den Broucke, S., & Vandereycken, W. (1988). Anorexia and bulimia nervosa in married patients: A review. *Comprehensive Psychiatry*, 29, 165-173.
- Van den Broucke, S., & Vandereycken, W. (1989). The marital relationship of patients with an eating disorder: A questionnaire study. *International Journal of Eating Disorders*, 8, 541-556.
- Van den Broucke, S., Vandereycken, W., & Vertommen, H. (1995a). Conflict managment in married eating disorder patients: A controlled observational study. *Journal of Social and Personal Relationships*, 12(1), 27-48. doi: 10.1177/0265407595121003.
- Van den Broucke, S., Vandereycken, W., & Vertommen, H. (1995b). Marital communication in eating disorder patients: A controlled observational study. *International Journal of Eating Disorders*, 17(1), 1-21.
- Van den Broucke, S., Vandereycken, W., & Vertommen, H. (1995c). Marital intimacy in patients with an eating disorder: A controlled self-report study. *British Journal of Clinical Psychology*, 34(1), 67-78.
- van Hoeken, D., Seidell, J., & Hoek, H.W. (2003). Epidemiology. In J. Treasure, U. Schmidt, & E. van Furth (Eds.), *Handbook of Eating Disorders* (2<sup>nd</sup> ed., pp. 11-34). West Sussex, ENG: John Wiley & Sons, Ltd.
- van Manen, M. (1997a). From meaning to method. *Qualitative Health Research*, 7(3), 345-369.
- van Manen, M. (1997b). *Researching lived experience: Human science for an action sensitive pedagogy* (2<sup>nd</sup> ed.). London, ON: The Althouse Press.



- van Manen, M. (2006). Writing qualitatively, or the demands of writing. *Qualitative Health Research, 16*, 713-722. doi: 10.1177/1049732306286911.
- Vansteenkiste, M., Soenens, B., & Vandereycken, W. (2005). Motivation to change in eating disorder patients: A conceptual clarification on the basis of self-determination theory. *International Journal of Eating Disorders, 37*(3), 207-219.
- von Soest, T., & Wichstrom, L. (2006). Cohabitation reduces bulimic symptoms in young women. *International Journal of Eating Disorders, 39*, 484-491. doi: 10.1002/eat.20273.
- Vitousek, K., Watson, S., & Wilson, T.G. (1998). Enhancing motivation for change in treatment-resistant Eating Disorders. *Clinical Psychology Review, 18*(4), 391-420.
- Von Holle, A., Pinheiro, A.P., Thornton, L.M., Klump, K.L., Berrettini, W.H., Brandt, H., et al. (2008). Temporal patterns of recovery across eating disorder subtypes. *Australian and New Zealand Journal of Psychiatry, 42*, 108-117.
- Waller, G. (2012). The myths of motivation: Time for a fresh look at some received wisdom in the eating disorders? *International Journal of Eating Disorders, 45*, 1-16.
- Wasson, D.H. (2003). A qualitative investigation of the relapse experiences of women with bulimia nervosa. *Eating Disorders, 11*, 73-88. doi: 10.1080/10640260390199271.
- Weaver, K., Wuest, J., & Ciliska, D. (2005). Understanding women's journey of recovering from anorexia nervosa. *Qualitative Health Research, 15*(2), 188-206.
- Wechsler, L.S., Riggs, S.A., Stabb, S.D., & Marshall, D.M. (2006). Mutuality, self-silencing, and disordered eating in college women. *Journal of College Student Psychotherapy, 21*(1), 51-76. doi: 10.1300/J035v21n01\_05.

- Weller, J.E., & Dziegielewska, S.F. (2004). The relationship between romantic partner support styles and body image disturbance. *Journal of Human Behavior in the Social Environment, 10*(2), 71-92. doi: 10.1300/J137v10n02\_04.
- Wertz, F.J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167-177. DOI: 10.1037/0022-0167.52.2.167.
- Wiederman, M.W., & Pryor, T. (1994). A comparison of ever-married and never-married women with anorexia nervosa or bulimia nervosa. *International Journal of Eating Disorders, 22*, 395-401.
- Wiegel, D. J. (2010). Mutuality of commitment in romantic relationships: Exploring a dyadic model. *Personal Relationships, 17*, 495-513. doi: 10.1111/j.1475-6811.2010.01303.x
- Willig, C. (2008). A phenomenological investigation of the experience of taking part in 'extreme sports.' *Journal of Health Psychology, 13*(5), 690-702. DOI: 10.1177/1359105307082459.
- Wilson, G.T. (2005). Psychological treatment of eating disorders. *Annual Review of Clinical Psychology, 1*, 439-465.
- Winn, S., Perkins, S., Murray, J., Murphy, R., & Schmidt, U. (2004). A qualitative study of the experience of caring for a person with bulimia nervosa. Part 2: Carers' needs and experiences of services and other support. *International Journal of Eating Disorders, 36*, 269-279. doi: 10.1002/eat.20068.
- Woodside, D.B., Kohn, M., & Kerr, A. (1998). Patterns of relapse and recovery following intensive treatment for eating disorders: A qualitative description. *Eating Disorders, 6*, 231-239.

Woodside, D.B., Lackstrom, J.B., & Shekter-Wolfson, L. (2000). Marriage in eating disorders: Comparisons between patients and spouses and changes over the course of treatment.

*Journal of Psychosomatic Research*, 49, 165-168.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.

Young, K. (2014, October). *An affair with ED: Addressing intimacy and sexuality in couples with eating disorders*. Workshop presented at the Eating Disorders Association of Canada Conference, Vancouver, BC.

Young, R. A., Valach, L., & Domene, J. F. (2005). The qualitative action-project method in counseling psychology. *Journal of Counseling Psychology*, 52(2), 215-223. doi: 10.1037/0022-0167.52.2.215

## **Appendix A: DSM-IV Eating Disorder Criteria**

### DSM-IV Criteria for an Eating Disorder (APA, 2000)

**(1) Anorexia Nervosa:**

- a. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 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).
- b. Intense fear of gaining weight or becoming fat, even though underweight.
- c. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- d. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)
- e. Subtypes:
  - i. Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)
  - ii. Binge-eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas) (APA, 2000, p. 589)

**(2) Bulimia Nervosa:**

- a. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - i. 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
  - ii. a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
- b. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
- c. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
- d. Self-evaluation is unduly influenced by body shape and weight.
- e. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.
- f. Subtypes:
  - i. 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
  - ii. Nonpurging Type: during the current episode of Bulimia Nervosa, the

person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (APA, 2000, p. 594)

(3) Eating Disorder Not Otherwise Specified:

- a. The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific Eating Disorder. Examples include:
  - i. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
  - ii. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
  - iii. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
  - iv. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
  - v. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
  - vi. Binge-eating disorder: recurrent episodes of binge eating, in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa. (APA, 2000, p. 594-595)

## Appendix B: Recruitment Poster

# INTIMATE PARTNER RELATIONSHIPS AND RECOVERY FROM AN EATING DISORDER



**a place of mind**  
THE UNIVERSITY OF BRITISH COLUMBIA

A PhD student in Counselling Psychology at the University of British Columbia is interested in hearing your story of recovery from an eating disorder. Megan Hughes-Jones is conducting a study, under the supervision of Dr. Beth Haverkamp, to increase understanding of women's experience of their intimate partner relationships in supporting their recovery from an eating disorder.

**We would be grateful to hear your story if you...**

- Are a woman over the age of 19
- Feel you have recovered from your eating disorder
- Were in an intimate relationship lasting at least six months during your recovery process
- Feel that this intimate relationship was significant in your attainment of recovery
- Would be willing to share your experience in confidential interviews lasting approximately 2-3 hours total

We invite you to please pass this information on to anyone you feel may be eligible for and interested in participation. Please call Megan Hughes-Jones at XXX-XXX-XXXX or email X@hotmail.com if you would like to participate or obtain further information about this study. Thank-you!



## **Appendix C: Print, Electronic, and Social Media Recruitment Notice**



**a place of mind**  
THE UNIVERSITY OF BRITISH COLUMBIA

### **Intimate Partner Relationships and Recovery From an Eating Disorder**

A PhD student in Counselling Psychology at the University of British Columbia is interested in hearing your story of recovery from an eating disorder. Megan Hughes-Jones is conducting a study, under the supervision of Dr. Beth Haverkamp, to increase understanding of women's experience of their intimate partner relationships in supporting their recovery from an eating disorder. We would be grateful to hear your story if you...

- Are a woman over the age of 19
- Feel you have recovered from your eating disorder
- Were in an intimate relationship lasting at least six months during your recovery process
- Feel that this intimate relationship was significant in your attainment of recovery
- Would be willing to share your experience in confidential interviews lasting approximately 2-3 hours total

We invite you to please pass this information on to anyone you feel may be eligible for and interested in participation. Please call Megan Hughes-Jones at XXX-XXX-XXXX or email X@hotmail.com if you would like to participate or obtain further information about this study. Thank-you!

### **Inclusion Note for Recruitment using Social Media**

Given that this is a public forum, your personal information may become visible to other users and you will be publicly associated with the study if you comment on this notice/page.



### Appendix D: Telephone Screening Form

- (1) Thank-you for calling, this is Megan, the primary researcher conducting the study *Intimate Partner Relationships and Recovery from an Eating Disorder*. This study is being conducted as part of my doctoral degree in Counselling Psychology at The University of British Columbia, under the supervision of Dr. Beth Haverkamp, a faculty member in Counselling Psychology.
  - a. Obtain the woman's name and ensure no previous clinical contact.
- (2) Why don't we begin with me sharing a little more about myself and the study, to give you a clear sense of our aims and what involvement would entail? I invite any questions you may have, at any point...
  - a. I am a 3rd year doctoral student in Counselling Psychology at UBC, and my research and clinical work focuses on eating disorders. I have worked on numerous research projects in this area and have been a counsellor in a community, outpatient eating disorder program for the past five years. My experiences have supported me in developing this particular study, and increased my desire to better understand this important aspect of women's recovery experiences.
  - b. To this end, the purpose of the study is to increase understanding of women's experiences of their intimate partner relationship in facilitating their recovery from an eating disorder. While we know that relationships can play a central role in recovery, we know very little about the specific role that partners may play. We know even less about women's personal perspectives on this. This study seeks to contribute to the literature and clinical practice by exploring this aspect of women's experience.
- (3) If you do indeed decide to participate in this study, we will schedule a time to meet in person for an interview, ideally within the next two weeks (i.e., this may vary depending on the course of recruitment). The interview will take place at a mutually agreed upon place. For example, some people feel most comfortable in their home, others in private space on the UBC campus. The interview is confidential, meaning that your personal information will be protected and anonymity ensured throughout the research process; this is something we will discuss in more detail before starting the interview. The interview will be audio-recorded for research purposes, and last approximately an hour and a half to two hours. For the interview, you will be asked to describe your experience of your intimate partner relationship in supporting your recovery from an ED. In some cases, I may invite participants for a second interview, to afford more time for me to hear/you to share your story; I do not anticipate this happening frequently, however, want to remain open to the possibility.
- (4) I'll give you an overview of what the research process looks like, after the initial interview. The interviews will be transcribed and thematic analysis will be conducted to identify themes in participants' experiences. I will send participants my initial findings to obtain feedback. I will have also written a brief biographical note about each participant, to help put the study's findings in context, and I will ask for your feedback on this. I will

then contact you to schedule a follow-up interview to discuss the extent to which you feel the biographical note and thematic findings reflect your experience. This interview may be in person or over the phone and may not happen for some time after the initial interview. This follow-up interview may last approximately a half hour to one hour. Once I have incorporated any feedback, finalized the findings, and written the final document, the findings will be made available to you and shared within academic and clinical communities.

- i. Check-in/any questions?
- ii. Assess interest in participating.
  - 1. If yes: Proceed to question five below (i.e., eligibility).
  - 2. If no: Invite the woman to call back if she changes her mind or has any further questions, ask if there was anything specific that deterred her, thank her for her interest.

(5) Before moving forward, I would like to ask you a few questions to confirm you meet the guidelines for participation in the study (i.e., some questions may have already been addressed during our conversation up to the point).

- a. What is your age?
- b. Do you have a history of a clinically diagnosable eating disorder?
  - i. If this is unclear or I feel I need more information: I'd like to ask you a few more specific questions to get a better sense of what your ED symptoms looked like.
    - 1. Were you ever given a diagnosis by a professional or have you ever received professional support for your ED?
      - a. If yes: What was your diagnosis? What was the nature of the support?
      - b. If no: Proceed to question two, directly below.
    - 2. To the best of your recollection, what were your primary symptoms and how frequently did you experience them?
      - a. If the woman has difficulty recalling, I will refer to Appendix A and use the DSM-IV-TR criteria to guide my inquiry about symptom presence, frequency, and intensity. I will then make a decision about whether or not the woman has met the inclusion requirement of a history of a clinically diagnosable ED.
- c. Do you feel that you have recovered from your eating disorder?
  - i. When did you last engage in an ED *behavior* (i.e., extreme restriction, objective binge, purge, excessive exercise, or other form of inappropriate compensation)
    - 1. If necessary, I will ask more specific questions to ensure that the woman has not met criteria for an ED in the past year and has not engaged in any ED behaviors in the past year. If a woman has engaged in minimal/residual ED behavior(s) in the past year, however, self-identifies as having recovered, I will inquire in detail about the behavior(s) to determine whether the woman meets this criteria. I will use clinical judgment, coupled with empirical

research, to make this decision. If necessary, I will consult with my supervisor to clarify and consider the implications of involvement or declining involvement.

2. If the woman meets criteria: Continue with question d, below.
  3. If the woman does not meet criteria: Inform her of this, thank her for her interest; I will have my resources from Appendix H ready if it appears clinically appropriate or indicated to offer supports/resources.
- d. During your recovery process, that is, as you were working to reduce your ED symptoms, were you in an intimate relationship lasting at least six months?
    - i. If yes: Proceed to question e below.
    - ii. If no: Inform her that she unfortunately does not meet the study requirements for participation and thank her for her interest.
  - e. How long ago were you in this relationship (i.e., must have been within 5-10 years)?
    - i. If meets criteria: Proceed to question f below.
    - ii. If does not meet criteria: Inform her that she unfortunately does not meet the study requirements for participation and thank her for her interest.
  - f. Do you feel that this intimate partner relationship was significant in your attainment of recovery from the ED?
    - i. If yes: Proceed to question six below.
    - ii. If no: Inform her that she unfortunately does not meet the study requirements for participation and thank her for her interest.
- (6) Thank-you for sharing that information with me, I appreciate that it's not always easy or comfortable to discuss these experiences. From what we've discussed, you meet the guidelines for participation.
- (7) I want to re-iterate that participation in this study is entirely voluntary and you may choose to withdraw at any time. Unfortunately, I am not able to offer any compensation for participation in the study. However, participants in research of this nature sometimes feel that it is rewarding and validating to share their story and contribute to our understanding of the issue.
- (8) After hearing more about the study and what participation will involve, are you still interested in participating?
- a. If no: Ask if there was anything specific that deterred her, and thank her for her interest.
  - b. If yes: Schedule the interview.

## Appendix E: Informed Consent Form



**a place of mind**  
THE UNIVERSITY OF BRITISH COLUMBIA

**Faculty of Education**  
Vancouver Campus  
Educational & Counselling Psychology,  
And Special Education  
2125 Main Mall  
Vancouver, B.C. Canada V6T 1Z4

Phone 604-822-0242  
Fax 604-822-3302  
[www.ecps.educ.ubc.ca](http://www.ecps.educ.ubc.ca)

### Consent Form

#### Intimate Partner Relationships and Recovery from an Eating Disorder

**Principal Investigator:** Dr. Beth Haverkamp  
Department of Counselling Psychology, Faculty of Education  
The University of British Columbia  
Contact: XXX-XXX-XXXX or X@ubc.ca

**Co-Investigator:** Megan Hughes-Jones, MA, PhD Candidate  
Department of Counselling Psychology, Faculty of Education  
The University of British Columbia  
Contact: XXX-XXX-XXXX or [X@hotmail.com](mailto:X@hotmail.com)

#### Purpose of the Study:

To explore the meaning and experience of intimate partner relationships in supporting recovery from an eating disorder. This study is the doctoral dissertation research project for the co-investigator, Megan Hughes-Jones. The study is supported by a Social Sciences and Humanities Research Council Joseph-Armand Bombardier Canada Graduate Scholarship, awarded to Megan Hughes-Jones for her doctoral degree and research in Counselling Psychology.

You have been invited to participate in this study because you feel that your intimate partner relationship was significant in your attainment of recovery from an eating disorder, and you are willing and able to share about this experience in an interview(s) with the co-investigator, Megan Hughes-Jones.

#### Study Procedures:

Participation in this study will involve approximately two to three hours of your time, over the course of an initial interview(s) and follow-up interview with Megan Hughes-Jones. In the initial interview(s), you will be asked to describe your experience of your intimate partner relationship in supporting your recovery from an eating disorder. This interview will be audio-recorded, transcribed, and reviewed in order to identify themes. Common themes identified across *all* interviews will be sent to you for review. A brief biographical note will also be sent to you for review. In the follow-up interview you will be asked for feedback around the note and themes, including the extent to which they reflect your experiences. Findings will be presented in a final

written text (i.e., dissertation). This document and/or portions thereof will be available to you and presented within academic and clinical contexts (e.g., conferences, journals).

### **Risks and Benefits:**

There are no clear anticipated risks or benefits associated with participation in this study. You may feel some emotional discomfort associated with recalling and sharing personal and sensitive information. You may also find that sharing your story is rewarding and meaningful. If you would like to discuss your experience of participating in the research, you may contact the co-investigator and/or refer to the list of resources provided to you.

### **Confidentiality:**

Identifying information shared within the context of this study will remain completely confidential unless required by law (e.g., there are some legal limits to confidentiality, namely, if you disclose that you or another person are at risk of harm). You will generate a pseudonym for use throughout the duration of the study to ensure that your identity is not associated with the study or findings. Study documents will be stored in a locked filing cabinet and destroyed after five years.

### **Compensation:**

There is no compensation for participating in the study.

### **Contact Information:**

If you have any questions or concerns about the study, please contact the Principal Investigator, Dr. Beth Haverkamp, at the phone number or email address provided at the top of this form. If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance email [RSIL@ors.ubc.ca](mailto:RSIL@ors.ubc.ca) or call toll free 1-877-822-8598.

### **Consent and Signature:**

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact or personal consequence.

Your signature below indicates that you have had an opportunity to ask any questions you may have about the research and participation, that you have read and received a copy of this consent form for your own records, and that you consent to participate in this study.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant Printed Name

\_\_\_\_\_  
\*Participant Contact Information

\*Preferred form of contact, such as phone, email, mailing address. This information will be kept confidential and used only to reach you for study related matters and/or to send you initial and final findings for review.

## Appendix F: Informed Consent Form for Skype Interviews



**a place of mind**  
THE UNIVERSITY OF BRITISH COLUMBIA

**Faculty of Education**  
Vancouver Campus  
Educational & Counselling Psychology,  
And Special Education  
2125 Main Mall  
Vancouver, B.C. Canada V6T 1Z4

Phone 604-822-0242  
Fax 604-822-3302  
[www.ecps.educ.ubc.ca](http://www.ecps.educ.ubc.ca)

### Consent Form

#### Intimate Partner Relationships and Recovery from an Eating Disorder

**Principal Investigator:** Dr. Beth Haverkamp  
Department of Counselling Psychology, Faculty of Education  
The University of British Columbia  
Contact: XXX-XXX-XXXX or X@ubc.ca

**Co-Investigator:** Megan Hughes-Jones, MA, PhD Candidate  
Department of Counselling Psychology, Faculty of Education  
The University of British Columbia  
Contact: XXX-XXX-XXXX or [X@hotmail.com](mailto:X@hotmail.com)

#### Purpose of the Study:

To explore the meaning and experience of intimate partner relationships in supporting recovery from an eating disorder. This study is the doctoral dissertation research project for the co-investigator, Megan Hughes-Jones. The study is supported by a Social Sciences and Humanities Research Council Joseph-Armand Bombardier Canada Graduate Scholarship, awarded to Megan Hughes-Jones for her doctoral degree and research in Counselling Psychology.

You have been invited to participate in this study because you feel that your intimate partner relationship was significant in your attainment of recovery from an eating disorder, and you are willing and able to share about this experience in an interview(s) with the co-investigator, Megan Hughes-Jones.

#### Study Procedures:

Participation in this study will involve approximately two to three hours of your time, over the course of an initial interview(s) and follow-up interview with Megan Hughes-Jones. In the initial interview(s), you will be asked to describe your experience of your intimate partner relationship in supporting your recovery from an eating disorder. This interview will be audio-recorded, transcribed, and reviewed in order to identify themes. Common themes identified across *all* interviews will be sent to you for review. A brief biographical note will also be sent to you for review. In the follow-up interview you will be asked for feedback around the note and themes, including the extent to which they reflect your experiences. Findings will be presented in a final

written text (i.e., dissertation). This document and/or portions thereof will be available to you and presented within academic and clinical contexts (e.g., conferences, journals).

### **Risks and Benefits:**

There are no clear anticipated risks or benefits associated with participation in this study. You may feel some emotional discomfort associated with recalling and sharing personal and sensitive information. You may also find that sharing your story is rewarding and meaningful. If you would like to discuss your experience of participating in the research, you may contact the co-investigator and/or refer to the list of resources provided to you.

### **Confidentiality:**

Identifying information shared within the context of this study will remain completely confidential unless required by law (e.g., there are some legal limits to confidentiality, namely, if you disclose that you or another person are at risk of harm). You will generate a pseudonym for use throughout the duration of the study to ensure that your identity is not associated with the study or findings. Study documents will be stored in a locked filing cabinet and destroyed after five years. Please note, there are additional limits to privacy, confidentiality, and security of information disclosed during the interview due to the use of Skype as a medium of communication.

### **Compensation:**

There is no compensation for participating in the study.

### **Contact Information:**

If you have any questions or concerns about the study, please contact the Principal Investigator, Dr. Beth Haverkamp, at the phone number or email address provided at the top of this form. If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance email [RSIL@ors.ubc.ca](mailto:RSIL@ors.ubc.ca) or call toll free 1-877-822-8598.

### **Consent and Signature:**

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact or personal consequence.

Your signature below indicates that you have had an opportunity to ask any questions you may have about the research and participation, that you have read and received a copy of this consent form for your own records, and that you consent to participate in this study.

---

Participant Signature

---

Date

---

Participant Printed Name

---

\*Participant Contact Information



\*Preferred form of contact, such as phone, email, mailing address. This information will be kept confidential and used only to reach you for study related matters and/or to send you initial and final findings for review.

### Appendix G: Interview Orienting Statement

“This is Megan and I am here with [pseudonym] on [date] for our interview. As we’ve discussed, the purpose of this interview is for you to share your experiences of your intimate partner relationship in supporting your recovery from your eating disorder. Specifically, I am interested in hearing what it was like for you to have this relationship as a support during your recovery process. I am interested in how you understand the role your partner played in supporting your recovery process. You can share your story in any way that feels comfortable to you. For example, some people share events and experiences like a story, with a beginning, middle, and end. Others use examples as a starting point, to help describe their experience. The interview will be largely unstructured, meaning that I will do my best to create space for you to share anything that you feel is important to this experience, and I will allow you to guide the direction and pace of the interview. At times however, I may ask you to elaborate, ask for clarification, ask for a specific example or instance, and/or gently re-direct us to ensure we’re capturing your experience of your relationship in supporting your recovery in its fullest. This will help to ensure I understand your experience. You can say as much or as little as you feel comfortable, and decline to answer any question that you are not comfortable with. If you would like to take a break at any point, please just let me know. Is this clear? Do you have any questions? As a starting point for the interview, I will ask you to answer the following question as completely and comprehensively as you can: looking back, **“what was your experience of having your intimate partner relationship support your recovery from your eating disorder?”** Whenever you are ready, you can begin describing this experience.

## **Appendix H: Interview Questions**

### *Primary Research Question*

“what is the meaning of lived experience of intimate partner relationships in supporting recovery from an eating disorder?”

### *Primary Interview Question*

“What was your experience of having your intimate partner relationship support your recovery from your eating disorder?”

### *Additional Interview Questions*

(1) “Can you please describe a specific example/instance of how you feel your relationship with your partner supported your recovery?”

- a. “What was this like for you?”
- b. “Can you please tell me more about how you felt at that time?”
- c. “Can you please tell me more about how you understand that experience?”
- d. “How did you respond or act at that time?”
- e. “What did you notice about yourself, in response to this?”
- f. “What did you notice about your recovery process, in response to this?”
- g. “What did you notice about your relationship, in response to this?”

(2) “What about your relationship with [name of partner] stands out to you, as being particularly supportive in terms of your recovery?”

- a. “How do you see [the supportive characteristics] as influencing your recovery?”

- (3) “How did your relationship with [name of partner] differ from other relationships in your life (i.e., that you also found to be supportive; that you found to be less supportive)?”
- (4) “What does it mean to you to have had [name of partner] support your recovery?”
- (5) “What do you think your recovery would have been like without your relationship with [name of partner], without his/her support?”
- (6) “Looking back now, are there other things about this relationship you feel would have assisted you in your recovery?”



**a place of mind**  
THE UNIVERSITY OF BRITISH COLUMBIA

### **Appendix I: Resources**

After discussing sensitive personal material, you may feel some emotional discomfort. If you feel distressed and/or would like some additional support, the following community resources are available. If you have any questions about these resources, please contact the co-investigator, Megan Hughes-Jones, at XXX-XXX-XXXX or X@hotmail.com.

- (1) British Columbia Clinical Counsellors' Association (BCACC): This website contains contact information for Registered Clinical Counsellors.
  - a. Website: [www.bc-counsellors.org](http://www.bc-counsellors.org)
- (2) New Westminster – University of British Columbia Counselling Centre: This counselling centre offers counselling provided by UBC Counselling Psychology graduate students at no cost.
  - a. Phone: XXX-XXX-XXXX
- (3) Kelty Resource Centre: This online resource contains information and resources related to mental health and wellness.
  - a. Website: [www.keltymentalhealth.ca](http://www.keltymentalhealth.ca)

## Appendix J: Transcription Services Confidentiality Agreement



**a place of mind**  
THE UNIVERSITY OF BRITISH COLUMBIA

**Faculty of Education**  
Vancouver Campus  
Educational & Counselling Psychology,  
And Special Education  
2125 Main Mall  
Vancouver, B.C. Canada V6T 1Z4

Phone 604-822-0242  
Fax 604-822-3302  
[www.ecps.educ.ubc.ca](http://www.ecps.educ.ubc.ca)

### Intimate Partner Relationships and Recovery from an Eating Disorder

I, \_\_\_\_\_, the transcriptionist, have been employed to transcribe confidential audio recorded material (i.e., research interviews) for the research study *Intimate Partner Relationships and Recovery from an Eating Disorder*. I agree to maintain full confidentiality in regards to any and all research material for this study. Specifically, I agree to:

- (1) Keep all the research material and information shared with me completely confidential, by not discussing or sharing any of the research material and information in any form or format (e.g., computer files, audio files, transcripts) with anyone other than the co-investigator, Megan Hughes-Jones.
- (2) Keep all the research material and information safe and secure while it is in my possession.
- (3) Hold in strictest confidence the identification of any individual that may be inadvertently revealed in any of the research material and/or during the transcription process.
- (4) Not make copies of any audio recordings, computer files, or transcripts, unless specifically requested by the co-investigator.
- (5) Return all the research material and information to the co-investigator when I have completed the research task of transcribing the audio recorded material.
- (6) After consulting with the co-investigator, destroy (i.e., erase) all research material and information that has not been returned to the co-investigator.

Your signature below indicates that you agree to adhere to the aforementioned expectations regarding the management of confidential research material and information.

\_\_\_\_\_  
Transcriptionist Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Transcriptionist Signature