THE EXPERIENCE OF RECOVERY FROM AN EATING DISORDER: AN INTERPRETIVE PHENOMENOLOGICAL DESCRIPTION

by

GEORGINA ELIZABETH MALTBY

B.Sc.N., McMaster University, 1990
M.A., The University of British Columbia, 1999

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Abstract

Although eating disorders are a significant problem for some women, there is a lack of understanding of what recovery entails and what it means to be recovered. The purpose of this study was to describe the experience of recovery from an eating disorder drawing on the Empirical Phenomenological Psychological method (Karlsson, 1993). Eight women participated in in-depth interviews that explored their recovery experience. The women ranged in age from 28 to 53 years. All of the women had been recovered for a minimum of 5 years (\(M = 10\) years; Range = 5 to 18 years).

I conducted a phenomenological interpretive analysis of the transcribed interviews, which produced a description of each participant's recovery experience (i.e., situated structure). Next, I developed the general structure and essential themes of the experience of recovery across all participants, and the commonalities in "being recovered" as revealed in the existentials of body, time, space, and relation (Van Manen, 2000). The findings revealed that there was a common structure to the experience of recovery. Three themes were essential to the recovery experience: (a) knowingness and allowing what is needed to recover; (b) deepening awareness and discovery of oneself; and (c) deepening of being, discovering, and embracing life's possibilities. All of the women in this study acknowledged a full recovery, albeit a long, difficult, and lonely experience that required courage, persistence, and determination. The women in this study described an agentic, strategic, and a faith-based approach to recovery that mirrored, resisted, and offered alternatives to the dominant societal and medical discourses of eating disorders and recovery. Future research that explores a multifaceted experience of recovery, and interventions that facilitate self-reflection in order to deepen awareness of the individual's experience and responsibility for change may be helpful.
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Thank you all.
Dedication

I dedicate this dissertation to the strong and courageous women who are living with and are recovered from an eating disorder.
CHAPTER I: Introduction

Despite the voluminous literature that contains empirical and theoretical explanations for the problem of eating disorders, there remains insufficient understanding of the experience of recovery from the perspective of women who have maintained long-term recovery from this complex problem. Eating disorders constitute a serious medical and psychological problem (Becker, Grinspoon, Klibanski, & Herzog, 1999), especially affecting girls and women in Western societies (Hsu, 1989). The mortality rate for 7% of individuals with anorexia nervosa is 12-years (Fichter, Quadflieg, & Hedlund, 2006), and there is a 50% relapse rate for individuals with bulimia following cognitive behavioral treatment (Fairburn et al., 1995). Although a large body of “expert” knowledge exists on the hypothesized cause, characteristics, and course of eating disorders (Collings & King, 1994; Eckert, Halmi, Marchi, Grove, & Crosby, 1995; Fairburn et al., 1995; Herzog, Keller, & Lavori, 1988; Strober, Freeman, & Morrell, 1997), there is limited information about the experience of recovery. Therefore, in contrast to the research that employs an explanatory approach to the problem (e.g., causal factors implicated in its development and resolution), the purpose of this study was to describe, in depth, the experiences of individuals who view themselves as being recovered from an eating disorder using an interpretive method of inquiry.

The dictionary describes recovery as a return to an original state during which something is gained or restored (Houghton Mifflin Company, 2000). Recovery has been considered a process, an outlook, a vision, and/or a guiding principle. There is neither a single agreed upon definition of recovery nor a single way to measure it (Surgeon General, 2006), yet the underlying message is that hope and restoration of health are possible. Longitudinal
research continues to explore the factors that promote physical and psychological recovery from eating disorders.

Recovery from an eating disorder is typically a slow and lengthy experience. For instance, success rates on the physical recovery of individuals with an early onset of an eating disorder (early adolescence), who have received a form of hospital-based treatment, indicated that between 50% to 60% of individuals with anorexia nervosa achieved a good to intermediate outcome, and 15% to 25% remained chronic (Fichter et al., 2006; Pike, 1998). In studies of adolescents who received hospital treatment, rates of partial and full physical recovery ranged from 18% to 55% after 5 years, and 73% to 84% after 10 years (Johnson, Lund, & Yates, 2003; Strober et al., 1997). Qualitative investigations that have focused on early recovery (typically after one year) revealed a lengthy and complex series of psychological changes (e.g., O’Byrne, 1992). These studies provided an understanding of how recovery begins and described a lengthy and complex experience, however, they failed to fully describe the long-term nature of recovery and transformation from eating disorders to living without an eating disorder. Clinicians and researchers are left with an inadequate understanding of what recovery is and how it may be promoted in individuals who are in need of assistance (Jarman & Walsh, 1999; Pike, 1998).

The majority of treatment programs for eating disorders have adopted an integrative biopsychosocial-spiritual model (e.g., APA, 2000; Engel, 1980), whereas research on eating disorders has defined recovery in narrow terms. Treatment approaches for eating disorders have included practical strategies that promote physical, psychological, and spiritual health (e.g., Johnston, 1996; Lelwica, 1999) as well as media literacy. Yet understanding recovery from the perspective of the client has been limited by how recovery has been defined and investigated.
For instance, recovery has been conceptualized as a problem that requires: (a) a physical focus (e.g., weight gain; Herzog, Nussbaum, & Marmor, 1996; Strober et al., 1997), (b) an alteration of psychological functioning (e.g., distorted thoughts about one’s shape and/or weight) and/or motivation (Fairburn, 1985; Garner, Vitousek, & Pike, 1997; Geller, Cockell, & Drab, 2001; Geller, Zaitsoff, & Srikameswaran, 2005; Vitousek, Watson, & Wilson, 1998), and (c) an increase in media literacy and awareness of societal influences that influence eating habits and perceptions (Wooley, 1995; Zerbe, 1996).

Qualitative researchers have tended to narrowly conceptualize the experience of recovery from eating disorders as changes that occurred in early recovery (e.g., first year of recovery). These changes have been described as a developmental series of stages that began as an individual effort that required transformation of the self and an increased self-awareness (Lamoureux & Botoroff, 2005; Maine, 1985; O’Byrne, 1992; Weaver, Wuest, & Ciliska, 2005). An assumption that eating disorders are similar to an addiction and represent a coping strategy (Holderness, Brooks-Gunn, & Warren, 1994; Roth, 1989) in response to developmental or life stressors (Smolak & Levine, 1993) and societal pressures regarding weight and shape underlies the recovery literature. In addition, the medical and societal explanations or discourse for the problem of eating disorders and recovery replicate the assumption that recovery is situated in the individual (Brooks, Le Couteur, & Hepworth, 1998; Hepworth, 1999). However, both the individual and the social context are likely to influence the problem of recovery from an eating disorder. The focus of current theory, research, and practice on the individual’s efforts to change their behaviours in the initial aspects of recovery, typically one year after beginning recovery, is limited in its scope because of the lengthy nature
of the recovery experience (Geller & Drab, 1999; O'Byrne, 1992; Peters & Fallon, 1994; Platt, 1992; Shillito, 1994).

Eating disorders are a significant problem for some women, and additional knowledge that describes the experience of recovery and how it is lived is needed to further inform theory, research, and practice (Jarman & Walsh, 1999). Rather than a deductive approach to the problem of recovery, I used an inductive and interpretive method of inquiry in order to broaden the scope of possibilities and to provide a fuller description of the experience that informs future research and practice in the area. My goal was to articulate a common psychological experience of recovery for women who have experienced an eating disorder using a phenomenological interpretive method, Empirical Psychological Phenomenology (EPP; Karlsson, 1993).

In the present study, I viewed the behavioral and psychological symptoms of anorexia and bulimia as interrelated, and therefore I used the term eating disorder throughout this study. The rationale for using this term is supported by empirical research. Although a controversy persists regarding the distinctiveness of anorexia and bulimia and whether they are to be considered separate or similar problems, the presence of binge eating (Bruch, 1974, 1978; Russell, 1979) and compensatory behaviors (e.g., vomiting, laxative, exercise) continues to be documented in individuals with anorexia nervosa (Casper, 1983). For a substantial number of individuals that are diagnosed with anorexia nervosa, the development of bulimia nervosa appears to be a part of the course of their eating disorder. Thus, given the research, my choice of an inductive method of inquiry, and the focus of the present study (i.e., long-term recovery), I used eating disorders to describe the participants' eating problems.
Eating disorders are serious physical and psychological problems that are difficult to treat, and there is no evidence that they are on the decline. Eating disorders also occur in men (Andersen, 1995; Braun, Sunday, Huang, & Halmi, 1999), however, there is limited evidence that they are similar or comparable to the experiences of women. Thus, in the present study, I focused on the experiences of women in order to build on the existent knowledge.

The purpose of the present study was to provide a description of the lived experience of recovery from an eating disorder. Consistent with a phenomenological strategy of inquiry (Karlsson, 1993), my interview questions aimed to reveal the essential meaning structures of the experience. The following broad research questions guided this research: What constitutes recovery from an eating disorder? What are the essential structures that pervade the experiences of recovery from an eating disorder? What does it mean to be recovered from an eating disorder?
CHAPTER II: Literature Review

The purpose of this study was to describe the subjective accounts of women who have experienced an eating disorder and who view themselves as being recovered in order to deepen our understanding of recovery. In this review, I examine how eating disorders were initially understood as a medical problem, and the additional interpretations that arose in the etiological literature in which eating disorders were conceptualized as physical, psychological, spiritual, and/or social problems. I consider how the etiological factors that were implicated in eating disorders have affected our current understanding of recovery. I critique the role of individual agency as I discuss the addiction model, and the stress and coping literature as it pertains to eating disorders and recovery. I then broaden the discussion to include feminist and postmodern views of eating disorders that offer a social interpretation for the problem of eating disorders. Because the literature offers both individual and social interpretations for the problem of eating disorders and recovery, an integrative model for understanding recovery has been recommended. I conclude this review with the rationale for phenomenology as a method for deepening our understanding of the complex problem of eating disorders and recovery.

History of Eating Disorders

Eating disorders are popularized in the media and well recognized by society in general. Anorexia nervosa initially was identified as a medical problem for young women in the 1700s (Silverman, 1997). Later in the 1970s the phenomenon of bulimia nervosa was observed in some individuals with anorexia nervosa and among college women (Boskind-White & White, 1983). Bulimia nervosa was first described as a variation of anorexia nervosa, in which episodic overeating, vomiting, and/or laxative abuse were present (Russell, 1979). Later in the 20th century, as more was learned about the problem, anorexia was viewed with greater
complexity as a physical and psychological disorder with multi-determined causes (Garner & Garfinkel, 1984).

The inclusion of anorexia nervosa in the Diagnostic and Statistical Manual of Mental Disorders (DSM, APA, 1972), and the subsequent addition of bulimia nervosa and 'eating disorder not otherwise specified' (EDNOS) categories in later editions of the DSM, provided the impetus for the conceptualization of eating disorders as a medical and a psychiatric phenomenon. Today, eating disorders as a broad term refers to behaviors that include fasting, binge eating, and the compensatory behaviors of exercise, laxative abuse, self-induced vomiting, and diuretic use (APA, 1994). At the present time, the dominant classification system for eating disorders is outlined in the DSM-IV (APA, 1994). There are three categories of eating disorders: anorexia nervosa, bulimia nervosa, and EDNOS. The EDNOS is a category created for those people who do not fully satisfy the diagnostic criteria for an eating disorder. The five identified types of EDNOS are: menstruating anorexia, anorexia-normal weight, sub-threshold bulimia, and non-bingeing bulimia-normal weight. At present, binge eating disorder is under review for inclusion in the next DSM (e.g., Widiger & Samuel, 2005). In the present study, individuals who received traditional forms of treatment as well as nontraditional treatments for their diagnosed eating disorder were the focus of this research.

Etiology of Eating Disorders

Although clinicians have recognized the value of an integrative model in understanding the etiology and treatment of eating disorders (APA, 2000), the application of a multi-factorial model in the study of recovery has been problematic (Jarman & Walsh, 1999). Despite the fact that there is a lack of consensus on what causes an eating disorder (Striegel-Moore & Cachelin, 2001), there is considerable support for a multi-factorial model of etiology that involves
biological vulnerability, psychological predispositions, family, and the social climate (Garner & Garfinkel, 1984). In this section, I provide a summary of the major etiological theories for eating disorders that have implications for the conceptualizations of recovery. Given the considerable time that it takes to recover from an eating disorder, what starts the problem may not necessarily be what maintains or resolves it. Moreover, I incorporate theory and research regarding risk factors for eating disorders because these factors also may be associated with the recovery experience.

**Biology.** Biological theories view eating disorders as a result of an organic cause or a problem in the biological processes of an individual. The biomedical literature includes research that has explored different endocrinological and neurological abnormalities. Considerable research has investigated possible problems in the hippocampus, the area of the brain that controls and regulates a variety of homeostatic processes such as respiration, circulation, food and water intake, digestion, metabolism, and body temperature in individuals with eating disorders (Steiger & Seguin, 1999). One challenge for this type of research is whether changes in brain function are a cause or a result of the eating disorder. In addition, the biomedical model does not explain why females are more susceptible than males to the biochemical changes that are observed in some cases of anorexia nervosa (e.g., the production of excess cortisol). Finally, the biomedical model does not address the social characteristics of the population or the high incidence of eating disorders in this particular time period. The biomedical model explains the development of eating disorders as an illness. This interpretation has implications for treatment and recovery and fuels attempts to identify the cause, symptoms, and the course of an eating disorder, and includes ways to cure the illness.
Psychology. Psychological theories of etiology include psychodynamic (Bruch, 1974) and family systems theory (Minuchin et al., 1978; Strober & Humphrey, 1987). This perspective has investigated how individual factors (e.g., personality) contribute to the development of eating disorders (Vitousek & Manke, 1994). Some researchers have suggested that anorexia nervosa is a form of obsessive-compulsive disorder noted by rumination and obsession with food, a rigid and defensive attitude, as well as behavioral compulsivity (Bulik, 1995). Borderline personality disorder and childhood trauma have been implicated in the development of bulimia nervosa (Brady, Killeen, Brewerton, & Lucerini, 2000), however, research has not demonstrated a specific association between sexual abuse and eating disorders (Fairburn et al., 1995). In the psychodynamic and family areas, eating disorders have been viewed as developmental crises in response to the demands of adulthood and/or a symptom of unresolved familial conflict (Bruch, 1974). Family researchers have reported enmeshed boundaries and greater conflict in families of individuals with eating disorders (Minuchin et al., 1978). Problems in the mother-daughter relationship and family relationships (Bruch, 1978) were hypothesized to lead to problems in separation and individuation during adolescence, which increase the risk for an eating disorder.

Research has also implicated stress and coping in eating disorders, and has suggested that developmental and/or psychosocial stressors (Cattanach & Rodin, 1988; Striegel-Moore et al., 1986) increase one’s vulnerability to the onset of an eating disorder. According to this model, young girls develop eating disorders as a response to a stressor, which then becomes a habitual way of coping. The addiction model of eating disorders is related to the perspective that eating disorders represent a way of coping (Roth, 1989). According to this model, the behaviors that are associated with an eating disorder become habitual, in part, because they
result in psychological and physiological changes (Salzman, 1981). Support for the theory is provided by the characteristic denial that is observed in some individuals with an eating disorder (Bemis, 1978), despite poor physical and psychological health that results. In summary, the psychological explanation for eating disorders are similar to the biological explanations of etiology because there is a lack of consideration for the social aspects of the problem, and the problem tends to be situated within the individual. Furthermore, this approach does not address the factors that make it largely a female problem that is generally confined to Westernized countries (Brumberg, 2000).

Society. The socio-cultural explanation for eating disorders postulates that eating disorders result from society’s obsession with thinness as an imperative for young girls and women. Psychological studies have confirmed that preoccupation with weight and shape is a normative obsession that affects older as well as young women (Striegel-Moore et al., 1986; Wooley, 1994). According to the cultural model, the widespread beliefs about weight and shape that are communicated via the media are harmful and fuel the preoccupation with thinness and development of eating disorders (Orbach, 1986). Proponents of this model include feminists as well as therapists who are concerned with the prevalence of disordered eating among women. These clinicians and researchers have postulated that eating problems are linked to living in a patriarchal society that demeans women through the objectification of their bodies and through gender role socialization that teaches girls to focus on their appearance (Bordo, 1993; Orbach, 1986).

Cultural models have made a valuable contribution to the understanding of eating disorders as well as the role of the social context in the expression of female identity. Before feminist analyses were conducted, eating disorders were considered to be primarily an
individual psychological problem. However, the cultural explanation does not provide an explanation for why all women do not develop an eating disorder despite being subjected to the same socio-cultural messages regarding shape and weight. Also, some feminists who portray eating disorders as a form of social protest do not give adequate consideration to the severe physical and psychological impact of an eating disorder and the immense struggle that typically accompanies recovery efforts. The cultural model is limited in its view that eating disorders are a new phenomenon (Brumberg, 2000), and that the disease is either freely chosen as a social protest or imposed on young women as victims without the involvement of biology or psychological factors.

Spirituality. In contrast to the literature reviewed thus far, several authors have placed spirituality as a dimension that is involved in the etiology of eating disorders (Garrett, 1993, 1997; Lelwica, 1999). In her popular book, *Starving for Salvation*, Lelwica (1999) explored the spiritual nature of eating disorders and challenged the conventional explanations that are framed in the language of psychological, behavioral, feminist, sociological, and/or medical literature. Lelwica (1999) proposed that social values and patriarchal religion contribute to the pain and emptiness that women experience. She posited that as a response to these feelings, women turn to the symbolic use of food and control of weight to satiate their spiritual hunger.

Based on Garrett's (1993) interviews of former anorexia sufferers, Garrett (1997) expanded on the spiritual interpretation of anorexia nervosa. She interpreted self-starvation as a ritualistic attempt to construct the self, and anorexia as a rite of passage that begins with self-starvation in an attempt to separate as the individual begins the process of adulthood. Recovery and the rituals that accompany it constitute the reconnecting part of the rite when the individual is reincorporated into the community and strengthened through suffering. Garrett defined
spirituality as the connection and reconnection of the self with others, nature, and the body with the mind, which she interpreted as present in the participants’ narratives.

Implications for understanding recovery. How do the etiological models contribute to an understanding of recovery? According to the biomedical model, the use of medical treatments to correct or restore biological processes and the promotion of physical health are key aspects of recovery. The recovery literature that has investigated the course of eating disorders for individuals who received hospital-based treatment is an example of research that implies, in part, a biological causal perspective. The psychological model seeks to address the underlying resolution of problematic relationships, and the restructuring of negative thoughts and attitudes that promote eating disorders. In contrast, the socio-cultural model seeks to raise awareness and increase women’s knowledge about the effects of societal messages on how women perceive themselves and their bodies. Finally, the spiritual model seeks the enhancement of healthier rituals that acknowledge the inner wisdom of women (e.g., Johnston, 1996), and transform relationships with one’s body and food via myths, metaphors, and storytelling.

There tends to be two general perspectives on recovery, each of which define recovery differently (Root, 1990). Some researchers have viewed a cure as achievable with the resolution of underlying issues that maintain the problem (Bruch, 1988). Others have viewed recovery as only a partial cure with a continuing vulnerability that is a result of psychological and/or socio-cultural influences (Wooley, 1994). For instance, feminist theory has suggested that women may recover but still continue to struggle with issues around food, body, weight, and shape because of socio-cultural pressures (Orbach, 1986), and that an important aspect of recovery is the development of a critical self-awareness of the societal and media influences on
shape and weight. Advocates of the cultural model have suggested that networking with other women who have a similar problem and educating the public about the societal influences are key to recovery. A full recovery is not believed to be possible due to the ubiquitous socio-cultural pressures regarding shape and weight.

Although clinicians have recognized the value of an integrative model in understanding recovery from an eating disorder, a similar perspective is absent in the literature, which is partly a result of the limitation of a deductive approach towards inquiry (Jarman & Walsh, 1999). In the next section, I review the empirical research on recovery and eating disorders. Based on the investigations to date, we do not have an adequate understanding or a description of what recovery is like, especially for those women who have maintained a long-term recovery.

Recovery from an Eating Disorder

Physical recovery. Research on recovery has been guided by the medical and psychiatric categorizations of the problem of eating disorders. Subsequent to the identification of anorexia nervosa as a medical illness, research efforts that described the prognosis, course, and outcome of anorexia nervosa and/or bulimia nervosa were the focus for this type of research. One of the aims of this research has been to provide continued support for the efficacy of treatment programs, and therefore the results were based on those individuals who received hospital-based treatment for their eating disorder (Strober et al., 1997).

The study of recovery from eating disorders began with an exclusive focus on the amelioration of the physical symptoms that were associated with eating disorders (Brumberg, 2000). Earlier investigations did not provide details of their requirements for recovery status (Herzog et al., 1988), and the popular criteria for defining recovery were physical markers.
Unfortunately, researchers were not overt about how recovery was measured, and therefore the definition and the length of time of recovery at the time of the study were inconsistent. The criteria of weight gain and restoration of menstruation in individuals with anorexia (Crisp, Hsu, Harding, & Hartshorn, 1980; Falk & Halmi, 1982) were paralleled by the cessation of binge eating and purging in individuals with bulimia nervosa as indicators of recovery (Agras, 1981; Fairburn, Jones, Peveler, Hope, & O’Connor, 1993).

In many cases, the Morgan-Russell (1975) categories of good, intermediate, and poor were used to determine recovery status for individuals with eating disorders. Good outcome is rated when weight is within 15% of average and normal cyclical menstruation occurs; intermediate outcome is rated when the above weight criterion cannot be maintained consistently and/or there is menstrual irregularity; and poor outcome is when weight is below 85% of average and menstruation is absent, or nearly always so, or if bulimia nervosa is exhibited (Ratnasuriya, Eisler, Szmukler, & Russell, 1991). An individual’s score on the measure and evaluation of recovery is based on the absence of eating disorder symptoms for a period of at least 8 weeks. For instance, a good outcome is designated when the aforementioned criteria are sustained for at least 8 consecutive weeks. Therefore, the empirical evidence largely documents the physical recovery for those individuals with an early onset of an eating disorder (early adolescence) who have received a form of hospital-based treatment (Strober et al., 1997).

The evidence thus far has demonstrated that a range of 50% to 60% of individuals with anorexia nervosa achieves a good to intermediate outcome, and 15% to 25% remain chronic (Pike, 1998). However, the rates of recovery were more optimistic in studies of individuals who received hospital treatment. In these studies, recovery was assessed semi-annually for 5 years, and each year thereafter for 10 to 15 years after their initial hospital admission (Strober et al.,
Rates of partial and full physical recovery ranged from 18% to 55% after 5 years, and 73% to 84% after 10 years for adolescents who received hospital-based treatment. Researchers were cautiously optimistic about these recent findings and suggested that they required replication (Pike, 1998).

These quantifiable measures of restoration of weight and menstruation for anorexia nervosa, and absence of bingeing and purging for bulimia nervosa, are useful for researchers who seek objective data from which comparisons across studies can be made. However, researchers have demonstrated that although clinicians may view individuals as recovered, continued psychological attitudes towards food, eating, shape, and weight often persist (Clinton & McKinlay, 1986). Therefore, the utility of these physical and behavioral indices of change used to define recovery appear to be limited in their scope.

Follow-up studies have incorporated measures of psychological adjustment such as marriage, children, employment, or academic achievement. Approximately 50% of women with eating disorders that were hospitalized reported problems in psychosocial adjustment at one year follow-up (Gillberg, Rastam, & Gillberg, 1994; Ratnasuriya et al., 1991). More recent research that included measures of body image disturbance and functioning in social relationships, school, and/or career, and the level of social adjustment (Strober et al., 1997), demonstrated that overall better rates of recovery were associated with more adaptive psychosocial functioning (Eisler et al., 1997; Fairburn, 1993). In a study of 69 women ($M_{age} = 32$) who received hospital treatment for anorexia, the results of standardized interviews indicated that the three common factors mentioned as contributors to recovery were: a supportive relationship or partner, maturation or growing out of their disorder, and therapy or counselling (Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). These results have provided
evidence for the influence of the social context, however they have not provided a clear description or a deeper understanding of how these factors operate in recovery.

The outcome literature has been characterized by methodological differences that include how the sample was selected, diagnostic criteria, the length of follow up, outcome criteria, and limited or absent data for those individuals who did not complete the study. Because one of the aims of recovery research is to provide a consistent picture of the pathway of an eating disorder, methodological differences seriously limit the ability to do so. Evidence to date has suggested a variable course for eating disorders (Pike, 1998), a lack of consistency in terms of the physical changes that occur following hospital treatment, and little information about the psychological experiences of recovery from the perspective of the individual rather than the clinician. Thus far, the attempts to quantify a predictable course and normative outcomes for eating disorders have eluded researchers (Pike, 1998). Broader problems for researchers and clinicians are the disappointing outcomes and the length of recovery for eating disorders.

In summary, research has indicated that eating disorders do not follow a predictable course and that recovery is a difficult and lengthy experience. Based on the treatment efficacy and follow-up literature of hospital-based programs, there is initial success in symptom reduction and weight restoration. Thus, hospital treatment providers can enjoy a certain degree of confidence in their ability to restore physical health in individuals with eating disorders, albeit for varying lengths of time (Pike, 1998). The restoration of physical health and stabilization of health threatening behaviors remains a priority for hospitalized individuals, however eating disorders also exert a powerful impact on psychological functioning that warrants further investigation. In the literature, there is an ongoing emphasis on the evaluation
of treatment efficacy and improved service delivery, which may further hamper the exploration of a comprehensive understanding of recovery (Jarman & Walsh, 1999). The psychological and social experiences for those individuals with eating disorders who continue to recover after or without treatment are not clearly understood and require further investigation (Jarman & Walsh, 1999).

Clinicians have long recognized the importance of psychological dimensions of recovery from eating disorders (Bruch, 1974, 1988). However, the psychological aspects of recovery, such as reduction in fears about becoming fat, preoccupation with food, appearance, and disturbances in body image have received far less attention in outcome evaluations. For example, Hsu's (1980) review of outcome studies of individuals with anorexia (from 1954 to 1978) revealed that very few early studies explored their continued over concern with body weight and shape at follow-up (Hsu, Crisp, & Harding, 1979; Morgan & Russell, 1975; Theander, 1970). For the clinician and individuals who have an eating disorder, there remains confusion regarding what it actually means to be recovered or recovering from an eating disorder (Jarman & Walsh, 1999). Thus, a phenomenological investigation provides an in-depth description of recovery that may make an important practical contribution.

Attempts to describe the course of an eating disorder in order to more effectively treat it will continue and are necessary. The physical ramifications of an eating disorder often require medical intervention, and weight restoration is, in some cases, essential prior to any form of psychological intervention. However, for the numerous individuals whose eating disorder does not completely fulfill the diagnostic criteria or for those who cannot access hospital treatments, other forms of intervention are required. The present study provides a description and understanding of the recovery experiences that occurred outside of hospital treatment programs.

Researchers are beginning to understand the psychological and subjective aspects of recovery and provide us with information about the early aspects of recovery. In the next section, I review research based on qualitative methodology that has been used to explain and describe the subjective experiences of individuals who were recovering from an eating disorder. I do not use the term recovered to describe the participants in these investigations because in the majority of cases, except one (Lamoreaux & Bottorff, 2005), the data were collected after approximately one year of recovery. Because of the lengthy recovery period that is associated with the problem of eating disorders, this research only provides information about the early aspects of recovery.

Subjective experiences of early recovery. Broadly speaking, qualitative research methodologies capture subjective perspectives, and may facilitate the identification of commonalities among individuals' experiences (Denzin & Lincoln, 2000). Several unpublished doctoral theses explored the subjective experiences of individuals with eating disorders and their recovery experience (Maine, 1985; Milstein, 2001; O'Byrne, 1992; Peters, 1990; Platt, 1992; Shillito, 1994). In general, this research conceptualized recovery as a process that was developmental and existential in nature. These studies emphasized the individual's agentic
qualities in facilitating the recovery process. Overall, the results of these studies offered useful information about the key turning points that characterized the early aspect of recovery. During early recovery the individual made the decision to address the eating disorder behaviors (e.g., fasting, bingeing, purging), and the decision was hypothesized to be a turning point in the recovery process. What happened once the behaviors were under control is less well understood. In all of the studies reviewed here, there were no attempts to encourage the participants to describe their present or future experience and how it relates to past recovery experience.

Several researchers have explored critical factors in recovery from eating disorders using grounded theory methodology (D'Abundo & Chally, 2004; Lamoureux & Bottorff, 2005; O'Byrne, 1992; Weaver et al., 2005) or thematic analysis of the interview data (Peters, 1990; Shillito, 1994). Grounded theory methods aim to develop and describe an explanatory mid-range theory of the process of recovery that is grounded in the participants' interview data (Denzin & Lincoln, 2000). The factors that constitute, explain, and predict the process of recovery are the focus of the analysis. Although thematic analysis is a part of grounded theory methods, in some cases it represents the primary method of analysis.

O'Byrne (1992) asked 7 women, who had recovered from bulimia (M age = 27), what was the most significant in their recovery. All of the participants had recovered for one year, 5 had received treatment, and 2 participants had not received treatment for their eating disorder. From her analysis of the interviews, opening the self (p. 570), was the core category of recovery that was present across all of the interviews and throughout four stages of the recovery process. The four stages of recovery O'Byrne identified were: contemplation, action, recovered, and maintenance. Some characteristics of the stages included taking action and
reducing the frequency of bulimic behaviors, knowing and feeling better, and eating, exercising, and monitoring feelings.

The O'Byrne (1992) study delineated recovery from the perspective of a developmental process that proceeded along a somewhat predictable path. Although her methodology allowed the theory to emerge from the participants’ stories, the author made several assumptions prior to her investigation. She assumed that recovery would resemble a series of stages or a process, and likened an eating disorder to an addiction. Therefore, her approach was largely deductive rather than inductive in nature. One of the limitations of a study that is deductive is that one is not fully open to the possibilities that may describe the phenomenon that is under study. In contrast, the present study provides an in-depth description of the recovery experience that considers all dimensions of how the experience is lived through (Van Manen, 1997). 

D’Abundo and Chally (2004) explored the process of recovery of women who had recovered or were in the process of recovering ($N = 20$, age range = 17 to 46 years). The women were in different stages of recovery, and participated in informal semi-structured interviews, participant observation of a support group, and a focus group. Their findings generated a cyclical model of eating disorders, which the authors termed the eating disorder curve. The components of the eating disorder curve included the increasing severity of the eating disorder, the circle of acceptance that involved the acceptance of the disease and the process of gaining self-worth in recovery, and decreasing severity of the eating disorder. The authors noted that few of the participants had fully recovered and that many of the participants described restricting and bingeing behaviours. It is likely that this research provides an understanding of the early aspects of the recovery experience, rather than providing a
description of the entire process of recovery. However, the authors used the term disease throughout their study and concluded that eating disorders were a chronic illness.

Lamoureux and Bottorff (2005) investigated the process of recovery from anorexia nervosa in 9 women using a grounded theory methodology (age range = 19 to 48 years). The women in this study ranged from 18 to 38 years and their length of recovery experience ranged from 3 to 24 years. The results of this study described a complex and lengthy process of recovery that focused on the rediscovery and redefinition of the self, with "becoming the real me" (p. 174) as the central process of recovery. The authors of this study described recovery as a conscious process that mainly involved efforts to alter the negative mindset of the eating disorder.

Weaver et al. (2005) explored the subjective process of women who were recovering and had recovered from anorexia nervosa (N = 12; age range = 14 to 63 years) using a feminist grounded theory methodology. The authors constructed a theory of self-development from "perilous self-soothing" to "informed self-care" (p. 191) that represented their journey of recovery. Although the study was aimed towards understanding recovery, the authors included their theory of etiology of anorexia nervosa in their model. Anorexia was portrayed as a coping strategy, especially in response to difficult transitions, and anorexia and recovery were promoted within the women's interactions with the social structure. Although the authors considered the role of the social context in recovery, this study did not attend to the role that the dominant discourse on eating disorders may have had in their interpretations. For example, the discourse of eating disorders as a coping strategy.

Peters (1990) explored women's perceptions of change in their intra- and interpersonal relationships during their recovery from bulimia nervosa (N = 17, M age = 29 years). The
average length of recovery was 15 months. The methodology was similar to a grounded theory approach in that the author’s intent was to articulate a theory that described the internal and social changes that occurred for women who were in the process of recovering from bulimia nervosa. The results of the thematic analysis of interview data described three dimensions of change: (a) a denial to reality continuum, (b) a private to social continuum, and (c) an avoidance to intentionality continuum. The denial to reality continuum was characterized by an increasing awareness of hidden feelings and hunger. The private to social continuum started with isolation and moved to an increased empathy with others. The avoidance to intentionality continuum concerned the development of future plans. Peters posited that a control versus a victim perspective on life promoted self-enhancement and self-actualization and was significant in recovery. Recovery from an eating disorder represented a developmental process of identity formation and self-actualization during which the individual experienced a multitude of changes both intrapersonally and interpersonally. In the recovery process, self-awareness emerged along with a renewed connection with others. Peters’s analysis of the interview data was primarily thematic and did not provide a substantive theory that was grounded in the participants’ stories. Moreover, Peters’s use of a continuum to describe changes during recovery implied that there was a linear and developmental process of growth.

Similarly, Platt’s (1992) thematic analysis of the narratives of recovery of 10 women who were recovering from bulimia nervosa outlined a developmental process of recovery. Participants’ length of recovery ranged from 1 to 8 years. Platt described the abstinence of bingeing and purging as the beginning of recovery, followed by internal changes in self-perception. The first of the three stages of recovery revealed that bulimia was viewed as a dystonic and unwanted coping mechanism and a decision was made to stop bingeing and
purging. Second, the behaviors were stopped, alternative ones were substituted, and the individual learned to accommodate the accompanying uncomfortable physical sensations. In the final phase, more adaptive coping behaviors were developed that promoted feelings of self-esteem, which was an on-going process of internal changes in self-perception.

The aim of these qualitative investigations was to outline a mid-range theory that explained the recovery process. However, these studies were limited by interview data that did not include the present experiences of the women as recovered. In summary, the factors that were described as significant in the recovery process emphasized the turning point experience in which the individual cognitively decided to try to change their disturbed eating behaviors, and the on-going nature of the process in early recovery experiences. These studies adopted a developmental perspective of recovery and were based on the theoretical assumption that the eating disorder was a form of addiction and a coping strategy that must be overcome and changed by the individual. The following research also viewed recovery as a developmental process but incorporated an existential perspective to the view of the experience.

Several unpublished doctoral theses have described recovery in existential terms as a struggle for meaning that was not solely focused on physical appearance. For example, Shillito (1993) described recovery in terms of the discovery of meaning in living as well as turning point experiences that were characterized by intuitive realizations or breakthroughs where the individual made the decision to change their eating disordered behavior. Her work was based on interviews with 6 women who defined themselves as in recovery from bulimia nervosa for one year. In her doctoral work, Maine (1985) investigated the recovery process of 25 women who had been out of medical crisis for at least 3 years. Based on semi-structured interviews, she conducted thematic content analysis, which revealed that themes of self-acceptance,
personal responsibility, and an active desire for change were central to the recovery process (essential variables to the process). The participants reported different views on their recovery status. Seven reported that they were fully recovered, 8 felt moderately comfortable, and 10 remained uncomfortable. Maine characterized individuals who were fully recovered as displaying themes of an increase in cognitive flexibility and a tolerance for conflict and change. Maine identified residual problems of a lack of self-acceptance, control, perfectionism, and a negative body image in those who were not fully recovered.

In addition to the analysis of the recovery process, in a case study of 3 individuals conducted within the same investigation, Maine (1985) identified the family and its symbolic use of food, chronic unresolved conflict; and, in general, dysfunction within familial relationships as critical developmental points for the eating problem. These findings bear a resemblance to the empirical investigations of the families of eating disordered adolescents that were published at the time or shortly prior to Maine’s investigation (Minuchin et al., 1978).

Similar to other investigators, Maine’s (1985) approach, although based on the subjective experiences of the participants, was deductive in nature. An existential and psychodynamic theoretical lens was used to conceptualize the problem. For example, eating disorders were viewed existentially as problems in identity and meaning that derived from early familial relationships. Subsequently, the recovery process was represented as an awareness of one’s self in the family, and a resultant separation process that involved self-acceptance and assertion. Maine’s exhaustive work and the themes that she identified in the process of her research validated the empirical view of the problem that was supported at the time. At present, the etiology of the problem and recovery has expanded to the consideration of other factors although the consideration of the family remains an area of interest, especially in the adolescent
population.

*Summary of qualitative research on recovery.* Researchers who have described or explained the subjective experiences of recovery from an eating disorder have assumed that the process was under the control of the individual. Thus, success in recovery is partially representative of the degree of mastery demonstrated over the problem (Peters, 1990; Shillito, 1994). The assumption of human agency was dominant in these studies and was portrayed in the following ways. In general, these studies identified a turning point in which the individual made a decision to begin to try to stop the disordered eating behavior(s). For some, this decision was straightforward, whereas for others more of a struggle was implied in the decision-making process. The researchers described changes in self-perception towards eating disordered behavior including the admission that there was a problem that needed to be changed (O’Byrne, 1992; Peters, 1990). Indeed, participants’ reduction in eating disorder symptoms seemed to be a significant part of their recovery at the time of the interview. In general, the overriding themes described in these studies were identity development, self-acceptance, and self-actualization that developed throughout the recovery process (Lamoureux & Bottorff, 2005; Maine, 1985; O’Byrne, 1992; Peters, 1990; Weaver et al., 2005). All of the research privileged the recovered women’s accounts and assumed that there was an underlying proactive and intentional meaning to the problem of eating disorders. The present study considers the themes of agency and self-development in early and later aspects of recovery and expands on our understanding of their role in the experience of recovery.

Overall, the view that eating disorders are both a physical illness and a psychological problem underlies the research on recovery. Researchers have investigated the course of an eating disorder for individuals who received hospital-based treatment and in some cases imply
a biological causal perspective. In contrast, a psychological theory of recovery supports the resolution of the underlying issues that maintain the eating problem and suggests that a complete recovery is possible (Bruch, 1988). The psychological model leads to treatments such as cognitive behavioral techniques, which address negative thoughts regarding shape and weight believed to exacerbate the behaviors. Recovery from an eating disorder according to this model involves the exploration, identification, and resolution of the thoughts and feelings that may have origins in early relationships and maintain the eating disorder. Both the biological and psychological theories emphasize individual factors in the etiology, maintenance, and resolution of an eating disorder.

Change in Recovery

In addition to the concept of human agency and its role in recovery, how change occurs also has been explored. For instance, the stages of change that were described in the process of recovery (O’Byrne, 1992; Platt; 1992) bear a striking resemblance to the motivational theory of change that was first applied to the problem of addictions (Prochaska & DiClemente, 1992). Prochaska and DiClemente identified five stages of change: precontemplation, contemplation, preparation, action, and maintenance, and hypothesized that an individual’s motivation for change will depend partially on what stage they are in. For example, precontemplators are considering making a change in their behavior versus contemplators who have made a decision that they want to change their behavior. Specific interventions used to enhance motivation for each stage of change are considered more efficacious. Treatment efficacy studies are now underway that apply these concepts to the problem of initiating change and early recovery in individuals who are hospitalized with eating disorders (e.g., Geller & Drab, 1999; Geller et al., 2005). The overall implication of this approach is that the impetus for change is situated in the
individual, and can be enhanced by specific motivational strategies that are facilitated by the clinician. Although the individual’s perceived ambivalence to treatment was acknowledged, the clinician primarily promoted change based on the motivational theory of change (Prochaska & Diclemente, 1992). The impact of the context (i.e., hospital) on the individual’s beliefs about their capacity to change was not considered in this approach.

A strength of this interpretation of recovery is that it offers a partial explanation of ambivalence to treatment and the difficulty in overcoming an eating disorder commonly observed in individuals who are hospitalized with an eating disorder. Instead of viewing the client as resistant and thus somehow willfully resisting help, ambivalence is viewed as a form of reluctance that can be addressed in therapy. A clinician can assess the readiness for change and react accordingly to the stage of change that the individual appears to be situated in, and it is assumed that motivation can be enhanced in a specific fashion. Thus, through consideration of the stages of change rather than the simple directive to eat, the underlying psychological complexity and effects of the eating disorder are somewhat respected.

*The Addiction Model*

Various hypotheses have been explored in the literature that view the behaviors that characterize eating disorders as a coping strategy in response to an underlying psychological conflict or the pervasive socio-cultural pressures on appearance. From this perspective, eating disorders are a serious and powerful addiction characterized by compulsive behaviors and denial of difficulty (Gold, Frost-Pineda, & Jacobs, 2003; Roth, 1989; Salzman, 1981). According to the addiction model, dieting, emotions, and psychosocial conflict trigger the urge to binge as a way of coping that is followed by purging to get rid of the excess calories, and the
subsequent resolve to diet again. It is through this binge and purge cycle that the behaviors are reinforced and become habitual.

The Twelve-Step program of Alcoholics Anonymous, translated into programs such as Overeaters Anonymous, conceptualize bulimia and binge eating as a disease or an addiction that will always remain with the individual. Theories that implicate the role of bingeing and purging in the self-regulation of affect in individuals with bulimia promote the addiction model of eating disorders (e.g., Heatherton & Baumeister, 1992). There is mixed support for this hypothesis; in that, for some women who binge and purge mood remains unaffected, whereas for others the act of bingeing and purging serves a self-regulatory function. The addiction model arose from Alcoholics Anonymous, which was initially founded by men for their problem with alcohol. Critiques of this model query whether it makes sense to view eating disorders, a largely female problem, as similar to alcoholism. Despite the limitations and relevance of the metaphor of eating disorders as an addiction, it is very prevalent in the literature on recovery.

**The paradox of agency.** Eating disorders are portrayed as coping strategies and yet in individuals who present for treatment, a common characteristic is a sense of a lack of control with regard to the eating disorder behaviours and the eating disorder mindset. The theory of eating disorder as an addiction is paradoxical in how it conceptualizes human agency. Although the individual is viewed as powerless and void of choice in the behavior, the problem is considered a coping strategy that becomes habitual. Two clinical articles illustrated this paradoxical relationship, which contains both positive and negative elements that are assumed to exist between the individual and the eating disorder. In one study, 18 women with anorexia wrote two letters to their anorexia nervosa, one addressing it as a friend and the other as an
enemy (Serpell, Treasure, Teasdale, & Sullivan, 1999). In the other study, 30 women with bulimia wrote two letters to their bulimia nervosa, one addressing it as a friend and the other as an enemy (Serpell & Treasure, 2002). The results of the thematic analysis revealed the benefits and the costs of the anorexia nervosa and bulimia nervosa. The perceived benefits of anorexia that were most commonly mentioned were its function as a guardian followed by themes of attractiveness, providing control or structure, difference or specialness, and avoidance for coping with emotions. The perceived benefits of bulimia included its function as avoidance for coping with emotions, and allowing one to eat without gaining weight, as well as the guardian theme. The perceived costs included being tricked by the anorexia, loss of social relationships, loss of control, and feeling taken over. The perceived costs included shame or low self-esteem for having bulimia and obsessive thoughts of shape and weight.

Overall, individuals with anorexia and bulimia both expressed a greater degree of negatives than positives regarding their eating disorder, and when compared with individuals with anorexia, individuals with bulimia expressed more negative functions. The authors suggested that the perceived benefits might have been factors that were associated with maintaining the eating disorder. Their results revealed inconclusive findings regarding the role of societal expectations for attractiveness, and anorexia as an attempt to meet a slim cultural ideal was not supported in their study. Overall these studies supported the view of anorexia and bulimia nervosa as powerful coping strategies or a way of dealing with life that has many benefits and thus is very difficult to give up.

**Stress and Coping and Eating Disorders**

The stress and coping literature mainly focuses on etiological stressors (e.g., life events, trauma, anxiety) of eating disorders (Bennett & Cooper, 1999), or differences in coping
strategies of individuals with eating disorders, compared with those without eating problems (Troop, Holbrey, Trowler, & Treasure, 1994; Yager, Rorty, & Rossotto, 1995). Research in the stress and coping area has primarily investigated two lines of thinking: whether or not people who develop eating disorders have a greater degree of stress (Bennett & Cooper, 1999; Cattanach & Rodin, 1988; Welch, Doll, & Fairburn, 1997), or if they have poorer coping responses or poorer coping skills in response to stressors (Troop, Holbrey, & Treasure, 1998). Because of the dominant view that eating disorders are a coping strategy, some researchers have suggested that, to a certain extent, recovery from an eating disorder entails the learning and adoption of new coping skills (Fairburn, 1995; Tobin, 2000). A serious limitation of the research to date is that stressors and coping strategies are generally assessed as separate constructs rather than as part of a stress and coping process (Lazarus & Folkman, 1984).

*Life event stressors.* Research on the role of stress in the onset and maintenance of eating disorders has revealed relatively inconclusive results. In eating disorder research, stress has been defined objectively in terms of life event stressors (e.g., separation from family, interpersonal conflict, stressful job situations, unfulfilling relationships, parental and marital conflicts, and childhood trauma) that were developmental or traumatic in nature, none of which have demonstrated a specific association with the development of eating disorders in young women (Bennett & Cooper, 1999). Despite findings from several studies that a greater number of stressful events preceded the onset of anorexia and bulimia (Lacey, Coker, & Birtchnell, 1986; Strober, 1984), these findings were based on retrospective self-report measures, and there did not appear to be a specific stressor that differentially predicted the onset or maintenance of an eating disorder (e.g., certain types of stressors that predispose individuals to eating disorders).
Methodological weaknesses of these studies include cross-sectional designs and self-report indices. In the few studies with longitudinal designs, stress was assessed over a one year period, retrospectively (Schmidt, Tiller, Blanchard, Andrews, & Treasure, 1997; Welch et al., 1997), which does not accurately reflect the time that it typically takes for an individual to develop an eating disorder (Bennett & Cooper, 1999). Although stressful events preceded the onset of anorexia and bulimia in some cases (Schmidt et al., 1991), the stressors were measured retrospectively and many of these events were typical (i.e., part of the normal range of experiences) for young women. Based on the research thus far, there is limited evidence that stressful life events play a precipitating role in the development and maintenance of an eating disorder. Furthermore, the evidence is weakened by how stress was conceptualized as a single variable without attention to the surrounding elements of the stress and coping relationship (Lazarus, 1990).

Despite the evidence of the transactional nature and complexity of the stress and coping process, studies to date have considered stress in a narrow and simplistic fashion. Stress has been defined as a discrete stressful event that is assumed to be accessible to self-report and is objective in nature. In these studies, the dynamic and transactional nature of the stress and coping process was not taken into account (see Lazarus & Folkman, 1984). According to Lazarus’s transactional model of stress and coping, psychological stress results when an individual appraises a situation as stressful and in which demands exceed available resources. Thus, rather than an objective, discrete event, stress is a subjective appraisal that is made by an individual. If the event is perceived as harmful or threatening then coping processes are brought into play in order to manage the mismatch between person and the environment (Lazarus, 1990). So far, researchers have measured stress independently of how the individual appraised
the stressor (e.g., harm, treat, benign) and the accompanying emotions, coping efforts, and perceived efficacy of the selected coping strategies (Lacey et al., 1986; Schmidt et al., 1997; Strober, 1984; Welch et al., 1997).

**Stress and coping: A dynamic relationship.** Because life stressors are normative and there is a paucity of evidence linking stress as the cause of eating disorders, Cattanach and Rodin (1988) proposed the application of the transactional model of stress and coping (Lazarus & Folkman, 1984) to the problem of eating disorders. Recent reviews of the literature almost universally accept that coping is a transactional process (Aldwin, 1994; Holohan, Moos, & Schaefer, 1996). The transactional model (Lazarus & Folkman, 1984) views the stress and coping process as a complex interaction that is influenced by individual and contextual factors that change over time. Coping is defined as the constantly changing cognitive and behavioral efforts to manage, tolerate, or reduce the specific external and internal demands that are appraised as taxing or exceeding the resources of a person (Lazarus & Folkman, 1984). Lazarus proposed that there are two major functions of coping: problem-focused and emotion-focused coping. Problem-focused coping is associated with actions that are undertaken to change the environment and to deal directly with the problem such as: information seeking, developing a plan of action, and generating different solutions. Emotion-focused coping strategies attempt to deal with the emotions that arise from the stressful encounter and include strategies such as: expressing emotions and/or using distraction. Recent research has identified additional coping functions that are directed towards the maintenance of interpersonal relationships (DeLongis & O’Brien, 2001).

The degree of appraised control of the stressor is hypothesized to influence coping responses. In situations in which there is perceived control, the tendency to utilize problem-
focused coping is enhanced, whereas in situations in which there is low control or the stressor is perceived as changeable, the use of emotion-focused coping strategies are more likely (Holohan et al., 1996). Researchers have explored whether there are differences in coping strategies in individuals with eating disorders (Koff & Sangani, 1997; Shatford & Evans, 1986; Troop et al., 1994; Yager et al., 1995).

In two investigations of female undergraduates, higher levels of emotion-focused or avoidant coping styles (i.e., self-report of how they typically cope with stressful events) were associated with greater levels of disordered eating and a negative body image (Koff & Sangani, 1997; Shatford & Evans, 1986). Similar findings were reported in clinical samples. Troop et al. (1994) examined coping strategies used to deal with a self-nominated stressor in women with and without eating disorders. They found that women with anorexia \( n = 24 \) and bulimia nervosa \( n = 66 \) used more avoidance strategies than the control group \( n = 30 \), however the degree of statistical power was small.

In an investigation of women with and without eating disorders, Troop, Holbrey, and Treasure (1994, 1998) used semi-structured interviews to assess retrospectively how participants coped with adversities in childhood. The interviewers rated the participants’ responses in terms of the degree of helplessness or mastery that they perceived was demonstrated in the childhood scenarios described. Results revealed that cognitive avoidance and cognitive rumination were higher in women with eating disorders \( n = 43 \), compared with women without eating disorders \( n = 20 \) in response to a stressful life events checklist. The ratings of the severity of the crises were determined from contextual information and not the participant’s subjective report of severity. The findings are weakened by the lack of consideration of subjective appraisals and the outcome of their coping efforts, as well as the
retrospective recall method. Therefore, the conclusion that women with eating disorders were less masterful in their coping, compared with women without eating disorders, cannot be stated unequivocally. Rather, based on their single assessment of participants’ retrospective self-report of how they coped with a crisis, the women with anorexia and bulimia nervosa reported greater use of avoidant coping strategies.

There is limited empirical evidence that eating disorders are ineffective coping responses to developmental and/or life event stressors (Troop et al., 1994; Troop et al., 1998). Furthermore, in the stress research, the underlying assumption appears to be that coping is a stable trait. From this perspective, maladaptive coping is associated with strategies that do not deal directly with the stressor, but instead seem to reflect an avoidance of dealing with the stressor through various strategies such as distraction and/or dealing with the affect that is present. Adaptive coping is often presumed to encompass problem-solving strategies that focus on cognitive problem solving and actively seeking resources to deal with the stressor.

Weaknesses of the research in this area are its lack of attention to the measurement of the stress and coping process. The research that conceptualizes coping as a style views coping as a personality characteristic rather than a process that occurs over time during which one’s coping strategies change and are shaped by the demands of the context (Folkman & Lazarus, 1985). A process view of coping refers to adaptive coping as the degree to which the selected coping strategy is effective in improving the outcome, rather than labeling certain coping strategies as maladaptive (Lazarus, 1993).

Coping in recovered and non-recovered women. Coping styles among women who were recovered from bulimia \((n = 40)\), active bulimics \((n = 40)\), and non-eating disordered women \((n = 40)\) were assessed through semi-structured interviews after one year of recovery in
order to examine the impact coping might exert on the recovery process (Yager et al., 1995). Recovered women demonstrated similar rates of active coping, in comparison to the control group, and were more likely to cope with difficulty by seeking emotional support from others, compared with active bulimics. Women in the recovered group also reported a greater focus on venting emotions, compared with the active bulimic group. The authors suggested that rather than serving a maladaptive function, these types of coping strategies serve an adaptive function (Carver, Scheier, & Weintraub, 1989). Specifically, women in the recovered group emphasized the importance of allowing themselves to express their emotions, whether positive or negative, as an alternative to escaping through bingeing and purging.

Because the study was cross sectional, one cannot assess how coping changes through the process of recovering, if having an eating disorder affects coping, or whether coping contributes to the development of an eating disorder. The important finding was that recovered women and non-eating disordered women did not differ on any of the coping dimensions, which provides further evidence for the study of coping as a process and for the assessment of the efficacy of coping strategies in light of the context and situational demands.

**Summary of stress and coping research.** In these studies, stress was typically measured retrospectively using self-report measures and therefore was susceptible to bias and distortion. Furthermore, stress was measured in isolation without assessing participants' appraisals and coping strategies, or the impact of the surrounding context. In addition, appraisals and coping efficacy beliefs were suggested as possible individual vulnerability factors for the development of binge eating (Cattanach & Rodin, 1988). In particular, interpersonal stress was considered to be the greatest risk factor, however this variable remains under researched. The use of a checklist to assess coping cannot capture the contextual factors, the meaning that a situation has
for an individual, or the resources that are available (Coyne, 1994). Furthermore, coping inventories do not allow for the influence of power differences in women’s self-report of their coping responses (Morrow & Smith, 1994). This is especially important in the eating disorder literature, as the research samples are often female in-patients, two factors that likely engender a powerless position. Thus, the findings that hospitalized women or women who have recently received treatment for an eating disorder tend to endorse “avoidant” coping strategies might be considered in light of the context and not pathologized as it is in some cases. In general, the evidence accumulated thus far is inconclusive as to whether coping precedes, maintains, or changes as a result of an eating disorder, and researchers have tended to focus on the assessment of the individual with a lack of attention to their social context.

Because of the cross-sectional designs, self-report measures of stress and coping styles, and exclusion of appraisals and contextual factors, a complete representation of the dynamic nature of the stress and coping process is lacking. The psychological stress and coping process refers to a particular relationship between a person and the environment and requires within and between person designs and in-depth qualitative studies of the interaction between personal characteristic variables, appraisals, coping, and contextual factors, which, to my knowledge, has yet to be applied to the area of eating disorders.

Eating disorders as a maladaptive way of coping continues to inform the empirical and popular literature on recovery (Tobin, 2000). Despite the paucity of research and the lack of evidence that women with eating disorders use greater maladaptive coping, efforts to teach more effective coping are a substantial part of treatment plans for this population. For instance, cognitive behavioral treatment (CBT) for eating disorders focuses on teaching self-regulatory techniques, problem-solving strategies, and cognitive re-structuring techniques in order to deal
with stressful situations (Wilson & Fairburn, 1993). One of the assumptions that underlie the CBT approach is that stressful situations act as triggers for eating disordered behaviors. The assumption that coping can be taught or learned is a promising avenue of research with therapeutic implications. CBT has been successful in the promotion of initial symptom reduction in individuals with bulimia nervosa (Wilson & Fairburn, 1993) and more recent forms of CBT treatment are incorporating client motivational variables into treatment plans (e.g., Geller & Drab, 1999; Geller et al., 2005).

The belief that mastery over one’s problems or stressors is the preferable method of coping underlies research and treatment in the area of stress and coping and eating disorders (Tobin, 2000; Treasure & Ward, 1997; Troop et al., 1998). Mastery is viewed as adaptive and is evident in the content of problem-focused coping strategies (Troop et al., 1994). A lack of control or helplessness is conveyed in the emotion-focused or avoidant forms of coping. Missing from the literature is how an individual appraises a stressful event, their attempts to cope, and the lived experience of the process. There is a reliance on the cognitive aspects of coping without attention to the experiential and less rational knowledge that, in addition to cognitions, considers emotions and intent towards the experience. In the present phenomenological investigation, I focus on the explicit and implicit forms of meaning and intent that are a part of the recovery experience. In addition, I describe other factors that constitute the experience of being-in-the-world as recovered.

An Alternative View of Coping

Troop (1998) criticized the way in which the hypothesized relationship between coping and eating disorders is conceptualized in the literature. He suggested that eating disorders as a way of coping is not accurate if one utilizes the generally accepted definition of coping as those
conscious and intentional goal-directed efforts towards handling a perceived problem (Lazarus & Folkman, 1984). Troop argued that the reason eating disorders are not coping strategies is because they probably did not start as a specific goal-directed response to a specific stressor, but through practice acquired a coping function. However, others have suggested that a broader definition of coping in chronic situations may be appropriate (Compas, 1997). The belief that eating disorders are a coping strategy may reflect the modern causal explanation or the discourse that surrounds the phenomenon of binge eating and dieting; that women engage in these behaviors as a coping mechanism in order to feel better or as a reward during or after a long and tiring day. Furthermore, the characteristic ambivalence to treatment that is observed in individuals who are hospitalized with an eating disorder has led some clinicians and researchers to assume that eating disorders are a coping strategy.

Troop’s (1998) critique of the coping literature raises questions about how our culture affects an individual’s perception of the recovery experience. Culture provides us with explanations that we may borrow to explain our behaviors (e.g., we over eat when we are stressed). Eating disorders as coping strategies reflect the association between stress and symptoms or ill health that is a part of the broader discourse (i.e., societal explanations for phenomenon) that is espoused in society. However, empirical research has revealed that stress is not a necessary requirement for the development and perpetuation of eating disorders. Furthermore, the belief that there is a causal link between stress and eating disorders has implications for practice and may prevent other possibilities and explanations from being explored. The role of culture and the role of stress in the etiology of eating disorders is a complex issue. Due to the normative and developmental nature of cultural pressures regarding shape and weight, combined with the fact that not all women develop an eating disorder, the
role of individual differences cannot be ignored. Researchers have explored individual differences in terms of personality, coping ability, locus of control, social support, and affective disorders, but they have not identified a consistent etiological framework.

One implication of the conceptualization of eating disorders as a way of coping is that it confers an acceptable way of handling life’s problems despite evidence for its efficacy. In addition, the idea of coping may send a message to people that they are obligated to act and that certain ways of coping (e.g., problem focused) are inherently better than others (Labonte, 1992; Morrow & Smith, 1995). In the next section, I focus on socio-cultural explanations of recovery from an eating disorder and the literature that explains the problem from feminist and postmodern perspectives.

**Feminist and Socio-Cultural Theory**

Broadly speaking, feminist and sociological theories investigate how societal and cultural factors contribute to the phenomenon of eating disorders, in contrast to those that place the focus on the individual (Brumberg, 2000). The rise of feminism coincided with the interpretation of eating disorders as a medical problem. Feminist theorists were critical of this conceptualization of eating disorders for the following reasons. Preoccupation with weight and shape and disordered eating behaviors and attitudes are not limited to a small number of women as proposed by the DSM classification system (1994), but rather there is a normative discontent about one’s shape and weight for the majority of women (Striegel-Moore et al., 1986). In addition, the inclusion of eating disorders and common widespread beliefs about weight and shape into the DSM (APA, 1994) frames women’s experiences as pathological. Finally, the conceptualization of eating disorders as a medical problem discourages the exploration of the socio-cultural influences on disordered eating, and the connections between
the conditions of women’s lives and eating problems. In contrast to the medical explanation for eating disorders, feminist theorists typically have a broad focus on the social, familial, and political aspects of women’s lives. Feminist explanations for eating disorders include a patriarchal society, unequal distribution of power, being female, media and societal pressures regarding shape and weight, enmeshed mother-daughter relationships, and problems in identity and role conflict.

Early feminist writers conceptualized eating disorders as a form of rebellion against patriarchal society or as a form of female social protest against the demands of motherhood (Orbach, 1986). The gaunt female form associated with anorexia was viewed as a message of control and strength and an available and socially sanctioned form of expression for women. Initial formulations by feminist authors (Wooley & Wooley, 1984) included the now conventional observation that since the late 1960s and early 1970s appearance norms have become increasingly oppressive and unrealistic for the majority of women. The rise of the mass media and the promotion of a narrow ideal body shape for women have obviously influenced women’s desire for thinness.

Some feminist theory concentrates on the analysis of the socio-cultural context; specifically it focuses on the impact that power and gender exert on women’s relationship with their bodies and the relationships between women’s experiences of living in western society. In her feminist analysis of anorexia, Bordo (1988, 1990) suggested that rather than individual pathologies, anorexia and bulimia are shared embodiments of gender that are culturally situated. Some feminist researchers have viewed the lack of power and discrimination as a major chronic strain for women, which increase their vulnerability to the development of an eating disorder. In Marxist feminist analysis, the consideration of social class in addition to
gender is utilized in the analysis of anorexia (Fraad, 1994). The female body is portrayed as a
site on which contradictory forces act, and eating disorders are expressions of the management
of contradictions within rapidly changing class and gender processes. In addition to their
participation in the production of household goods, services, and nurturance, women are
expected to participate in the labour market and to satisfy media images of female
attractiveness. In today’s society, role demands and role ambiguity, along with violence and
aggression towards the female body are hypothesized to contribute to eating disorders as a
response to this situation (Fallon, Katzman, & Wooley, 1994).

In addition, gender-role socialization for girls that teach a reliance on others’ approval
and an attention to physical appearance may increase one’s susceptibility to societal messages
around shape and weight (Streigel-Moore et al., 1993). Feminists theorize that gender-role
socialization places women at a higher risk for the development of an eating disorder as a way
to obtain others’ approval. Because girls are socialized to please others, and that their
appearance is important, they are more susceptible to societal messages regarding shape and
weight. The behaviors of dieting offer a clear set of guidelines for a young woman to follow
and provide a sense of direction, and with weight loss, the approval of others.

In addition to the impact of power and gender, feminists implicate family of origin
issues. The feminist psychoanalytic viewpoint emphasizes psychological difficulties associated
with the transition from girlhood to adulthood (Orbach, 1986). The gaunt female form of
anorexia is hypothesized as an escape from sexuality and a return to childhood in response to
the pubertal changes of adolescence (Bruch, 1972; Crisp, Palmer, & Lacey, 1976). Experiences
in the mother-daughter relationship, such as unclear communication or enmeshed boundaries
contribute to an unclear sense of self and identity and the development of an eating disorder
(Chernin, 1986), especially during adolescence when the developmental need to separate and individuate is present (Bruch, 1973). Some of the feminist literature is criticized for its emphasis on the mother-daughter relationship in the etiology of eating disorders. Also research on adolescent girls’ development re-conceptualized the need for independence that was based on male models, to a desire for interdependence and a connection with others as a developmental requirement for females (Gilligan, 1982). To this day, the developmental perspective influences research and practice in the area of eating disorders.

In summary, feminist literature interprets eating disorders as a developmental response that is learned and reinforced by our culture, and as an individual’s struggle for acceptance, recognition, control, and power in response to familial and societal demands. The issue of control is central to many of the feminist interpretations of eating disorders and reflects a paradox. Whereas Orbach (1986) viewed anorexia as a type of power, other researchers viewed an individual with an eating disorder as a victim or as powerless. In light of the powerful million dollar dieting and weight control industry, some feminist theorists view eating problems as systematic and pervasive attempts to control women’s bodies (Rabinor, 1994). Alternatively, women can achieve power through dieting, which may be considered a disciplinary practice for women who are living within a patriarchal society (Bordo, 1993).

The cycle of bulimia is construed as the expression of need through the binge, guilt through successive purges, and the will to succeed through dieting and starvation. Therefore, an individual with an eating disorder may be a victim or a willing architect of her drive for thinness and fear of fat. The paradoxical concept of agency is a part of the feminist literature. Eating disorders are framed as either a thing that is imposed on young girls as victims, or as a freely chosen form of social protest without any biological or physical contribution. Limitations
of the cultural models are that they do not explain why all women do not develop an eating disorder despite being exposed to the same environment. Furthermore, these models assume that eating disorders are a recent phenomenon despite the socio-historical research that traces the historical accounts of girls and women and their use of food and control of appetite and the body (see Brumberg, 2000; Hepworth, 1999).

The feminist and sociological literature reviewed provides information with which to consider the individual as situated within a wider social context. Feminist theory provides an understanding of the individual and social factors that are involved in the experience of an eating disorder. Some of the factors identified by feminist researchers may emerge in the analysis of the participants' accounts of recovery. Of note are the themes of power, self-acceptance, identity, role conflict, and spirituality along with societal messages about what it means to be female. However, the feminist literature that I reviewed thus far does not illuminate the experience of recovery as lived and the shifts in psychological meaning that a woman experiences as she recovers.

*Sociological and Spiritual Sources of Recovery*

In contrast to the literature reviewed thus far, Garrett (1997) and other clinicians (Johnston, 1996; Lelwica, 1999) have offered an interpretation of recovery that was primarily spiritual. Garrett (1993), a former woman with anorexia, explored the social sources of recovery in her thematic analysis of individual stories of recovery. Her sociological interpretation of recovery from anorexia was based on interviews with 32 former sufferers at various stages of recovery. Her narrative analysis revealed an overall theme of reconstructing the self that resembled a spiritual quest in the process of recovery.
Garrett (1993) suggested that the participants' stories resembled a conversion experience that was religious in nature because it usually referred to a force that was beyond themselves, a sense of peace within themselves, and oneness with nature and other people. Garrett described how participants talked about their bodily experiences and the process of re-integrating the mind with the body and deepening bodily awareness using experiential practices such as yoga, dancing, gardening, cycling, walking, and running. She acknowledged the importance of addressing the experiences of change in the bodily self in addition to the changes in attitudes and behaviors in recovery. Johnston's (1996) approach to recovery involved the use of myths, metaphors, and storytelling as a way to transform women's relationships with food and to value their internal wisdom and experience.

The degree to which Garrett's findings reflected her own experience of recovery was unclear because self-reflexivity was not incorporated explicitly into her work. Garrett (1997) indicated that all of the participants but one used a language of spirituality as a source of meaning during their recovery. Because the reader is not provided with a clear and detailed description of the methodology, it is unknown whether the author's emphasis on spirituality was a personal assumption rather than the dominant theme expressed across participants. Further, the participants were not asked to comment on her interpretations. Spirituality may be a component of recovery but there were likely additional elements of recovery that were not explored and described.

Garrett's (1993, 1997) studies acknowledged that there are positive instances of recovery from an eating disorder. In contrast to the research that described individual cognitions and feelings in recovery, Garrett described the being-in-the-world experience of time
and space. These elements are explored and described further in the present phenomenological investigation of long-term recovery.

It is likely that the individual, others, and society play a role in the recovery experience. Different approaches to the problem tend to emphasize each dimension to varying degrees. The emphasis in the present study is on both the commonalities and exceptions across the experience of recovery. The emphasis and assumptions of the present study focus on the individual’s experience, however dominant discourses exert an influence on the participant’s understanding of recovery. Therefore, in the next section, I examine research that has investigated eating disorders and recovery from a postmodern perspective.

Postmodern Approaches

Postmodern approaches to research (e.g., discourse analysis) may offer an alternative explanation of eating disorders and recovery. An underlying assumption of discourse analysis is that knowledge and reality are socially and historically constructed and that social practices reproduce particular discourses, ways of thinking, and explanations for problems (Sturrock, 1986). Discourse is derived from social constructivist theory, which posits that reality is represented through language that arises from the social and cultural context. A deconstruction of the language that is used to define, manage, and limit the explanation of eating disorders yields the dominant ways or the discourse that is used to explain the problem. One of the criticisms of psychological accounts of eating disorders is that they are insufficient because they are ahistorical and asocial. In addition, discourse analysis assumes that the self is constructed via the language that we are situated in, rather than as a product of individual psychological factors. Postmodern views of the self recognize the multiplicity of identity and the self as socially and culturally constructed (Gergen, 1991).
The application of social constructivist theory challenges the concept of agency and places the social context as the determining factor in human behavior. This assumption stands in contrast to the methodology I employ in the present study that privileges the role of individual human agency. However, this phenomenological approach also acknowledges the role of society and culture as a mediator of the individual's meaning-making process (Karlsson, 1993).

*Anorexia as a social construction.* In the book, *The Social Construction of Anorexia Nervosa*, Hepworth (1999) challenged the categorization of anorexia nervosa as a manifestation of psychopathology, and traced the historical development and recognition of anorexia nervosa as a female mental illness. In addition, based on interviews with 11 health care workers, Hepworth analyzed the interviews for the discourse that participants used to describe and explain eating disorders as a contemporary problem, and the practices that were employed in the patients that they work with. The explanations that were offered for eating disorders by the health care workers centered on control, the abuse of women, the mother-daughter relationship, and socio-cultural pressures regarding weight and shape. The analysis of the construction of gender identity revealed that anorexia was represented as a condition that is inextricably linked to being female and with female psychology. Hepworth (1999) argued that these constructions reproduce the societal explanations for the problem.

From her analysis, Hepworth (1999) concluded that anorexia is constructed as a problem of weight loss and that hospital programs are structured in order to promote weight gain. She limited her analysis of recovery to the significance that is given to weight gain and that success is judged by the duration of the maintenance of "normal weight." She added that
recovery is complex and that she observed a major distinction between short-term and long-term outcomes.

*Discourse of bulimia nervosa.* Brooks, LeCouteur, and Hepworth (1998) examined the discourse of bulimia nervosa in interviews conducted with 10 women and 1 man in order to identify the participants’ variety of constructions of bulimia, and to identify the functions and consequences of these constructions. All the participants reported active bulimia or past bulimia nervosa, which ranged in duration of two occasions to 23 years. The interview transcripts were analyzed using a discourse analytic approach (Parker, 1992; Potter & Wetherell, 1987). The analysis of the societal ideologies that the participants used to explain bulimia revealed how their power might shape the discourse present in the interviews.

Brooks et al. (1998) identified dominant ways of talking about bulimia nervosa as a destructive and damaging entity that had power over the person to ruin their life and overtake one’s mind. Thus, bulimia was construed as a disease or an illness of which one is a victim. Recovery was described in both passive and active terms. Those individuals who described their recovery as passive mentioned that recovery occurred when the bulimia “dropped off,” “passed,” or “was over” (p. 196). Conversely, the authors noted that those individuals who described their recovery as active spoke of “dealing with it,” “getting over it,” and “overcoming it” (p. 196).

Brooks et al. (1998) identified a repertoire that constructs bulimia as an action that one performs on oneself, and as being a victim of oneself. Examples of reflexive verbs used to describe one’s self as being acted on included “make myself,” and “starve myself” (p. 197). Two of the participants spoke of bulimia as a positive thing when they spoke of bulimia as a “coping mechanism” or a “comfort source” (p. 196) that one could turn to. Bulimia was
described as “something that one can act upon,” (p. 197) as a construction of the self that was in a more powerful position, compared with bulimia that was described as dominant and debilitating. The results reflected a paradox of power in that some participants felt that they had control over their eating disorder, and others felt as if they had no self-control.

Societal ideologies present in the interviews were the valuing of individual will power and self-mastery, the need to control the body, and the dichotomy between the mind and the body (Brooks et al., 1998). Reflected in these findings was the Western ideal of will power and self-mastery that dominates as an ideology and was reflected in how the participants described bulimia nervosa.

Brooks et al. (1998) concluded that individuals construct themselves as victims of bulimia according to the language that they use, however, they concurred that there are exceptions to this discourse. The results were somewhat contradictory and inconclusive in how power and agency were construed in the discourse on recovery. On the one hand, the authors interpreted bulimia as a powerful entity of which the individual was a victim; on the other hand, they mentioned two exceptions where bulimia was talked about as a coping mechanism. However, Brooks et al. (1998) did not describe whether participants were involved in active bulimic behaviors or in recovery. Despite the mention of exceptions that contradicted the dominant discourse, examples were not provided. The lack of attention to the ways that individuals resisted the dominant discourse is a common criticism of writing in this area (Cosgrove, 2000). In contrast, in the present study, I provide a more in-depth examination of the meaning and perception of agency within the recovery experience over time, which assists in our understanding of this complex experience.
Although a postmodern approach provides us with a view of the multiple ways in which individuals construct themselves in response to societal influences and the impact of power on perceptions of reality, it does not provide us with a sense of unity or coherence and does not integrate multiple discourses (Cosgrove, 2000). A social constructivist approach fails to fully address how, why, and in what ways women are able to resist dominant discourses. The concept of human agency is not fully addressed because the emphasis is on the influence of the social context. Social constructivist approaches tend to position the individual as a victim (especially women) of the dominant societal ideology that prevents agency and choice within their experience. However, as Cosgrove suggested, “how can there be a possibility of agency, of exercising choice or resistance over our experiences if all we are is the effect or product of discourses?” (2000, p. 258). We need to be able to understand why and how some women are able to resist discourses that work to position so many women into the role of victim. The complex themes of power and human agency and their influence in the experience of recovery from an eating disorder are further described in this phenomenological research.

Rationale for Phenomenology

A phenomenological approach privileges agency and emphasizes the individual’s lived world and the importance of the structural unity among experiences, which include the dimensions of body, time, space, and relation to others (Van Manen, 1997), and is referred to as being in the world. Despite the constraints of our context, phenomenology assumes that individuals exercise choice and agency and thus are co-constructors of experience. Phenomenology is primarily a descriptive approach and an analysis of meaning that focuses on individual experiences. Rather than the assumption that individuals are constituted by language,
phenomenology offers the opportunity to explore the experiential aspect of experience and how it impacts therapeutic change.

The recovery literature is replete with evidence that the experience itself is overwhelming and that remarkable transformations result from the experience of living with and through an eating disorder. Research to date has conceptualized recovery as a series of stages or turning points for individuals with a relatively recent reduction in the behavioral symptoms of their eating disorder (O'Byrne, 1992; Peters & Fallon, 1994). Based on the evidence thus far, there is a general understanding of what early aspects of recovery entail; how the behaviors are addressed and interrupted, and the subsequent recovery experience remains less well understood. Individuals who have experienced the initial recovery phase and continue to experience shifts in meaning and experiences relative to recovery represent a valuable source of understanding. Thus, the results of the present investigation of the subjective experiences of individuals who are recovered from an eating disorder might offer tentative ideas for prevention strategies and treatment.

A phenomenological approach to the recovery from an eating disorder provides an opportunity to deepen our understanding of how individuals experience and maintain their health. In this review, I described how the assumption of human agency affects how the problem of eating disorders is construed (e.g., as an addiction). It is also an assumption that pervades the recovery literature and reflects an individualistic perspective. In addition to the recovery experiences that describe overcoming a problem, phenomenological analysis is also open to the being in the world experience and what it is like. Thus, in addition to the forward goal-directed behavior that has been assumed and searched for in previous studies, in the present phenomenological study, participants’ shifts in thoughts, feelings, time, and space
relative to recovery were explored (Karlsson, 1993; Van Manen, 1997). This inductive approach allows all dimensions of the problem to be explored, rather than those that are akin to the underlying theoretical approach to the problem. A psychological phenomenological attitude towards recovery from an eating disorder opens possibilities that include aspects that maintain and assist recovery previously not emphasized. Rather than an application of various theories to the problem of recovery, this inductive approach broadly inquires about what the experience entailed. The phenomenological approach places the meaning, the lived experiential, and subjective experiences at the forefront and provides a novel way of understanding the complex phenomenon of eating disorders.
CHAPTER III: Method

In this chapter, I position the inquiry and describe the application of an interpretive psychological phenomenological method that I used to investigate the psychological processes and meaning that constituted long-term recovery from an eating disorder.

Situating the Inquiry

In order to situate the present phenomenological study, I clarify my approach to the phenomenon under study—the experience of recovery from an eating disorder. I begin with a definition of phenomenology and the underlying philosophical assumptions of the specific method I used in the practice of phenomenology. Next, I describe the assumptions and biases about recovery from eating disorders that were incorporated into the interpretive analysis. I then explicate the sample, the phenomenon under study, and the steps that describe the method (EPP; Karlsson, 1993).

Definition of phenomenology. Phenomenology is a philosophy and a method that seeks to understand a person’s lived experience and the meaning making process of an individual. It is used to describe the essential structure of a phenomenon; the qualities that make a phenomenon what it is and that give it meaning (Karlsson, 1993). The phenomenological stance asserts that understanding dwells within consciousness (Paci, 1972) and phenomena possess an inner individual subjectivity, but that there is also an essence that can be shared that is inter-subjective in nature (Gadamer, 1979). In order to attain a phenomenological understanding, the researcher adopts an attitude towards the phenomenon that allows the experience as it exists in consciousness to appear while also reflecting and interpreting the essential meaning structures of the phenomenon.
Phenomenological attitude. The nature of the phenomenological attitude is informed by existential philosophy and is central to the ability to practice phenomenology. The existential perspective, “the world is not what I think, but what I live through, and reflection does not withdraw from the world, it steps back to watch the forms of transcendence fly up like sparks from a fire” (Merleau-Ponty, 1962, p. 63), expresses the beauty and challenge of phenomenology. The researcher brackets their beliefs and suspends presuppositions in order to experience the phenomenon in the moment, and focuses on seeing, clarifying, and determining meaning (Husserl, 1956). The phenomenological attitude is in some ways reminiscent of the attitude of a client-centered therapist, who is open to and a facilitator of the client’s experience (Rogers, 1951). In addition, the relationship between the researcher and the interviewee, and the transcendental quality of sharing the interviewee’s experience of being vulnerable defines the ethical aspect of doing phenomenology (Van Manen, 2001).

The ability to adopt a phenomenological attitude facilitates the depth of the discovery of the experience of the phenomenon. The psychological phenomenological attitude implies a logical ordering of the phenomenon over time, which results in a deeper understanding and awareness of the intentionality of consciousness that permeates the subject-object relationship (Karlsson, 1993). A phenomenological attitude is a reflection on how things are given in and through consciousness, and places the nature of consciousness at the focal point of inquiry. The assumption that underlies the intentionality of consciousness is that humans are agentic in the sense that they move toward understanding the objects in their world. Thus, in the present study, a phenomenological approach provides the opportunity to privilege agency and to understand and describe the meaning making experience as it relates to recovery from an eating disorder.
Subject-object of inquiry. In addition to the phenomenological attitude, consciousness-as-intentionality is a philosophical foundation of the research method (Karlsson, 1993). The aim of phenomenology is to discover the meaning structure of the phenomenon via description that discloses the relationship between the subject and object of experience (i.e., consciousness of intentionality). Consciousness is subjective and existential in the sense that the subject (i.e., participant) co-constitutes understanding in their world, and the subject-object is linked through intentionality or being-in-the-world (Heidegger, 1962). There is no separation between the person and the world. Phenomenology claims that to explore human consciousness is to explore the actual world-for-the-individual. In this approach, the agency of the individual and the meaning-making process is assumed to be the major part of consciousness. The underlying assumption is that, although the contents of various life worlds (i.e., culture) may differ, they share a common structure that is spatio-temporal (e.g., lived time and space) that provides a logical order to the experience of the phenomenon (Karlsson, 1993).

Purpose of phenomenological inquiry. A phenomenological approach places meaning and lived experience as the focus of understanding and in-depth description. The aim of the EPP-method is to describe the meaning structures and the logical ordering of a psychological phenomenon (Karlsson, 1993). According to Karlsson (1993), the subject’s concrete description of the phenomenon is on a phenomenal level, which the researcher attempts to bring to the phenomenological level, in order to discover the logos or structure of the lived experience.

Meaning. Meaning is a concept that reflects the intentionality of consciousness of the subject-object relationship. This includes the thoughts, feelings, and intent towards the experience that are explicit and implicit. This definition of meaning is psychological in the
assumption that humans are agents in how they experience a phenomenon, and are oriented
towards movement, understanding, or meaning making. In the analysis of women’s experience
of recovery, I was open and aware of their explicit and implicit mode of understanding, relative
to the phenomenon or the object (i.e., how the subject understood and perceived recovery).

Lived experience. In order to further capture the complexity of the recovery experience
for the women in this study, I used guided existential reflection on the four existentials of lived
space, lived body, lived time, and lived human relations, which Van Manen (2002) considers to
universally pervade our life worlds. As I reflected, I was open to how recovery was
experienced, and the changes that occurred along the four lived existentials as the women
recovered. For example, as I read the interview transcripts, I considered how the women’s
experience of their body shifted to a sense of neutrality or enjoyment as they recovered. The
description of these existentials enriched and deepened the understanding of what the
phenomenon was like, and the experiential qualities that constituted recovery from an eating
disorder.

The aim of phenomenological inquiry is to capture the relationship between the subject
and the object with respect to being in the world (Heidegger, 1962), and the intentional
character of consciousness or the bestowing of meaning upon an object by a constant stream of
conscious intentional acts (Karlsson, 1993). The subject-object relationship is discovered via
reduction, the primary technique that is associated with the practice of phenomenology.

The process of reduction of the text. Partial phenomenological psychological reduction
is the bracketing of theories and hypotheses, which are otherwise used to explain the
phenomenon in question. Bracketing facilitates an open stance towards inquiry and a
phenomenological attitude (Karlsson, 1993; Van Manen, 1997). One of the purposes of this
inductive method of bracketing is to allow the data to *speak for themselves* in spite of the researcher's presuppositions. The aim is to grasp a clear understanding of the phenomenon via the interpretive process and, to reduce a complex problem into its basic components. The existential perspective asserts that understanding cannot exist in a vacuum, and that, in the hermeneutic or interpretive phase, the researcher does not attempt to seek the absolute understanding or a complete suppression of biases (Packer, 1985). However, through interpretation that incorporates the awareness of one's own and society's presuppositions, new meanings can surface and better interpretations and richer descriptions of the recovery experience achieved.

In phenomenological research, the identification of assumptions or biases prior to conducting interviews and interpretation, and their examination in concert with the researchers' hermeneutic circle is recommended (Heidegger, 1962). Assumptions and biases are both an obstacle and an aid to understanding the fusion of horizons that occurs between the text and the interpreter (Gadamer, 1979; Geanellos, 1998). A lack of awareness regarding the dominant view; inadequate knowledge of a culture, language, or discipline; unchallenged biases; unconscious pre-understandings; premature interpretive closure, and ideological constraints may prevent the expression of or privilege certain ideas over others and lead to errors of understanding of the text (Geanellos, 1998). For instance, because I have an extensive knowledge of the theoretical and empirical literature on eating disorders, and practical experience in assisting individuals with an eating disorder, it was important that I was aware of what my opinions were about recovery from an eating disorder. This awareness acted as a safeguard for premature interpretive closure or the reinforcement of my own beliefs about recovery.
Personal Assumptions and Biases

My assumptions about recovery from an eating disorder were influenced by previous experiences; therefore, I begin with a description of how I was first introduced to the problem of eating disorders, in 1986. In my first year of university, one of my close friends experienced bulimia nervosa. When I began to understand the enormous pain and anxiety that she was experiencing, I was surprised and concerned because I had been unaware of the problem that she was dealing with, despite our daily contact. After accompanying her to the hospital when she was acutely suicidal, I was motivated to learn as much as I could about eating disorders.

This experience affected my beliefs about recovery in several ways. My friends' experiences in a 12-step group program appeared to be harmful and I remain wary of the potential ethical problems (e.g., boundary violations) that may result without adequate knowledge, professional training, and expertise. My friend shared with me her denial, anger, and pain, along with caring and intelligent thoughts about her experience. I began to understand how tremendously difficult recovery was, and that unconditional support from others appeared to be the key. Breaking through the isolation, although very difficult, seemed to be essential.

After completing my Nursing degree in 1990, I began work as a Community Health Nurse. One of my priorities was to prevent eating disorders in young girls and adolescents. My friend and I visited classrooms to speak about her experience. She emphasized the struggle that she went through, how her eating disorder negatively affected her life, and how she was getting better, but that it was a long and difficult road. On reflecting back, I think that at that time she was in the early stages of recovery. Speaking to others about her experience was a helpful aspect of her recovery. I lost touch with my friend and did not have the opportunity to understand fully her experience of recovery.
My interest in the area of eating disorders continued as I counselled individuals in a university setting, facilitated CBT and narrative groups for women, completed my theses on eating disorders, perfectionism, adult attachment style, and social support, and worked briefly as a nurse in an inpatient setting. These experiences contributed to my clinical practice that promotes a genuine, non-judgmental, therapeutic relationship, using CBT strategies and experiential work. Of note, I believe that the empowerment of women with eating disorders enhances recovery and that a full recovery is possible.

Phenomenological Analysis

A phenomenological stance develops understanding through the reflective study of experience and meaning. Moreover, understanding can only be approximated and interpretation of the text aims to understand the text and not the author (Gadamer, 1979; Heidegger, 1962). The text is viewed as describing a relationship between a subject (participant) imbuing the described world (object) with meaning and in this case represents the experience of recovery from an eating disorder. The essential structures of experience are the meaning structure(s) which are the “common thread(s) which run through all diverse manifestations of a phenomenon” (Karlsson, 1993, p. 93). The results of phenomenology are not assumed to be an example of immutable reality but partially representative of the phenomenon that is mediated by the language and culture within which the interpretation is situated.

Hermeneutic interpretation. In the interpretive phenomenological method, the relationship between the researcher and the text is hermeneutical (Gadamer, 1979; Geanellos, 1998). The hermeneutic represents an overarching interplay between interactions with the research participant, myself, and the text that is generated. Through interpretation, I was attentive to the descriptive qualities of the experience of recovery while simultaneously
interpreting the meanings as represented by the intentionality of consciousness within the
subject-object relationship. As I continued to engage in this hermeneutic, interpretive, reflective
process, I grasped and discovered meaning in order that a more complete or different
understanding could occur, and what was hidden, fragmentary, or confused was made clear.
Analysis of the transcribed texts revealed the significance of meanings and essential themes
that were present the interviews.

Descriptions of the phenomenological method vary with respect to the degree of
subjectivity that is assumed to characterize the analytical process. The approach that I used
placed significance on both the textual analysis and the writing process to produce an
understanding. Although Van Manen (1997) emphasized the writing process as interpretive and
argued that the form of analysis will emerge from the data, Karlsson (1993) offered an
approach to analysis that is more objective in nature. I drew on the EPP method (Karlsson,
1993) that emphasized the subject-object relationship or the psychological meaning that can be
discovered through analysis of the text.

I represented my findings with the general structure, essential themes (Karlsson, 1993),
and lived existentials (Van Manen, 1997), all of which described the experience of recovery.
The general structure is a configuration of meaning discovered in the interview texts, and
describes how the phenomenon is lived and what the phenomenon is (Karlsson, 1993). The
essential themes further reflect the essential qualities that make the experience of recovery what
it is (Karlsson, 1993). I provide additional description of the experience of recovery as lived
through reflection on the four lived existentials. I utilized these approaches for the purpose of
gaining an in-depth, comprehensive description in order to adequately represent and understand
the complexities of the recovery experience. Although the EPP approach is a rigorous method
of analysis, I assumed that the experience of recovery was complex, and therefore the additional approach of Van Manen (1997; 2002) offered another opportunity for deepening understanding and enriching description.

As shown in Figure 1.1, I used my empathic understanding (EU) and intuitive understanding (IU) as I read and re-read the interview transcripts and eventually began to divide the interview transcripts into meaning units (MUs). Throughout the analysis I engaged in reflection, writing, and rewriting as I moved between the transcribed interview texts, meaning units, transformations of MUs, situated structures (synopsis for each participant of the essential structures of meaning that comprised their experience of recovery), the general structure and essential themes of the recovery experience across all participants, and the four lived existentials. I rigorously analyzed the text for the psychological meaning and structure prior to writing about the commonalities of the experience of recovery—the general structure and three essential themes (Karlsson, 1993). As the structure and themes of recovery emerged in my writing process, I continued to reflect on the meaning and the existential quality of the recovery experience using the four lived existentials of time, space, body, and relation (Van Manen, 1997) in order to more deeply understand and describe the experience of recovery. I used guided existential reflection, an analytic method that consisted of reflecting and writing about how the women experienced changes in time, space, body, and relation as they recovered. Throughout the analytical process my empathic and intuitive understanding of the experience of recovery remained grounded in the interview texts of the women who participated in this study.
The aim of phenomenological interpretation was not to provide the essential themes and descriptive structure for each interviewee, but to treat the interviewee’s text as the phenomenon itself (Karlsson, 1993). The aim of the interpretation was the elucidation of what the experience of recovery from an eating disorder was like in concrete terms.

Part of my rationale for the present study was to provide a voice and a forum for women’s recovery experiences through an exploratory and descriptive qualitative method. Thus, my stance as a researcher placed the text as the focus of analysis (rather than myself), in order to reveal the meaning structures of the experience of recovery from an eating disorder that emphasized the participants’ experience. Thus far, I have described the philosophy and
practice of phenomenology as it pertains to the present study. Next, I outline the analytic steps
that I undertook and the practical strategies that were based on the EPP method.

*Application of the Phenomenological Method*

The broad research questions that guided my inquiry were: What constitutes recovery from an eating disorder? What are the essential structures that pervade the experience of recovery from an eating disorder? What does it mean to be recovered from an eating disorder?

*Recruitment*

Women were invited to participate through newspaper advertisements in community newspapers and posters that described the aim of the study (see Appendix A). In addition to advertisements, an article about the study was printed in a local newspaper based on my interview with a reporter.

*Participants*

Eight women who self-designated that they had recovered from an eating disorder participated in the present study. The criteria for inclusion included: (a) the volunteer was a woman, (b) the individual viewed herself as recovered from an eating disorder for a minimum of 5 years, and (c) was able to describe and reflect on the recovery experience. Long-term recovery was defined as not engaging in eating disorder behaviors that were characteristic of the eating disorder for a minimum of 5 years, taking into account the possibility of a slip within that time frame. If there were slips in the past 5 years they were not of a long duration (i.e., week or less). My intent was to be able to explore and understand the psychological aspects of recovery once the behavioural symptoms had been resolved for a sufficient time period. In clinical groups that I facilitated, those who were in the early stages of recovery (e.g., just left a treatment program or admitted that they had an eating disorder) still felt very confused and
overwhelmed about their experiences. My aim was to speak to women who were healthy and who could articulate the full range of recovery. I assumed that women who had maintained at least 5 years of recovery would be able to describe the psychological aspects of their recovery in phenomenological terms.

Eight interviews were conducted in 2002 and the women ranged in age from 28 to 53 years ($M = 39.12; SD = 7.42$). Five of the 8 women had been diagnosed and hospitalized for their eating disorder (anorexia nervosa). Of the remaining 3, 2 were diagnosed in the 1970s with anorexia and bulimia. One of the women was diagnosed with anorexia in 1976 when there was no available treatment for eating disorders, and the other was hospitalized with depression in the late 1970s and did not receive treatment for her eating disorder while hospitalized. Similarly, the third woman who was 44 at the time of the interview had been diagnosed with anorexia in 1976 and there was no available treatment. For the 5 women who were hospitalized for treatment were diagnosed with anorexia nervosa, 4 of the 5 developed bulimia that included self-induced vomiting (SIV), whereas the fifth used laxatives and exercise but not SIV. The remaining three developed bulimia with SIV and one of them developed binge eating and over exercising compensatory behaviours. All of the participants attempted to seek outside help for their eating disorder. The duration of the eating disorders ranged from 4 to 16 years ($M = 11.13; SD = 3.18$) with 7 of the 8 participants reporting 10 years or more. Participants had been recovered from 5 to 18 years ($M = 10.25; SD = 3.96$). When participants were re-contacted in 2005, all reported that they remained recovered and 2 were pregnant and married.
Table 1.1: Participant Characteristics

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age (years)</th>
<th>Duration of Eating Disorder (years)</th>
<th>Type of Treatment</th>
<th>Recovered (years)</th>
<th>Marital Status</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casey</td>
<td>28</td>
<td>4</td>
<td>HIP, HOP, Psychologist</td>
<td>6</td>
<td>Single</td>
<td>None</td>
</tr>
<tr>
<td>Sue</td>
<td>33</td>
<td>12</td>
<td>HIP, HOP, Psychiatrist, Therapist</td>
<td>5</td>
<td>Single</td>
<td>None</td>
</tr>
<tr>
<td>Samantha</td>
<td>42</td>
<td>11</td>
<td>HIP x 3</td>
<td>14</td>
<td>Married</td>
<td>1</td>
</tr>
<tr>
<td>Zoe</td>
<td>53</td>
<td>10</td>
<td>HIP</td>
<td>18</td>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>Vickie</td>
<td>41</td>
<td>12</td>
<td>HIP</td>
<td>11</td>
<td>Married</td>
<td>1</td>
</tr>
<tr>
<td>Jane</td>
<td>40</td>
<td>13</td>
<td>Support group</td>
<td>10</td>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>Christine</td>
<td>32</td>
<td>11</td>
<td>HIP x 7, HOP, Therapist</td>
<td>10</td>
<td>Single</td>
<td>None</td>
</tr>
<tr>
<td>Dorothy</td>
<td>44</td>
<td>16</td>
<td>Support group, Therapist</td>
<td>8</td>
<td>Married</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: Treatment: HIP = hospital inpatient, HOP = hospital outpatient.

Procedure

Telephone screening and initial conversation. I screened participants on the telephone (see Appendix B). If they qualified for the study, I informed them about what their participation would involve and we arranged for the interview. I explained that the purpose of the interview was to explore and understand their experience and perspective of recovery from an eating disorder.

Interview. Prior to beginning the interview, informed consent was obtained (see Appendix C). In-depth interviews were conducted and each interview ranged from 2 to 2 ½ hours in duration (see Appendix D for the interview protocol). I audiotaped and transcribed each interview. The aim of the interview was to elicit naive descriptions of the actuality of the experience as it was lived rather than to collect an account that the participant believed was expected by the researcher (Osborne, 1992). In the interviews, I used questions that emphasized
description of the experience and in some cases a deeper understanding of what their recovery entailed. For example, some of the questions that I used were: What does being recovered mean to you? What would your life be like if you weren’t recovered? What was recovery like for you? To encourage further elaboration of the participants’ examples of recovery, I used questions or statements such as: What was that like for you? Tell me more.

The women in this study were encouraged to comment on what the experience was like, and I encouraged the participants to elaborate when I noticed shifts in their intentionality of consciousness towards the recovery experience (e.g., thought, feeling, meaning-making). When I noticed a new realization that emerged for a participant, I encouraged deeper reflection and description of their understanding. If participants offered their opinions regarding the etiology of the eating disorder or recovery, I would direct them to a description of their recovery experience. I would often repeat or reword a question in order to deepen and/or clarify their descriptions. I asked whether they had anything they would like to add or if I noticed some hesitancy or curiosity I would invite them to take their time to further reflect on what they were experiencing in the moment.

The interviews were primarily open-ended and relatively unstructured. Every attempt was made to facilitate the participant’s full description of her experience of recovery and how it was lived through. Participants were encouraged to describe their feelings about recovery. Emphasizing the importance of feelings often facilitated the participant’s accounts of their own lived experience and its experiential quality. The interviews were as minimally intrusive as possible and allowed the individual’s experience to present itself. My empathic counselling skills, knowledge, and previous experience working with clients with eating disorders assisted in developing rapport with the participants.
Data Analysis

Step 1: Informal analysis. I read and reread the interview text until I had a good grasp and a sufficient understanding of the text. I refrained from explaining or analyzing the text, however I noted where the participant constituted the meaning of the experience of recovery (i.e., the intentionality of consciousness). In addition, concrete descriptions of recovery were noted. I stayed with the text until I developed a clear understanding, because it had consequences for later analytic stages and the degree of confidence in my interpretations. The aim of this step was to develop a clear understanding of the content, with each part being considered in light of the whole (i.e., the hermeneutic circle). An open stance or a phenomenological attitude to the text was essential.

Step 2: Division of the text into meaning units. I performed a formal meaning unit analysis on each interview text. In this step, the text was divided into MUs where I interpreted a shift in meaning and the subject-object relationship. Each meaning unit (MU) was considered in light of the whole. The division of MUs was a practical aid and facilitated a concentrated and dwelling attitude on each shift of the meaning in the text (Karlsson, 1993). During this step, I omitted some passages if they did not describe the experience of recovery.

Step 3: Transformation of meaning units. In step 3, I implemented a partial phenomenological reduction by using eidetic induction through interpretation. The implicit and explicit psychological meaning that the participant described and lived through was analyzed in the text. There was interplay between the implicit and the explicit meanings with implicit meanings brought into explicit awareness. I moved from a particular fact to its psychological meaning, and uncovered the meanings that imbued facts. More than one meaning was
associated with a fact or vice versa. A second level or deeper MU transformation was performed on all of the descriptions (see Appendix E).

To summarize, after the initial reading of the text, I divided the text into MUs during a second reading of the text. During the third reading of the text, I adjusted some of the MUs and began to transform them into phrases that eventually became the sentences that comprised the situated structure for each interview. During the fourth reading of the text, I transformed all of the MUs. Then I began to arrange the MUs into each participant’s story. As I read and reread the text, I made progressively more direct articulations of the essential psychological and structural components of the recovery experience.

In order to develop a description of each participant’s story, I synthesized the MUs into a narrative for their perusal and feedback. The participants’ words were transformed into the third or first person, along with my penetration into the psychological significance of each constituent. I combined similar MUs when necessary, and/or eliminated obvious redundancies. I rearranged MUs into a coherent description of the recovery experience in a narrative format. I shared the narratives through email with each participant and obtained their feedback as part of the process of writing and re-writing. The participants’ responses to the narratives indicated that I had represented their experience in an accurate and comprehensive way.

Step 4: Situated structure. In step 4, the transformed MUs were synthesized into a situated structure for each participant that was presented in the form of a synopsis written in the third person (Karlsson, 1993). I returned to the interview text and validated my interpretations. The situated structure described what the experience of recovery was like and how it was lived through in a combined fashion. During the analysis my methodological comments were noted via handwritten comments, which I included after some of my interpretations. They included
instances in which (a) participants' descriptions were transformed into a language of meaning or general significance, (b) my pre-understandings or biases were present, and (c) other examples of MUs that supported my interpretation (i.e., the hermeneutic circle) were evident. Steps 1 through 4 were repeated for each participant.

Step 5: The general structure. In this step, I made comparisons across all of the descriptions to reveal a general structure and the essential themes that constituted the experience of recovery. Imaginative variation was performed whereby I interrogated each constituent to determine whether change or deletion would alter the structure or meaning of the phenomenon. The necessary constituents were retained and the structure articulated their structural relatedness (i.e., the essential, significant, and interdependent relationship of each theme as they revealed the essential meaning structures of recovery).

Step 6: Guided existential reflection. In this final step, in order to deepen the description of the phenomenon, I focused on the four lived existentials of time, body, space, and relation (Van Manen, 1997; 2002). This process consisted of reflecting on how the women experienced changes as they recovered and in being recovered across these four dimensions. I reflected on the interviews, and the interview texts as I wrote and rewrote this section of the results until I achieved a rich description of these existentials, that further captured the experience of how recovery was lived.

Throughout the interpretive process, I employed a hermeneutic approach to the analysis as I re-circled back and forth between my understandings of the initial written description, the interview, and my biases. The analysis and interpretation of the various sources of data were a very intensive process that required balance, flexibility, and the ability to attend to the
particular and the universals and the tensions that were present in the descriptions of the phenomenon.

**Trustworthiness**

The concept of validity in phenomenological research is concerned with whether the findings are trustworthy and coherent. For instance, in the present study, the general structure of the recovery experience provides a description of the way that recovery was experienced according to the 8 women that were interviewed in this study. In order to enhance the trustworthiness of the findings, I provided the reader with examples of how I engaged in the interpretive process; the connections between the interview texts, MUs, MU transformations, the general structure and three essential themes, and the four lived existentials in order to offer an in-depth and rich description of the recovery experience. I documented the transformation of the interview data into phenomenological psychological expressions, synthesized the transformed MUs into a general structural description in a logical and coherent manner (Karlsson, 1993), and I was engaged in the analytical process over a period of years (Lincoln & Guba, 1985). I maintained rigor by presenting, revealing, and describing the participants’ experiences (Maxwell, 1992), and ensuring that I accounted for alternative interpretations of the data. The ways that I accomplished trustworthiness was by closely following the EPP method (Karlsson, 1993), and returning to the interview texts repeatedly throughout the analysis to be certain that I was remaining grounded to the accounts of recovery.

The trustworthiness of my findings was dependent on my ability to adopt a phenomenological attitude, offer a meaningful and consistent interpretation of the phenomenon across participants, and a deepening and clear understanding of recovery. I invited feedback from each participant regarding the structural description of recovery and the degree to which it
resonated with their experiences. The feedback that I received from the participants indicated that I recorded their experience with thoughtfulness and that it was representative of their recovery experience. With all of the women that I interviewed, I was able to establish an open and genuine rapport in which the women felt comfortable exploring their experiences. At the end of each interview all of the participants felt that they had fully described their experience to the degree that they were able to. Women utilized descriptions of dreams and metaphors to lend a deeper understanding to their experience, and expressed emotions of sadness, joy, relief, and gratitude as they talked about their recovery. There was a sense, at times, of not being able to fully articulate their experiences, and yet as we continued to explore and at times sit in silence, the meaning of their experiences became clearer. The success of my proposed research was enhanced by my interpersonal skills that enabled an open, empathic, genuine, and non-judgmental attitude towards the interviewee and facilitated the open exploration of the individual’s experience (Rogers, 1951), my professional experience that includes individual and group counseling, education, and research in the eating disorder area, and my knowledge and experience in the application of the EPP method (Karlsson, 1993). In my writing, I used language to evoke the experience of recovery. The adequacy, depth, and clarity of description, which is crucial to the quality of my findings (Van Manen, 1997, 2001) is determined by the reader.

The emphasis of phenomenology is on the discovery, description, and meaning of lived experience. This method permits the exploration of an individual’s being-in-the-world and thus can address the existential element of the recovery experience that privileges the accounts of the women themselves. The inductive approach to the problem of how women recover and what the experience is like allows for the various meanings to be described in an integrative
manner. The findings of my research are trustworthy to the extent that they resonate and provide an empathic understanding for others who have recovered from an eating disorder.
CHAPTER IV: Findings

The purpose of this study was to provide a phenomenological-interpretive description of recovery from an eating disorder in order to create a deeper understanding and appreciation for the recovery experience using a method of inquiry that considered the participants' perspective as germane to the findings. In this chapter, I present an interpretive phenomenological description of the experience of 8 women's recovery from an eating disorder. Answers to the following research questions are addressed in the findings (i.e., general structure which reflects what the experience is like and how it is lived across the 8 women in this study, essential themes, and lived existentials): What constitutes recovery from an eating disorder? What are the essential structures that pervade the experiences of recovery from an eating disorder? What does it mean to be recovered from an eating disorder? I begin this chapter with the women's reflections on being recovered. Next, I present the situated structures that were developed for each participant followed by the general structure of the experience of recovery, and the three essential themes that I derived from the analysis of the 8 interview texts. Finally, I further describe the recovery experience using guided existential reflection to identify significant aspects of the women's experiences, and intensify meaningfulness.

In order to further describe and deepen understanding, I include verbatim quotes that were expressed by the participants (minor editing was done to enhance the quotes' readability, without changing the meaning of the text). The quotes that I include are illustrative rather than exhaustive quotes. Pseudonyms are used throughout.

Reflections on Their Recovery

Prior to our interview, none of the participants had reflected on being recovered. As we talked, they appreciated the opportunity to reflect on and to understand their experience. It was
as though once they were recovered, there was no looking back. The participants’ reflections on being recovered included a range of emotions. Emotions of sadness for having an eating disorder; relief, gratitude, and pride for being recovered; and incredulity for having been so sick were present in all of the accounts of recovery. All of the women described feeling misunderstood and a sense of apartness from others whom they sensed did not really understand their recovery experience. Now that they had recovered, they described feeling as if they were a different person who was living a different life and embracing a different way of being. Despite feelings of sadness and regret, in terms of the time and experiences they lost when they were sick, all of the women expressed gratitude for the experience of having an eating disorder, and for recovering from it.

During the interview, when I asked how they knew they were recovered, the women described knowing that they were recovered when they realized that they were able to eat “normally.” They also realized they were recovered during certain moments, for example, as Sue said: “I knew I was recovered when really bad things happened and I didn’t get sick again.”

When they reflected on what their lives would be like if they had not recovered, their responses demonstrated their certainty of being recovered from an eating disorder. Without exception, all of the women voiced strong and definitive sentiments that they were recovered, and distress with the remembrance of the eating disorder. Casey described what it would be like not to be recovered:

To go back to the way I was? Where my world was very small, where it would keep getting smaller and smaller. I can’t imagine going back to not being recovered. And I don’t honestly know if anybody else in my life could actually live with me any longer. I see when I look back on it, I was unbearable, my life was so strict and I felt like I was a criminal. I had to do all this stuff but that was how I was coping at the time, so I don’t
honestly think I'd be here if I wasn't recovered. I don't know if I could go on for that many more years of an eating disorder, I can't imagine not being recovered.

In this study, all of the women described their recovery as being long and difficult. As Jane described:

It [recovery] was like this black pit with slippery sides with just enough little nooks and crannies where you could get a couple of footholds, and you'd start to climb and then the slippery slope. And then you'd go crashing down to the bottom again. And then you'd sit in a heap and stay for an hour, 2 hours, a day, a week, 3 weeks, 3 months, and then, Ok, time to pick yourself up again. And then you'd climb and find that little nook and that little crevice and that little handhold and maybe that time you'd be able to go a little bit further, and maybe you wouldn't! And you'd fall again. And then you'd get a little bit further.

Dorothy added:

It's [recovery] frustrating, because it does take a very, very long time. I mean there's no miracle cure and there is no one who can say that if you just do this and this, you will be well because life is going on while you're trying to recover and every time you think you're doing well, I mean life throws you a curve ball, and you're dealing with something you've never dealt with before.

The participants described their recovery experience as lengthy, extremely difficult, and an experience that required courage, persistence, and determination. All of the women echoed a sense of loneliness that encapsulated their recovery efforts, especially in the beginning. Despite the challenge of recovery, the women in this study viewed their experience as extremely worthwhile.

The participants had recovered and remain recovered, yet what does it mean to recover and to be recovered from an eating disorder? The findings that I offer represent several dimensions of description, each of which add a layer of understanding to the complexity of the recovery experience. I include these descriptions in order to provide as much interpretive insight as possible into the recovery experience. First, I describe the situated structures that
begin to reveal the complexities and the richness of the experience of recovery for each participant in this study. Then I illuminate the general structure of the recovery experience, which captures the commonalities of the experience across the 8 women who participated in this study; that is, what recovery was like and how it was lived through. I also describe the three essential themes of recovery in order to provide a different type of understanding by the distillation of the recovery experience into three essential themes that encapsulate the recovery experience for the women in this study. Finally, I reveal the existential quality of the recovery experience and being recovered as described by the four lived existentials of time, space, body, and relation because it offers a different way of knowing and understanding the life worlds of women as they recovered. I retained these ways of representing the findings because they deepen the level of description and understanding and are reflective of the complexities that the women shared as they described their experience of recovery and being recovered. To omit any of these elements would weaken and under represent the findings of this study.

*Situated Structures*

*Casey.* Recovery began with the realization that the eating disorder was taking up too much space, the decision to regain control, and a newness and unpredictability that enveloped recovery. Beginning to recover felt exciting and scary, and yet Casey knew that she no longer had the option of resorting to the eating disorder. The eating disorder was big, powerful, and overwhelming, and it offered a predictable routine that filled up available time and space. As she moved through recovery, the eating disorder took up less space and it became easier to be in the present. During early recovery, the experience of taking risks built self-confidence and positive energy to continue to make the effort to recover.
The eating disorder voice exerted effort towards sabotaging her recovery. It became louder and louder as her efforts grew stronger. It seemed as if nothing could penetrate the mindset of the eating disorder, which was like a fortress. It was most difficult when the voice attacked her worth as a person. It was extremely difficult not to believe it. There was a constant effort to challenge the voice along with the hope that it was wrong until she reached a place where the voice could be disregarded. The struggle was like two teams competing against each other with the eating disorder voice exerting greater and greater dominance especially when it was challenged. Courage and a constant faith in her strength to recover were required. As her voice developed and strengthened, the eating disorder voice faded. Daily journaling of the actions taken, the feelings evoked, and positive self-statements helped to encourage recovery because her accomplishments were brought into awareness when the journals were re-read.

As she recovered, she felt scared of continuing to feel lonely and isolated. She was anxious and acknowledged the distance from others. There was the intent to reconnect to others and a sense of awkwardness about how to do this. Regaining the trust and support of others and understanding how to be in relationship with others was a part of recovery.

Casey felt sadness when recovery began and control was being taken back. There was sadness about losing the familiarity of the eating disorder. There was confusion about the uncertainty of daily life without an eating disorder and doubts as to whether recovery was possible. At first she was angry with herself and the eating disorder, and then she experienced a fierce determination to regain control. After her feelings of regret, anger, and anxiety lessened, there was relief. The sense that a huge weight had been lifted off her shoulders, and a sense of accomplishment and freedom occurred. There was the realization that the eating disorder was gone and she had no intent to return.
The memory of the loneliness remains, and a sense of apartness, in the sense that nobody understands how difficult it was to recover. Casey felt sadness and regret when she reflected on how her body was abused, and at the impact of the harsh and cruel eating disorder voice on her self worth and quality of her daily life. Despite these difficult remembrances, the experience of having and overcoming an eating disorder was viewed as purposeful.

When the eating disorder was present, it was difficult to imagine not being in that space. Now being recovered, Casey is unable to imagine having an eating disorder. Recovery involved learning how to live differently. Now there is a sense of freedom and an expansion of possibilities. For example, Casey is open to fully experiencing emotions and to receiving others' support.

_Sue._ Recovery began when she decided to leave the outpatient program. She realized that she needed to take personal responsibility for her own recovery, and she knew that the health care field was not able to help. When she realized that she was sick and tired of having an eating disorder, and that it was not making sense, in that, she was not getting what she wanted, the decision to recover was a logical choice. She was angry because she was suffering and she was not getting what she wanted out of life. The eating disorder had become a ball and chain and something that was holding her back. This realization helped motivate her to recover.

Despite feeling alone, Sue believed in her decision to recover on her own. She remained committed to her recovery despite the challenges that ensued (e.g. losing weight, physical pain with eating and digestion). She knew that she needed to learn how to take care of herself. There was the knowledge that having an eating disorder was not good, but it was difficult to be different, to be someone without an eating disorder. Giving up the eating disorder was incredibly hard. Sue was helped by having a job because it provided her with another way to
define herself, other than a recovering anorexic. In the beginning, she avoided thinking about the change in her eating. She needed to trust that it would be all right. After 5 years her eating was normalized, she began to eat with more variety, and to view food as energy that enabled her to enjoy her new activities.

After the eating patterns were normalized, negative thought patterns, and tremendous anxiety along with sadness, loneliness, anger, and feelings of worthlessness were apparent. She knew that learning how to deal with her feelings directly became the next task of recovery. She experienced relief and a decrease in anxiety, and a growing self-awareness and confidence as she learned how to manage her emotions. The awareness of herself in relationships deepened as she realized that she often felt unworthy, fraudulent, afraid, and ashamed in relationships. Having others' support and their lack of judgment regarding her appearance were influential to her recovery. As she realized that she could be normal and that others viewed her as someone without an eating disorder, her confidence in her recovery grew.

Recovery was both a conscious and unconscious experience that was encapsulated within Sue's daily living. Change occurred in different ways. Recovery involved a series of steps (e.g., changing eating behaviours, challenging thought patterns, expressing and managing emotions), and a sense of knowing and trusting that recovery would happen despite not always knowing what the next step would be. Recovery was linked to her own experience of learning, accepting, and understanding, and fueled itself as her awareness and understanding deepened over time. Spiritual practices (e.g., tarot cards) began early in recovery, and provided a gentle outside source of guidance, meaning, and hope that she could get through the day.

Sue experienced sadness and regret because of what the eating disorder prevented her from experiencing. Although recovery was difficult and painful it was worthwhile. Seeing
others with eating disorders does not make her want to get sick now. She realized that she is no longer vulnerable. Being recovered, the eating disorder does not occupy her daily experience and she is able to simply live and be. It is shocking and almost unbelievable how different life was with the eating disorder. Being recovered means having friends, feeling free, making future plans, being able to enjoy one’s own company, and having a full life. Being recovered means freedom and feeling emotions. Life is more complete. There is an expanded awareness and gratitude for how life is lived being recovered.

Samantha. Recovery started with being enclosed in a room with nothing left. When Samantha had to be committed to the hospital (third hospitalization), she was angry and afraid. Yet when she was put into the bright blue room, she sensed that she was safe and that it was over. There was a window with a lot of light and blue everywhere and a sense of peacefulness and safety. She was left alone in the room. She sensed that there was still a chance that she could make it (recover) and not die. Despite the opportunity to purge (unlocked bathroom), she discovered that she was able to resist the powerful urge. Being able to resist throwing up the first meal in the hospital was the first step. She was able to continue to resist purging for the next 3 months that she was in the hospital.

This time Samantha really understood the risk of death that was there and that would worsen if the eating disorder continued. Being hospitalized made sense and receiving help was legitimate and acceptable. Her common sense returned when she gained weight. It made sense because the weight gain would make her feel and think better, avoid death, and be able to leave the hospital. Reality started to come back with weight gain, along with the desire to live.

After about 3 weeks in the hospital, Samantha sensed that she was going to be able to continue to gain the weight. When the first 10 pounds came back, she knew that she had to get
her life back. Her attitude towards food began to change and she began to view weight gain as energy gain. She did not want to continue to take the medications but attempts to assert her decision were unsuccessful. She sensed that others in the hospital did not respect her decision to stop taking her medication, and did not trust or believe in her resolve to recover.

During her hospitalization she connected with an older non-judgmental man who trusted her and was non-threatening. He was separate from the eating disorder and was able to support her recovery. Spending time with this friend helped to stimulate her desire to reconnect with the wider world.

Once Samantha sensed that the resolve to recover was there, she was impatient. However, her body did not allow her to regain the weight as quickly as she wanted to. Eating was extremely difficult because of the physical pain that she experienced. Despite these challenges, there was the determination to recover and the acceptance that the struggle was a part of her recovery.

Eventually there was a gradual shift in focus and energy towards thinking of other possibilities that did not involve eating and food. She felt insecure and unworthy as she made efforts to get back into the world. She slipped (purged once) when she took on too much at work and in her social life. She did not want to return to the eating disorder and so she refocused on her recovery and decreased her activities. She knew that she was recovered when she gained weight after a back injury and did not contemplate returning to eating disorder. Samantha met her current husband and she enjoyed her life again. She decided to take a course and obtained a job in a new area.

There is sadness about what her life was like with the eating disorder. It seems unbelievable to have lived with an eating disorder for so long. It is difficult for Samantha to
fully understand how she was able to recover. It is amazing that it was possible. Her determination and her strong will and discipline enabled her to recover. The experience of recovery instilled a sense of acceptance towards her self and others, and the ability to truly value her life. Being a mother provides a constant reminder of her accomplishment in being recovered. There is gratitude for being recovered. Being recovered means that she has regained her life, and it is full. There is freedom.

*Zoe.* Zoe realized that she did not want to be part of this craziness, the eating disorder, anymore. The eating disorder was all consuming and she wanted to get on with her life. She realized that what the hospital offered would not help her to recover. Recovery began with the decision to return to work. As she started to work there was less time available to binge and purge, and her sense of isolation and anxiety lessened. There was less space for the eating disorder. Recovery was slow and gradual and there were times of hopelessness in the first few years. But she kept moving. She wanted to keep everything moving.

One day as Zoe sat on her bedroom floor, she was aware that she would not be able to stand the misery of her marital relationship for the rest of her life. She felt as trapped in the relationship as she did in the eating disorder. She was uncertain about how her marriage would end, yet there was the awareness that this needed to happen in order to fully recover. After 2 years of working she met another man. She noticed that suddenly there was a sense of relaxation, peace, and oneness. When she realized that there was a future with this relationship she was able to fully recover.

Despite experiencing acute anxiety and depression after moving overseas, she did not resort to the eating disorder, instead she faced and endured her feelings. At first, she was unaware of the sadness that was there inside her. As her awareness increased and she was able
to face the sadness, it helped her to acknowledge and understand herself. This was very hard work and it was extremely difficult but it was much better than the eating disorder.

After 2 years overseas, Zoe returned and volunteered at a women’s center. She received training in self-esteem workshops and worked as a peer helper. Self-esteem meant learning how to accept and understand herself. She felt more at ease with herself.

Recovery did not involve a plan. There was a letting go and allowing of recovery to happen. Soon the eating disorder became something abhorrent and eventually it was not an option. One of the highlights of the recovery experience was when Zoe realized that she was free from the clutches of the oppressive presence of the eating disorder. She realized that she no longer had to accommodate a demon. She knew that she was recovered when she began to eat normally; without worry about whether she would gain weight.

Zoe felt sadness and regret about what she lost when she had the eating disorder. There is the sense sometimes that others’ do not really understand how extremely difficult it was to live with and then overcome an eating disorder. She imagines that she would not be alive today if she did not recover.

Being recovered feels like life is the way it should be. She feels grateful for being recovered. On the whole life is peaceful and simpler. When she had an eating disorder, life was like living in a cave. Now it feels like she is out in the daylight. Being recovered means being at peace with the present and positive about her future. Being recovered means freedom. There is a sense of possibility and a clear open vista ahead.

Vickie. Recovery began when Vickie’s father died. She realized that there were problems that needed to be taken care of that were not centered on her life. She realized that she
needed to take ownership for her recovery. There was no other choice. She did not want to have an eating disorder anymore.

Recovery was really hard work. Vickie had to learn to cope with daily life without an eating disorder. She decided to leave work and begin psychotherapy. It was difficult and uncomfortable in the beginning, because she needed to acknowledge and accept that she had emotional and psychological issues to deal with and it meant being vulnerable with someone else. With time she experienced a genuine and caring relationship with her therapist. When the therapist moved (after 4 years of therapy), she felt angry and abandoned and expressed these feelings directly to her therapist. This was a positive event. She realized that she was able to express her anger. She knew that her therapist had genuine faith in her recovery. After time, she felt more confident as she developed skills in identifying and expressing her emotions.

Vickie decided to move to a new house. Entering the new house felt completely liberating and there was a sense of positive energy and freedom. It was like stepping out of a tunnel into a new country with flowers and sunshine, like a new beginning. There were challenges in working through the impact that the eating disorder had on her reproductive health. Being able to adopt a child helped to lessen her sense of guilt and remorse about the impact of the eating disorder. She was accepted into a graduate program. It was both a challenging and an exciting time. She intended to rebuild her credibility in her work.

As she recovered, she was aware that she was lonely and she worked hard to learn how to make friends. She experienced validation and a positive sense of self worth within a new friendship. She wanted to help her friend without the expectation that she receive something in return. It was empowering. Being recovered, she noticed that it was easier and more meaningful to be with others.
As she recovered she gained a new perspective. She separated from the past and the people and places that were associated with her life when she was sick. Recovery was like shedding a mask, shedding the old life and becoming a new person who was no longer trapped.

Being recovered means there is freedom. Vickie regained a positive sense of credibility and worth. Being recovered means feeling good about her abilities and feeling confident, and having a good and a fulfilling life. She is able to be in relationships in a meaningful and positive way and no longer feels lonely. Now there is a sense of purpose and direction. She has coping skills for managing her emotions, and a deeper level of self-understanding.

*Jane.* Recovery began with Jane’s pregnancy, which brought relief from the eating disorder. During the pregnancy she experienced normal eating, and a connection with others. She realized that she missed these experiences. Her belief that recovery was possible grew. Being a parent provided her with additional motivation to be a healthy role model for her children. She made the decision to recover. The eating disorder became a nuisance that did not seem to go away.

Jane decided to begin a new career and to leave an unhealthy relationship. Reconnecting with her spiritual beliefs was a part of recovery as spiritual practices, music, and journaling were helpful in her recovery. Despite the great anxiety that she felt, she sensed that everything would be alright and that somehow she would get through her recovery.

Throughout recovery, Jane’s self-awareness and understanding deepened. She became aware of her feelings and developed ways to manage her emotions. She learned to identify her needs and to set limits, which was fundamental to her recovery. Her experience in relationships became more fulfilling and genuine. She became less judgmental and began to view herself differently, as a normal person.
Recovery was lengthy, difficult, and isolating and required discipline. Recovery was like being in a slippery black pit; a slippery slope with a couple of little footholds and crevices that she had to find. There would be a couple of steps up and then she would slip back down again. During Jane’s recovery, she created the image of water dripping on a stone; being persistent in a gentle way and knowing that over time water would wear away the stone. Recovery was a meaningful experience. Being recovered there is pride and a comfort with who she is and how she lives her life. There is freedom and a future of possibilities.

*Christine.* During a visit to the hospital emergency room, a medical professional recognized that Christine had an eating disorder. There was relief as she was sick and tired of falling through the cracks and pretending that she was all right. She went in and out of therapy. Therapy did not help her to be someone other than an anorexic, it encouraged her to stay in that role. Recovery was long and difficult. In the hospital, when a nurse recognized her beauty and encouraged her to take off her mask (i.e., remove her makeup), she experienced validation of her worth and beauty as a person. The memory remains of her friend who refused to leave her side when she was in a coma, despite the hopelessness of the health professionals who believed that she would not live.

Taking responsibility was essential to Christine’s recovery. As she gained self awareness, she began to take responsibility for her hurtful actions in her relationships (infidelity during her marriage). Through recovery, she learned about her self and she became aware of who she was through her experiences with others. As her self-respect grew, she wanted to stay well because it felt good. Initially it was difficult to feel good because it was a foreign feeling.
Christine decided to move away from her family, leave an abusive relationship, and to apply for university. Despite the lack of family support she made these changes. It was exciting and scary yet she knew that it was necessary.

Christine does not want to change the past despite how difficult and painful it was. There is gratitude for being recovered. Recovery meant that she realized her strengths, survived, and learned how to live her life in a different way. She learned to value her openness and honesty and to understand and accept her weaknesses. Journalling was helpful in being honest, gave her a sense of strength and purpose to her experience, and helped her to be who she is today.

Because she has recovered, having an eating disorder feels as if it was in a different lifetime and there is a sense of being a different person now. Being recovered she has a sense of pride and confidence in present and future challenges. There is a knowing that she can handle anything. Being recovered means there is openness, possibility, health, and being engaged in living. Being recovered means having a quality of life, not being preoccupied with weight or food, and enjoying one’s body.

Dorothy. Dorothy realized that she did not want to be sick anymore after 6 years of unsuccessful efforts to recover. She wanted to be able to give more as a parent. The eating disorder was like an albatross, something that prevented her from being the person she wanted to be. She sensed that there was more to life than having an eating disorder. She could not go on living like this as well as being a mother.

As she recovered, Dorothy’s awareness shifted from being robotic when she binged and purged, to a sense of discomfort with how her life was with an eating disorder. The eating disorder became something that was not wanted anymore. Her perspective changed in that she
began to have a sense of separateness from the eating disorder. Recovery was a long experience that was very difficult. She was overwhelmed with unfamiliar feelings and she required tremendous will power because the urge to purge was intense. It was like a battle. She used the strategy of distraction to avoid purging after a meal.

Dorothy learned how to be more independent in her decisions and she learned how to say no. She knew these changes were necessary to her recovery. She experienced a greater sense of control and purpose in her life in areas other than the eating disorder. She began a new career and a new friendship despite her tremendous anxiety.

Dorothy was amazed when she realized what she achieved in being recovered. She knows that she will not go back to the eating disorder. She found it difficult to imagine or remember what she was like when she had an eating disorder.

For Dorothy, being recovered means living normally, being free to eat, being social, and being involved in one’s life, and no longer holding a secret. When she had an eating disorder she was not able to interact with the outside world because she was too overwhelmed. Being recovered means that she is aware of the life that surrounds her, and there is a sense of peace and openness to other possibilities in thinking, doing, and in planning for the future.

General Structure of the Experience of Recovery from an Eating Disorder

The situated structures offer an understanding of the recovery experience and describe in detail each woman’s recovery experience; whereas, the general structure describes the commonalities of the experience of recovery and how it is lived through for all the women who were interviewed.

The decision to recover was made when the eating disorder felt like a ball and chain that was taking up too much space. There was the recognition of being sick and tired of being
sick and tired, and the sense that there was another way to live began to emerge. However, a
strong intent and resolve towards recovery was tempered with great fear, uncertainty, and
loneliness. Recovery was a long and difficult journey. There was an inner faith and trust that
one knew how to recover, despite the challenges. There also was an allowing of the experience
to happen as it needed to, and a tolerance of the uncertainty of recovery’s path.

A planful and disciplined attitude was taken towards eating and the restoration of
physical health. As eating became more normal, emotions arose that were unfamiliar and
overwhelming, but were faced and managed instead of being avoided or hidden. Confidence
and self-understanding grew as recovery proceeded and anxiety lessened. There was movement
out of a daze, towards the deepening of awareness of one self and others, to a sense of
connection and understanding. As the eating disorder receded, there was a coming to know
oneself and a connecting to others. The more inside one went, the more recovered one became.
There was a seeking of knowledge and honesty throughout, as well as learning the skills of
being in relationships. Risk taking continued in work settings and in relationships, and the
desire and possibility of living differently was strengthened.

Being recovered meant there were possibilities. Living was more open and fuller. There
was a sense of freedom and active participation in life and gratitude for the experience of
recovery. The experience was purposeful as one became stronger and living became more
meaningful. There was a sense of being able to handle anything. Not being recovered was
unimaginable and a certainty that one would not go back to the eating disorder took hold.

Themes of the Experience of Recovery from an Eating Disorder

The general structure describes both how recovery was lived through, and the actions
that the women engaged in that assisted in their recovery. From the general structure emerged
three essential themes that offer a deeper understanding, distillation, and description of the recovery experience. I supplement the themes with direct quotations.

The essential themes of recovery were related to experiencing an inner sense of confidence (knowingness and allowing what is needed to recover), discovering oneself (deepening awareness and discovery of oneself), and embracing action (deepening of being, discovering, and embracing life’s possibilities), and were connected to a deepening awareness in all of these levels.

*Knowingness and allowing what is needed to recover.* All of the women described a knowingness or an inner sense of confidence that emerged with recovery that was essential to their success in being able to recover. This was an awareness that every woman noticed and nurtured during their recovery. As Jane stated:

A knowingness that everything would be fine. So it’s the faith. So at times when I feel like I’m taking three steps backward instead of three steps forward and thinking, what is happening? I just had this momentary experience where I thought, OK, whatever happens I know that I can do it.

Knowingness emerged once the behaviours that were associated with the eating disorder had lessened and no longer required such a strong focus. There was a certain quality of attention required for the women to be aware of their urge to engage in eating disordered behaviours, and then the women noticed that their knowingness in recovery began to be experienced as Jane described:

And then you see the recovery part of that is accepting that, accepting that free falling is what needs to happen. Acknowledging that that is a way of putting a name to the feelings around the whole thing, and accepting that that’s my route that’s there, that I was not falling to my death. I was not. That something would have caught me, stopped me.
And Sue said:

I’m going to trust it because I don’t want to be sick anymore. I want to be normal. I don’t want to think about food 24 hours a day. And over the course of taking little steps it took care of itself. It just kind of went away.

Once a certain degree of success was experienced, then a different awareness was noticed and nurtured that was tied into a learning of who one was, and what one needed in order to live as desired. During the interviews, all of the women spoke at great length and with emotion of these spiritual experiences within their recovery, rather than what the experience of stopping the eating disorder behaviours and normalizing their eating entailed. For these women, the meaning of their recovery was located to a greater degree within what they learned and discovered about themselves and ways to live differently as the eating disorder left. All of the women mentioned journalling as helpful to their recovery in ways that acknowledged their efforts and kept them honest throughout their recovery. Other spiritual practices that the women used as they recovered included: Tarot cards, mediation, walking, yoga, dream analysis, imagery, and prayer. One of the participants, Jane, described an image that she created to assist her in her recovery:

The image I used was of water on a stone. It was an image from nature. And it’s not an over persistence. I took the image of water dripping on a stone and that could be anywhere, but the point is that over time the water wears away the stone [anorexia].

Finally, one of the women, Samantha, who had experienced numerous hospitalizations described what she felt during the last time she was hospitalized:

And I just had this strange feeling when I walked into the hospital and I was put in that room, it was a blue room that it was over. I don’t know, it was just, it was almost, you know how they say, a spiritual awakening? It was just like the weirdest feeling. I felt a feeling of safeness. After I felt safe, I think it was about 3 weeks, than I felt I think I’m going to be able to gain this weight slowly.
Spirituality was expressed through spiritual practices and during moments of peace and safety where a knowingness that everything would be all right and that recovery was possible was felt. Moreover, it encompassed trusting that what needed to happen was happening, without knowing on a conscious level, exactly what the next steps would be in the experience of recovery. The women felt that their experience was purposeful and worthwhile, and expressed gratitude for being recovered because they learned about themselves in the process, and how to live their life in a meaningful way.

**Deepening awareness and discovery of oneself.** All of the participants in this study described their recovery experience as deepening their awareness and understanding of themselves on many levels: interests, emotions, abilities, strengths, and weaknesses. For example, Vickie said: “I think recovery really means shedding the whole old life. Like shedding, taking off the mask that was horrible. It was like a face lift.” Another participant, Jane, described her experience as: “The drawing back of the eating disorder allowed me to experience who I was as a person,” and that there was “a willingness and a courage to work with who I was, to come to know who I was.”

There was a sense of possibility and an excitement that accompanied the experience of recovery as the eating disorder lessened and there was space for something else. There was not a strong sense of self described before the eating disorder, but rather a discovery of who one was other than the eating disorder that was constructed. As Sue said:

> It [recovery] was tied into my process and, yes, my feelings and my recovery. You know what? I think my recovery really tied into me learning about who I was, and getting to know me, and the more I got to know me, the more recovered I became.

> It was as if the eating disorder masked who they were, and as they recovered, they discovered their identities. None of the women spoke of their identity before they had the
eating disorder. When they mentioned the past, before their recovery began, it was always in reference to the eating disorder and how it defined who they were, how they were, and what they did. As they recovered, the women really worked to know who they were in a way that acknowledged their strengths and their weaknesses, and in a way that was holistic and respectful. As Zoe described: “I never knew who I was, it was always, I just had no sense of who I was. No sense of me and I became a person, and I had a voice, and I had opinions.”

*Deepening of being, discovering, and embracing life’s possibilities.* Underlying the experience of recovery were learning and discovery on the levels of *being* and *feeling.* The participants described learning how to feel as they recovered. As Dorothy described:

> You learn to feel, well, you just learn to feel. With eating disorders you don’t feel anything and as you become…while you’re recovering it’s almost like being a child, I mean you’re learning how to deal with anger, you’re learning how to deal with frustration, you’re learning how to deal with anxiety, all the feelings you’re learning how to feel them first and then you have to figure out what to do with them once they’re there.

Zoe described how she dealt with her emotions: “In recovery you’re just more aware and you have to deal with it [anxiety] differently. I faced it and went through it and came out the other side.”

All of the participants gave examples of taking risks in new areas as they recovered, which were connected to the discovery of their abilities, greater self confidence, and the subsequent possibilities in career, relationships, and living. As Vickie stated: “But being recovered, the more I think about it, I’m glad you’re asking me this, also means to move, not being a part of anybody or anything that was in my life at the time.” Despite feelings of fear associated with the risks they were taking, there was an excitement and a determination to follow through. As they embraced new possibilities in relationships, interests, and work, there was the realization of all that was possible for the present and the future. One participant
described how she felt when she moved into a new house. She made the decision to move and realized that where she lived contained memories of when she was sick, and that she needed to make a new environment for herself. Vickie said; “It was like I stepped into a new country. And visions of candlelight burning. It was like a new beginning. It was a big part of my recovery.” Zoe said:

It feels like being out in the sunlight as opposed to being in a cave. That’s the difference between night and day. Recovery was going out into the daylight and being in the normal world. It’s like a clear expanse without any fear or doom.

All of the women described the experience of opening and of freedom with recovery.

These descriptions make sense when they are compared with how the experience of eating disorders was described as “living in a cage” and “being trapped.”

**Summary: Themes of recovery.** The essential themes of recovery were related to experiencing knowingness, discovering oneself, and embracing action, and were connected to a deepening awareness and meaning in daily living. The participants developed a deepening awareness of and a coming to know themselves that was premised on acceptance and feelings of positive self worth. The women related to their experience as being purposeful and worthwhile, and expressed gratitude for being recovered, for what they learned about themselves, and how to live their life in a meaningful way.

**The Four Lived Existentials**

Intertwined within the experience of recovery, and in addition to its behavioral, psychological, and spiritual dimensions that make it what it is, are the experiential qualities of time, space, body, and relation. I used existential reflection (Van Manen, 2000; 2002), to further enrich the description of the women’s recovery experience by identifying how the women experienced body, time, space, and relationships in being recovered. There were
commonalties across the participants that existed across the existential ground of recovery as revealed in the lived existentials of body, time, space, and relation.

**Body.** Being recovered, the women spoke of having to see their body as it was without needing to alter it. There was the sense of re-inhabiting one’s body as self-awareness grew and as perspectives shifted towards being healthy. Jane described the enjoyment of her body and being able to laugh about the size and shape of her body as she shopped with her three daughters:

I remember shopping for bras with the girls, and um, I think one of them was in the booth with me, well, needless to say, I’m not, you know, heavily endowed but both the older girls have much um, more robust, but we they were just laughing hysterically with me trying on this teeny tiny bra...so it’s you know? There’s a level of comfort with my body.

This contrasts with how the body was experienced before recovery; with anxiety, discomfort, and shame, as Sue described: “Not being comfortable in my own body. Just feeling like there’s something deep at the core that’s wrong with me.” And being recovered:” I’m very comfortable in my body. Very comfortable in my body and very grounded.”

With recovery, the body was experienced with neutrality or enjoyment and appreciation. Vickie said: “You know I see myself in the mirror and you know I don’t freak out. It’s just like OK, Hi. It’s not significant at all. And I don’t, it’s not something I have to worry about.”

Women in this study described their enjoyment of the instrumentality of their body through exercise and, being recovered, the renewed energy that they felt in their body. As Casey described: “It [body] became not an object to be manipulated and tampered with, but it became something that I needed to work well for me, a goal that I wanted for me.” There was a reconnection with the physical body and an acceptance of what it is, as Christine described;
"The biggest thing is that I’m not exercising for weight control. I’m exercising because I love
the movement of my body, and I love the strength of my body, and I’m willing to appreciate
that I’ve got big thighs but they’re powerful."

**Time.** The experience of time became more and more conscious as one recovered. In the
beginning of their recovery, the experience of time was unbearably slow as the women battled
to resist the urge to binge and/or purge, and the option of escape through the eating disorder
being unavailable as a way to pass the time. As Casey described: “I mean for a long time
you’re counting days because you want to go a week without throwing up, you want to go 2
weeks, and there are slip backs.” Being sick was recalled as being in a place in which one was
unaware of time passing. As Zoe said: “There was no concept of time until you recover. There
is no time, you’re just in a trance.” In the beginning of the recovery experience, there was an
avoidance of orienting towards the future because the women wondered what is going to
happen. Is it going to get worse? Will I die? Will I be able to recover? What lay ahead was
uncertain, both with the eating disorder and when recovery began. As they became well, they
noticed that they were able to enjoy the present moment and to regard the future with a sense of
possibility and hope. Sue said; “I remember I started planning a future, like going back to
school, and I was like, wow! I’m planning for the future! I couldn’t do that when I was sick,
cuz all I thought about was food.”

**Space.** When the women were sick, they experienced their environments in an equally
limited way. As Dorothy stated:

It was almost a haze, it’s so hard to explain the haze that goes on when you’re very, the
haze, the unawareness, it’s just things are happening and you have no idea why, you’re
numb you don’t feel anything. You’re numb all the time. Um, you don’t even know
why you’re throwing up, you don’t know why you’re eating, and you don’t, you don’t
connect any feelings. There’s just nothing. The eating disorder can manage to take over
your whole body, your whole mind, and you don’t think or feel a thing. It’s just, you just do. You’re on like automatic pilot, you’re almost robotic.

For these women, there was the sense that the eating disorder took up all the space before they recovered. As Casey described: “It [the eating disorder] just got to be too big, it was something that was all consuming.” When they were sick, they felt trapped, as Samantha said:

My whole life when I had the eating disorder was just like that. It didn’t involve anything else other than not eating and exercising. You’re a sick person who’s become life is fun to like the kind of life I had. Stuck in a room. Enclosed with nothing left.

As they recovered, they perceived a greater openness and a lightness of being that remained, as Zoe indicated: “Being recovered feels liberating. It is extremely liberating. I guess in some sense I must have felt trapped before.”

Relation. Although all of the participants acknowledged an opening towards others and learning how to be with others, there were varying degrees of emphasis on the importance of supportive relationships in recovery. Three of the participants emphasized a relationship as being helpful and essential in validating a sense of positive self worth and belief that encouraged their recovery.

For the women in this study, relationships became possible as they recovered. There was loneliness attached to being sick and having to recover on one’s own, and as recovery unfolded there was the desire to reconnect and to begin new connections with others. The women emphasized supportive relationships to varying degrees as helpful to their recovery. However for all of the women who participated in this study, there was the intent to repair and to reconnect with others in a genuine healthy way. As Casey described:

I had lost most of my friends. I had lost the trust of my mum and dad, and a lot of other people, and it was trying to gain back their confidence or to actually participate in a
friendship was really hard because, I don’t know, maybe I had all the skills but I just had to try.

For all of the women, making new friendships and having intimate relationships was challenging. Christine described a helping relationship:

And she on purpose would give me hugs like physical contact. And it made my skin crawl, because the relationship that I had with my Mum was really abusive. And she would do it anyway. And at the end of each session, I would get ready for those cuz I knew that she was going to come at me, and, at first I really didn’t like it, but eventually I started to hug her back and feel more comfortable.

As recovery progressed the women’s efforts were successful and the quality of their relationships improved, which increased their self-confidence and self worth. Casey described her experience in a friendship:

When I went away for a weekend with my friend, I had a lot of fun and I think that’s where I built up another surge of self confidence, you know, that I could use. Cuz I really felt like more of myself. You know, I felt like I had regained a lot of what I had lost. I felt like my friendships, I could actually participate in conversations and the conversations weren’t just centered around me and the eating disorder, like I was able to talk about different things. I didn’t know how to do relationships with other people and now I feel that, you know, I’ve got a good handle on that. I’m a good friend and I can be there emotionally. I can be there if people need me.

All of the women expressed challenges in being with those who knew them when they were sick, because of others’ knowing about their eating disorder. For all of the women, there was a sense of anxiety, excitement, and freedom in making new connections and a sense of calm around not letting them know that they had had an eating disorder. As Sue described:

About 5 years ago, my eating started to normalize and I started spending time with someone I really cared about, and I wanted to be really well to be with him. And I didn’t want him to relate to me as just an anorexic. I wanted to be more than that.

In summary, collectively, the four lived existentials of body, time, space, and relation revealed changes as recovery unfolded. The eating disorder prevented them from experiencing these four dimensions in a conscious way, and as they recovered, their awareness deepened.
There was a sense of wonder and delight as their existence expanded and opened and their daily living became qualitatively better.

Summary of Findings

In summary, the findings of this study revealed that recovery is a complex, lengthy, difficult, and meaningful experience. The women in this study described their realization of the desire to recover and live differently, which they embraced despite years of having an eating disorder and trying to recover. The women expressed a strong sense of ownership and pride that was connected to the experience of recovery and to being recovered. The general structure of recovery encompassed both planful efforts and less tangible qualities that enabled the individual to address her physical, psychological, emotional, social, and spiritual dimensions of experience as she recovered. The experience of recovery involved a deepening awareness and learning within physical, psychological, emotional, spiritual, and relational spheres, and was lived in conscious and less conscious dimensions, which appeared to coincide with a deeper understanding of oneself, others, and meaning in daily living.
CHAPTER V: Discussion

The purpose of this study was to describe, in depth, the experiences of women who viewed themselves as being recovered from an eating disorder. This interpretive-phenomenological inquiry involved in-depth interviews with 8 women who had been recovered from an eating disorder for anywhere from 5 to 18 years. The findings of the present study describe how recovery is initiated and lived through, and expand our current understanding of recovery from an eating disorder. In this chapter, I discuss the findings relative to the existing literature on recovery, and I interpret the influence of the social context on the interpretive-phenomenological description of recovery as revealed in my findings. Finally, I discuss the limitations of this research and the implications for future research and practice in this area.

All of the women in the present study claimed that they were fully recovered. In contrast, previous qualitative studies described early recovery (typically after one year), as an ongoing process (Garrett, 1997) and eating disorders as a chronic condition (D’Abundo & Chally, 2004). In contrast, quantitative researchers have viewed physical recovery rates as both poor (Fichter et al., 2006; Steinhausen, 2002) and promising, with 75 to 90% achieving a full recovery (Johnson et al., 2003; Strober et al., 1997). However, previous research focused on early recovery or the physical aspects of recovery and did not capture personal experiences of recovery. A strength of the present study is that all of the women had been recovered for at least 5 years and were able to comprehensively describe their recovery experience. In addition, the sample was diverse in age, length of eating disorder, length of being recovered, and in eating disorder treatment backgrounds. Despite this diversity, a common structure to the recovery experience was revealed supporting a shared experience of recovery.
I begin this section of the discussion, with an interpretation of how the decision to recover as described in this study, relates to research that has examined motivational theory and readiness to change. Next, I discuss the findings relative to the literature that has described spirituality in recovery, and recovery in self-transformational terms. Finally, I discuss the societal and theoretical context within which the women were situated as it pertains to the interpretation of the recovery experience that I describe.

*The Realization and Decision to Recover*

When the women described their decision to recover, there was the sense of being *sick and tired of being sick and tired* and the realization that the eating disorder was no longer giving them what they wanted or needed, a sentiment echoed in other recovery studies (e.g., Lamoureux & Bottorff, 2005). However, in contrast to research that described a waxing and waning of the desire to recover, the agentic and steadfast attitude towards recovery revealed in the present study is a new finding.

All of the women had sought professional help and their physical health had been compromised to various degrees. Although there had been previous attempts to recover, there was a moment of realization that was highly personal that began their recovery experience. The emotions of being amazed and at peace, with a sense of determination and anger towards the eating disorder add a further existential quality and meaning to the decision to recover. Although there were brief one time slips described by two of the women in this study, there was the sense that they never looked back after the realization that they needed and wanted to recover. They expressed a knowingness and an inner sense of confidence that recovery would be realized, and the acknowledgement that recovery would require courage, patience, and determination.
The results of the present study offer a different perspective on the ambivalence to treatment that has been found in other studies (Geller & Drab, 1999). For the women in this study, ambivalence towards recovery was not an issue once the decision to recover was made. The women acknowledged that they had tried to recover prior to their decision; however, they described a qualitative difference and a sense of ownership for recovery that they did not have before. What appears to be important for full recovery is the woman's ability to come to the decision to recover on her own terms, a decision that concerned health professionals, parents, spouses, and friends may not view as appropriate.

*Therapeutic Change*

Despite the agentic and self motivated recovery that comprised the experiences of the women in this study, eating disorders remain a challenge to treat successfully. In the past, hospital treatment programs for eating disorders have demonstrated poor success rates and were recognized as being overly directive and restrictive (Eckert et al., 1995; Ratnasuriya et al., 1991). In response to these problems, clinicians and researchers have considered motivational theory and the transtheoretical model of change (Miller & Rollnick, 1991; Prochaska et al., 1992), and women who present for treatment have been assessed using motivational interviewing regarding their stage of change (i.e., precontemplation, contemplation, preparation, action, and maintenance), and corresponding cognitive interventions are implemented in order to facilitate change and reduce ambivalence (Geller & Drab, 1999; Treasure & Ward, 1997). The women in this study described being motivated to change when they realized that the eating disorder had become something that prevented them from living their life as they wanted. Furthermore, because they were sick, the women expressed anger at aspects of life they felt they were missing, which motivated their recovery efforts. The findings
of this study support the use of the motivational model in facilitating the awareness of the costs of the eating disorder, while simultaneously suggesting that women need to feel self determined and impassioned in motivating themselves towards their own recovery.

The strategies that the women in the present study reported they used to address and reduce their negative thinking patterns attributed to their eating disorder were, in cognitive-behavioural terms; cognitive restructuring and cognitive challenging strategies. These strategies are contained within CBT (Fairburn, 1995; Wilson & Fairburn, 1993). The women in this study described efforts to deal with the eating disordered behaviours initially, and then once the frequency of the behaviours diminished, being able to address their negative thinking patterns. As their negative thinking patterns diminished, they noticed their emotions resurfacing and were able to learn skills and experience the feelings rather than avoiding them as they did when they were sick. According to the women’s accounts of recovery; taking into account the length of the recovery experience, they behavioural changes were emphasized initially and took the shortest time to alter, followed by cognitive change and emotional management. These findings converge with research that demonstrated that behavioural change occurs before cognitive change for women who received hospital treatment for their eating disorder (e.g., Geller, Zaitsoff, & Srikameswaran, 2005), and support the cognitive-behavioural treatment model in the treatment of eating disorders in early recovery.

An Inner Sense of Knowingness in Recovery

The findings of this study expand our consideration of therapeutic change in recovery to the consideration of an inner sense of knowingness or self-confidence in supporting a successful recovery. The description of knowingness that was offered by the women extends our understanding of how an inner sense of self-confidence operates in the experience of
recovery and in being recovered from an eating disorder. The degree to which the women emphasized the role that their knowingness played in being able to cope with their recovery is a relatively new finding. The women described being aware that in addition to their strategies to recover (i.e., normalizing eating, challenging negative thinking patterns), they needed to be able to let go and trust the experience of recovery itself. The beginning of recovery was a frightening and exciting time because of the uncertainty of daily life and yet despite the fear, there was a determination to proceed and a sense of empowerment and ownership for recovery that increased as time went by. Thus, in addition to feeling empowered and able to recover using a strategic approach, the women described a knowingness or inner sense of confidence, and they needed to allow recovery to happen without being fully in control or in full awareness of the next steps.

Although the women described a deliberate and conscious approach to recovery and a sense of achievement in being recovered, there was also a less conscious, experiential quality to the experience from which additional meaning was derived. The women experienced qualitative differences in daily living that they remained grateful for some years after being recovered. The women recalled with amazement, gratitude, joy, and peace specific examples of knowing that they were recovered and a knowingness that it would be all right--having confidence in the recovery itself. These spiritual moments remained essential and a meaningful aspect of their recovery.

The findings of this study offer a different perspective of spirituality for women who recover from an eating disorder. Garrett (1997) conceptualized recovery as involving rituals of self transformation and the physical practices of meditation, yoga, gardening, and exercise that deepened awareness and sustained recovery. Recovery involved active embodiment through
physical practices in order to recapture the bodily self that the eating disorder had denied. In contrast, in the present study, spirituality was described as having a sense of inner confidence or knowingness in their ability to recover, and confidence in the world that surrounded them, in the sense that everything would be all right, and a knowingness that there was a greater guidance and support, rather than recovery as being a specific ritual towards a reconstruction of the self. The women expressed this spiritual quality as moments of peace that they felt in a bodily sense, during their practices and with others. The findings of the present study were similar to Garrett’s (1997), in that, the women described practices such as yoga, tarot cards, and meditation during their recovery. However, they used these practices for the purpose of anxiety reduction and/or connecting with themselves, and not in the ritualistic sense Garrett described. In the present study, the description of knowingness within the experience itself and how it operates in the recovery experience and in being recovered offer a deeper understanding of the meaning of spirituality for women with eating disorders and extends our understanding of this complex term.

**Self Transformation**

In addition to a deepening awareness and appreciation of their sense of inner knowingness, the women in this study described experiencing a deeper understanding and appreciation of themselves as they recovered. Bruch (1998) described recovery from anorexia as the need to discover or rediscover a lost or inadequately experienced self, and to experience a unified self and body. Other qualitative studies have described recovery as a redefining and transformation of the self (Lamoureux & Bottorff, 2005; Maine, 1985; O’Byrne, 1990), which suggested that there was a self that was reclaimed during recovery. In a recent study, a self-development model of recovery was described in which self awareness, self differentiation, and
self regulation were processes that occurred as women recovered (Weaver et al., 2005). The findings of the present study are similar in that one of the essential themes of the recovery experience was the discovery of themselves as a person without an eating disorder, which became more evident as the women recovered and were able to consider themselves in a different way. However, the women in this study described a discovery of themselves, rather than a reclaiming of who they were which differs from other descriptions that have been offered.

The participants in this study described their experience as transformational and one that required courage and spirituality, a finding that converges with meta-analytic research of the chronic illness experience (Thorne et al., 2002). Moreover, in a recent phenomenological study of men who had recovered from a cardiovascular problem (stroke), restoration of the self was described as an essential dimension of their recovery experience (Roman, 2006). Within the nursing sciences, Morse (1997) developed a model after reviewing the medical and nursing literature on theories of illness, with the purpose of extending the illness trajectory towards an improved understanding of recovery. Recovery and rehabilitation from acute or chronic illness was defined within a five-stage model: responding to threats to integrity of self, which was self transformational in nature. Taken together, this area of research suggests that there may be some similarities and differences for chronic illness and eating disorders in the tasks of self transformation in recovery. For example, it is likely that there are similarities in the meaning attached to the reconciliation of one’s identity before being sick with who one is now having had an illness. And yet the women in this study viewed themselves as fully recovered, and described the discovery of their self as being a person without an eating disorder, whereas
individuals with chronic illness likely manage their sense of self within a shifting process of illness being in and out of the foreground of their experiences (Paterson, 2001).

Although I did not focus my interviews on the women’s eating disorder per se, invariably the women spoke about when they were sick. When they spoke of themselves before recovery, they described how the eating disorder took over their daily lives and there were no references to a self, rather, they spoke of the eating disorder as the thing that was in control and made all of the decisions in daily living. Then, as they recovered, they began to rediscover the hidden aspects of themselves. This experience converges with a recent study by Maisel, Epston, and Borden (2004), who interviewed 39 women (ages ranged from 14 to 45 years) who were hospitalized with eating disorders. The results suggested that women with eating disorders constructed themselves in a multitude of ways other than as a patient, despite their caregivers conceptualizations of them as eating disorder patients. As they recovered, the women in the present study also described how they learned about themselves and who they were and developed their interests, work, relationships, and future possibilities in living, an experience that supports the development of multiple identities in women (Gilligan, 1982; Jones, 1997).

All of the women in the present study described experiences of learning how to feel their feelings. This is consistent with the development of emotional management skills Weaver et al. (2005) described as being an aspect of self-care in their grounded theory study of women who were recovering from anorexia nervosa. However, the findings of the present study offer additional temporal and existential detail in how women may begin to notice and develop emotional management skills during their recovery. The women described a resurfacing of their emotions as they normalized their eating and began to quiet the negative eating disorder voice,
and a readiness to face their emotions and live through them rather than avoiding them as they gained skills in emotional management.

Societal and Theoretical Discourse and Recovery

Although the findings of the present study emphasize the individual's meaning making experience, I acknowledge the influence of the social context within which these 8 women were situated. Discourse is represented in the language and the practices that are used to define, manage, and limit the explanation of eating disorders and recovery (Brooks et al., 1998; Burns, 2004; Hepworth, 1994, 1999; Malson, Finn, Treasure, Clarke, & Anderson, 2004), and thereby reflect the way the problem is generally understood in our society. Therefore, in order to consider the context within which the understanding of the experience of recovery is situated, I discuss the social and theoretical discourses on eating disorders and recovery as they pertain to the findings of this study.

Recovery as weight gain. Some research has revealed that health care professionals working in the area define the problem of eating disorders as a problem of weight loss (Hepworth, 1999). The findings of the present study indicated that weight gain was an aspect of their description of recovery, which some of the women mentioned regarding the early aspect of the recovery experience; however, weight gain was not a dominant way that the women described their recovery experience. Rather, the experience of gaining weight was confined to the descriptions of hospitalizations and early treatment and recovery if applicable, and was situated within the efforts that were utilized to stop the eating disorder behaviours. The language used to describe their efforts to reduce and to stop the behaviours that were associated with the eating disorder reflected a disciplined and planful approach to this aspect of physical recovery, in particular, the CBT approach to recovery that is communicated by clinicians and in
self help books for recovery (e.g., Fairburn, 1995; Roth, 1989). The discourse of eating disorders as a problem of weight was present in all accounts of recovery, especially in the beginning, however, in light of the other factors mentioned in recovery, the problem of weight becomes insignificant in relation to the other tasks of recovery. All of the women described strategies that reflected a discourse of using the power of positive thinking and behaviour modification to solve the problem of eating disorders (e.g., Fairburn, 1995), however, this represented one aspect of their experience that was described in matter of fact common sense terms by the participants.

Eating disorders as an illness. The discourse of eating disorders as an illness and an addiction (Brooks et al., 1998; Brumberg, 1988; Hepworth, 1999) was present in the women’s descriptions of being “sick” and all of the women had sought and received professional help for their eating disorder. When I asked women to comment on how they knew they were recovered, all of the women reflected on whether a full recovery was possible, a statement that reflects the addiction discourse of eating disorders. All of the women defined their recovery in medical terms; weight gain, normal eating, absence of bingeing, purging, and/or compensatory behaviours, and a healthy and realistic body image, and expressed that they were fully recovered, but not without questioning their own recovery. This questioning reflects the strength of the discourse of eating disorders as an addiction that is present in our society (Gold et al., 2003). Constructing themselves as recovered from an eating disorder is an example of women resisting the dominant discourse that constructs eating disorders as an addiction (Cosgrove, 2000).

Individual will power and mastery. The societal ideologies of individual will power and mastery (Beating the Odds, 2001; Brooks et al., 1998; Roth, 1989) were partially represented in
the description of recovery that the women in the present study offered to describe their efforts to recover. Women used the language of *overcoming* the urge to binge and/or purge and the term *will power* and *battling* the eating disorder in their descriptions of the decision to recover, as well as their initial efforts to reduce the eating disorder behaviours. For example, Christine said:

Yeah, my will. I must have had a strong will to get to 58 pounds, very disciplined, so my determination. And so a lot of it was through my own, I’ll call it willpower.

The discourse of the individual overcoming the problem was present in the descriptions of early recovery, however as the eating disorder behaviours receded, the women constructed a contrasting discourse in their experience of having a sense of knowingness in being able to recover and a realization that an essential part of recovery was allowing it to happen without always consciously exerting effort to do so. In addition to the language of *overcoming* and *battling* the eating disorder, there was the language of *knowing* in a felt experiential sense and an *allowing* of things to unfold, which is an alternative discourse to that of individual will power and mastery over a problem. For instance, as the women continued to reflect upon and describe their experience, they began to use language that implied a letting go of control and allowing recovery to happen as it needed to happen, without knowing exactly how it would continue to unfold, rather than mastery over a problem. Their language suggested a strong spiritual component to their experience that was needed to fully recover.

*Being a victim versus being in control.* The women described a paradoxical relationship that alternated between being a victim and being in control when they had an eating disorder and before they decided to recover, which echoes the literature (Serpell et al., 1999; Serpell & Treasure, 2002), and the societal discourse of eating disorders (Brooks et al., 1998; Hepworth, 1994, 1998; Malson et al., 2004). Women, such as Zoe, described being recovered as feeling in
control with “nothing standing behind lurking, and being free from the clutches of the eating disorder” and “no longer having to accommodate a demon.”

Once their recovery began, they described themselves and their experience in active terms. All of the women described the physical aspect of their recovery experience in active language and with a conscious approach to normalizing eating and reducing their eating disordered behaviors and some women talked of dealing with it or overcoming it (e.g., Brooks et al., 1998). The language that all of the women in the present study used suggested that these women claimed ownership for their decision to recover and for their recovery. All of the participants constituted their recovery as needing to assume responsibility, as Sue said: “I do remember that time that I forced myself to really make a change. I knew at that point that it had to come from me.” This contrasts with the discourse reflecting the women as a victim of an illness or addiction that requires professional help (Brooks et al., 1998; Hepworth, 1994, 1998; Malson et al., 2004) and portrays an agentic approach to recovery.

All of the women identified a decision within, often made after years of trying to recover. Casey described: “needing to take control away from the eating disorder and having to make themselves believe that they could do it [recover].” This likely reflects a discourse of overcoming adversity in a situation in which recovery is considered to be against all odds (Beating the Odds, 2001). The participants constructed their efforts to challenge the eating disorder behaviours and thinking patterns as a taking away control from the eating disorder and overcoming the urge to binge and/or purge and the negative mind set), which suggests that women constructed their experiences through viewing power and control as important in early recovery.
All of the women described their experience as purposeful and meaningful. They viewed the experience as making them a better, stronger, and more determined person, which reflects a discourse of benefiting from adversity (Bonanno, Papa, & O’Neill, 2001). The women all assumed a strong sense of personal responsibility for recovery and a strong sense of pride in being recovered. These overwhelmingly positive views of being recovered likely exist for both phenomenological or individual meanings and societal reasons; a focus on the self is also a dominant Western discourse.

Summary. The societal and theoretical discourses of illness, addiction, treatment, and recovery narratives were represented in the women’s accounts of recovery, and partially shaped women’s experiences and understanding of their early recovery experience and the ways in which they challenged the behaviours and thinking patterns that were associated with the eating disorder. However, an examination of the women’s language of recovery revealed that the women constructed themselves as being fully recovered and assumed responsibility for their recovery, which challenges the medical and societal discourse of eating disorders as an addiction, and a physical and mental disease that requires expert professional help. The women in the present study’s talk, partially reflected the dominant discourse of eating disorders and recovery, but also revealed additional meanings and experiences that supported a full recovery.

Limitations

The limitations of the present study can be clarified by understanding what interpretive-phenomenological findings contribute to our understanding of recovery. The purpose of interpretive-phenomenology is to “uncover shared practices and common meanings of lived experiences” (Gullickson, 1993, p. 1390), not to provide theoretical abstraction, solutions, causal relationships, or a basis for later empirical analysis. Because phenomenological
questions are always questions of meaning, they necessarily remain “open and anticipatory” because a “final complete interpretation” can never be realized (Schwandt, 1997, p. 115). Therefore, the findings of the present study are limited to the lives of the 8 women and to the extent that they were able to provide descriptions of their experience, as well as the extent to which I was able to engage in interpretive phenomenological analysis and writing. Nonetheless, the findings provide a description of the structure and the meaning of recovery from an eating disorder based on shared understandings that inform our research and practice. Finally, the experiential and existential description of recovery is limited by the discursive medium or text through which it is expressed, and thus the degree of understanding of the experience is at issue (Altheide & Johnson, 1994).

**Implications for Research and Practice**

The description of a general structure, essential themes, and existential quality of the experience of recovery facilitates accessibility to what recovery entails and the lived experience of recovery for researchers, clinicians, and individuals with eating disorders. It provides an understanding of the recovery experiences from the everyday, lived experiences of individuals who are actively engaged in recovery. I consider findings from phenomenological research to be a stimulus rather than a tool for theory exploration and development, and a guide for fostering empathy and understanding for effective therapeutic counselling practice. In knowing what the experience entails, future researchers and practitioners can build theory and identify strategies that facilitate and enhance psychological recovery. Because counselling psychologists typically help individuals who are not hospitalized, and with the increasing emphasis on outpatient care to deal with eating disorders, how individuals recover is of practical interest (Kashubeck-West & Mintz, 2001). The findings are a source of hope for those
women who are in the early aspects of recovery. Future studies would benefit from interviewing women with shorter and longer recovery periods at several points in time in order to increase our understanding of how these changes occur over time and in more detail.

My research contributes to the current state of knowledge and increases our understanding of the complex phenomenon of recovery in that it takes into consideration the physical, psychological, emotional, spiritual, and socio-cultural aspects of the problem and supports a multi-determined model of recovery (Jarman & Walsh, 1999). This interpretive-phenomenological inquiry reveals that recovery is multifaceted and that themes of knowingness, discovery, experiencing, and deepening awareness are avenues that could be further explored and developed in research and practice. The findings of this study support the changes in recovery that begin with challenging the physical and cognitive symptoms of the eating disorder, and extend the avenues for future research that considers the development of learning the alternative ways of being that the eating disorder had prevented. Research methodologies that explore and describe the experiential and non-verbal aspects of recovery would offer a more complete description and understanding of the multiple possibilities for change.

The EPP method (Karlsson, 1993) enabled the exploration of recovery in terms other than the medical and other explanatory models in order to describe what the experience is like. The findings suggest that, in our practice, we need to explore additional ways to empower women towards their own ways of recovery. In addition to the concepts of motivational interviewing and CBT strategies, narrative approaches (Maisel, Epston, & Borden, 2004; White, 1989; White & Epston, 1989) and expressive therapies (Dokter, 1995) are likely to be
useful in recovery and assist us to understand the client’s world; a significant part of the therapeutic process.

For instance, as the women in this study described their recovery experience, they began to use the language of externalization (White, 1989), and talked about “the eating disorder” rather than “my eating disorder.” The women described how the eating disorder takes over; thus, the externalization technique can assist in creating distance from the eating disorder and a new perspective. It is likely that providing stories of recovery and co-creating alternative stories about one self that provide examples of resistance and overcoming the eating disorder and being in a different place are ways to empower women towards recovery.

In addition to CBT approaches to recovery, experiential interventions that encourage the discourse of individual agency and empower women towards a personal responsibility for their recovery may facilitate motivation and change. The women indicated that self reflection was essential to their recovery and is a promising area for future therapeutic and research endeavors. The findings also revealed that the way the women talked about recovery reflected the dominant discourse of individual agency and willpower, which fuelled their early recovery efforts. In addition, their talk revealed alternative discourses that reflected the spiritual qualities of being and knowing, which were associated with full recovery.

Because the findings describe a deepening of awareness across dimensions; nonverbal interventions that encourage reflection and increased awareness (i.e., journaling, yoga, art, dance), and interventions that encourage the development of a spiritual quality in daily life (e.g., Johnston, 1996; Lelwica, 1999) may be important ways to encourage recovery. Moreover, interventions that are holistic and aimed at the consideration of one’s daily living, meaning, and
self concept, in addition to the more rational forms of treatment may be useful in facilitating recovery.

Conclusion

The findings of this interpretive-phenomenological study offer a rich and insightful description of recovery from an eating disorder that deepens our understanding of what recovery is and how it is lived through. There are implications for theory; how we facilitate change, and how the self is altered and experienced in recovery. Research implications have to do with how we explore and quantify change in recovery and practice; our treatment expectations and goals, and the type of interventions that we offer. The findings encourage researchers and clinicians to consider physical, cognitive, behavioural, emotional, spiritual, and experiential dimensions of change that occur over the length of the recovery experience.

The findings of the present study revealed a shared sense of meaning in the experience of recovery from an eating disorder, and offers hope for long-term recovery. All of the women had sought professional help for their eating disorder, yet they acknowledged that they were not completely committed to their own recovery at that time, and that aspects of the professional help they experienced were detrimental to their well being. The recovery experiences of these women remind us of the importance of joining women as they resist and separate from the eating disorder, and challenge us to conceptualize recovery in multidimensional terms.
References


Appendix B: Telephone Screening

The following script was used at the initial contact with a potential participant.

Thank you for inquiring about the research study on the experience of recovery from an eating disorder. My name is Georgina Maltby and I am a doctoral student in the Department of Counselling Psychology at the University of British Columbia. Dr. Bonnie Long, a Professor in the department, supervises this research project.

In this study I am exploring women's accounts of their experience of recovery from an eating disorder, in order to increase our understanding of what it means to be recovered from an eating disorder.

I'd like to start by asking you a few questions about your eating disorder and recovery in order to make sure that you meet the criteria that have been set out for this study. All of the answers will be kept strictly confidential. Please feel free to ask me any questions that come up for you as we talk.

Could you please describe to me what the symptoms and behaviours of your eating disorder were? Approximately how long did they last?
Restrict/Fast _____ Duration _____
Binge eat _____ Duration _____
Purge:
Laxatives _____ Duration _____ Diuretics _____ Duration _____
Exercise _____ Duration _____ Self-induced vomiting _____ Duration _____

From the time that you realized that you had an eating disorder, to the time that you were recovered, how long did your eating disorder last?

How long have you considered yourself as being recovered from your eating disorder?

If the participant does not qualify for the study (i.e., not recovered for 5 years) I will explain why and thank her for her interest. If the participant qualifies for the study (being recovered from an eating disorder for a minimum of 5 years), then the following information will be shared.

Based on these questions you are eligible to participate in this study. If you decide to take part, I'd like to give you an idea about what you can expect. As a volunteer, you will be asked to participate one to two interviews of 1 to 2 hours duration during which I will ask you to describe your recovery experience.

The interviews will be audio taped and transcribed. The only individuals who will have access to the tapes will be the investigator and the transcriber. You will have the opportunity to review a summary of the interview transcript, as your reaction to the data is a valuable part of the study. (Confidentiality will be maintained by omitting all names from the transcription of...
the tapes). For identification purposes we will use a pseudonym of your choice. Your participation is completely voluntary, and you may withdraw from the study at any time.

If the individual is interested in participating in the study then a date and time will be arranged for the first interview. Additional contact information will be collected (i.e., fax, phone number, email) for communication purposes.
Appendix C: Interview Guide

Prior to beginning the interview, the participant read the consent form and signed the consent form indicating their willingness to participate. Then I shared the following statements.

Thank you for your interest in this research. Please take the time now to carefully read this consent form. If you have any questions about participating in this research please do not hesitate to ask. Again your participation is completely voluntary and you can choose to withdraw from this study at any time.

Thank you for your participation in this study. The purpose of this interview is for you to describe your experiences of recovering from an eating disorder. I am interested hearing about all aspects of your experience, in order to help make sense of what it means to be recovered from an eating disorder. I would like you to describe your experiences in as much detail and for you to tell me as much as possible, in order for me to be able to try to fully understand your experience. Throughout the interview I will ask questions as needed to encourage you to explore and describe your experiences as fully as possible. The interviews will be tape recorded and transcribed by a professional transcriber or myself.

I will begin the interview with the following statement to invite the participant to begin to reflect on their experience of recovery:

Take some time now to reflect on your recovery experience. As you reflect on your recovery experience, begin to describe how it began for you.

The following questions will be used where needed to expand on and clarify the participant’s experience:

What was recovery like for you?

What were some of the highlights of your recovery experience?

How did you know that you were recovered?

What is your life like now without an eating disorder?

How would you describe how it is for you now, being recovered?

How is it different from when you had an eating disorder? Describe what it is like not to be recovered.

The following are additional questions or prompts to be used as needed throughout the interview to encourage further description and elaboration by the participant:

What was it like?
Can you describe how you felt during this time?
Can you describe what you thought during this time?
Can you give me an example?
How did you become aware of it?
How did it feel when __________?
What did it mean when __________?
How did you feel about __________
Could you tell me more about __________
You mentioned __________. Could you say more about that?
What do you mean by __________.

At the end of the interview I will ask the participant if at this time there is anything more that they would like to add?

Thank you again for your willingness to share your experiences with me. Your contribution to this research is valuable and will deepen our understanding of what recovery is like.

Now I would like to ask you several demographic questions for my records. All of the answers will be kept strictly confidential.

What is your birth date? (yr/m/d): __________
Are you single, married, or in a relationship? Married____ Living with partner____ Common-law____ Never married____ Divorced____ Separated____
Do you have any children? Yes____ No____
If yes, how many children do you have? ______ How old are your children? __________
What would you consider to be your cultural background (i.e., Canadian, European, Asian, etc.)? __________
What is your country of birth? __________
Are you employed at this time? Yes____ No____
If yes, what kind of work do you do? __________

Now I would like to ask you a few questions about your eating disorder. All of the information will be kept strictly confidential.

Did you ever receive a formal diagnosis of your eating disorder? If yes, what were you diagnosed with? When did you receive this diagnosis?
What, if any kind of treatment or counselling did you receive for your eating disorder?

Thank you for your time and your valuable comments about your experience of recovery. Once I have finished the initial analysis of the interview, I will contact you to arrange a time for us to meet. At this second meeting I will share the results of my initial analysis of the first interview and ask for your feedback as to whether the description makes sense to you. I will also ask you to clarify and/or expand on things that I may not be entirely sure about.
INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Title of Project: The Experience of Recovery from an Eating Disorder

This research is being conducted by Georgina Maltby a Ph.D. student in Counselling Psychology at the University of British Columbia, under the supervision of Dr. Bonnie Long in the Department of Education, Counselling Psychology, and Special Education at the University of British Columbia. The purpose of this study is to extend our understanding about recovery from an eating disorder. The findings of this study will provide information to individuals with eating disorders and professionals and a better understanding of the needs of individuals with eating disorders.

Volunteers who decide to participate in this research project are asked to participate in one interview of approximately 2 hours duration. The aim of the interview is to encourage the description of the recovery experience in as much depth as possible. The interviewer (Georgina Maltby) will ask questions about the experience of recovery. The interviews will be audio taped and transcribed. There will be an opportunity for participants to review and provide their reaction to the summary of the interview.

Any information resulting from this research study will be kept strictly confidential. The only individuals that will have access to the tapes will be the investigator and the transcriber. All documents will be identified only by code number and kept in a locked filing cabinet or stored under password on a hard drive. Participants will not be identified by name in any reports of the completed study. Confidentiality will be maintained by omitting all names from the transcription of tapes and using a pseudonym, and blanking out other identifying material.

Informed Consent:

This is to certify that I __________________________ agree to voluntarily participate in this investigation on recovery and eating disorders. I understand that I do not have to participate and that I am free to withdraw my consent and may terminate my participation at any time. This would not jeopardize my opportunity to participate in any other programs sponsored by the University of British Columbia. I have had a chance to ask any questions I want about this research project, and may do so at any time during my participation in this project. I acknowledge receipt of a copy of this consent form.

If I have any concerns about my rights or treatment as a research participant, I may contact Dr. Richard Spratley, Director of the UBC Office of Research Services and Administration, at 822-8598.

Participant’s Signature Date

Witness Signature Date
Appendix E: Example of Meaning Unit Transformation

The following are examples of meaning units (MUs): direct excerpts from the interview text where I interpreted that there was a shift in meaning, followed by the transformed MUs (in italics), which represented further interpretation of the text. In these examples, the meaning units are numbered according to the order that they appeared in the interview text. After I transformed the individual meaning units for each of the 8 interview texts, I shifted, omitted, and rearranged the individual meaning units into related sections. After further reflection, writing, and rewriting I developed a situated structure for each participant. In the following examples “S” stands for the participant. The excerpts that I provide here preceded the final situated structure that I developed based on the interview texts of Casey and Sue.

The entire interpretive process was hermeneutical in the sense that I circled and recircled through the interviews, meaning units, transformed meaning units, and situated structures over a period of years. I condensed the meaning unit transformations further and further and utilized an empathic and interpretive understanding in concert with my assumptions and my knowledge base that deepened and enriched the description of the experience of recovery.

The situated structures of the first interview texts were lengthier. As I became more familiar with the EPP method and the phenomenon of recovery, the situated structures became shorter and the essential structure and themes of the recovery experience emerged. Before I wrote the general structure and themes of recovery, I reflected on my understanding and re-read and re-circled among the interview texts and the situated structures.

Following are examples of meaning unit transformations and subsequent excerpts from the analysis that developed the situated structure based on the interview with Casey.

MU2 Umm it (the eating disorder) just got to be, um, in my life it got to be too big, it was something that um it was just sort of all consuming.

Excerpt from the development of the situated structure: S. realized that the beginning of her recovery was influenced by the consuming nature and the space of the eating disorder and she began to perceive the eating disorder being as too big in her daily life.

MU3 and I had to just take control over that again.

Excerpt from the development of the situated structure: Recovery began with the realization that the eating disorder was taking up too much space. There was the decision to regain control.

Following are examples of meaning unit transformations and subsequent excerpts from the analysis that developed the initial situated structure based on the interview with Sue.

MU29. And um I ended up going back to an old landlord that I’d lived with before I was sick and I ended up getting an apartment and I just moved out and I was terrified and I remember thinking I’m not going make it but I thought no no one’s telling me that I can’t make it. And so I moved out of X, lost some weight, um, again, and my Mum was again panicked.
Excerpt from the development of the situated structure: S. began to gain a sense of responsibility for recovery and persisted with her approach despite feeling terrified.

MU33. I was just sick and tired of the whole health field because I felt like they were keeping me sick (Ok), with what had happened at X, with the fact that a lot of the girls that I knew were going back to the hospital or being shipped down south, I had people tell me that I would never get better, and I was just sick of it and I thought this was like I felt like it was an industry. And they told you that you could never get better so you would keep going to get help so that you kept putting money in their pockets that’s what I felt. And I just thought forget it.

Excerpt from the development of the situated structure: S. became sick and tired of the health care field and the lack of hope about recovery that she perceived and decided that she would try to do it on her own. S. realized that the health care field would not be there for her and that they wouldn’t be able to help. She was alone and needed to do it her self.

MU40. And even though I got out of X and lost some weight again I think that stuck with me even though it wasn’t. I didn’t have the power to really act on that. The seed was planted (Right), and I knew that if I didn’t get my shit together I was going to be having to be living in a group home for the rest of my life and I didn’t want to do that.

Excerpt from the development of the situated structure: S. remained committed to her own recovery despite the challenges that ensued. For example when she lost weight after leaving the outpatient program she knew that she needed to take responsibility for her recovery and that returning to the system wasn’t an option.