RECOVERY FROM ANOREXIA NERVOSA:
"BECOMING THE REAL ME"

by

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Abstract

Over 100,000 females in Canada are estimated to be affected with anorexia nervosa. Anorexia nervosa is a serious and persistent mental health disorder that has the highest mortality risk of any other psychiatric illness. Research into recovery from anorexia nervosa has been limited to the medical aspects of the illness with minimal attention to the actual process of recovery. The purpose of this study was to capture the patient’s perspective of recovery from anorexia nervosa and to generate a theory that explains the recovery process.

This grounded theory study generated a contextually-grounded description of the main theme of recovery from anorexia nervosa, *Becoming the Real Me*. Through the use of purposive and theoretical sampling, data was collected from nine women in open-ended interviews that were audio-taped. Analysis of these data revealed a five-stage process of recovery that did not occur in a linear step-by-step progression. Rather, the women moved in a back and forth struggle across the stages that required “a lot of hard work” and were often involved in more than one stage at any one time. Recovery, for these women, required *becoming the real me*, which was characterized by a complex, five-stage process: (1) Catching glimpses of light: Seeing the dangers; (2) Inching out of darkness: Encountering support and learning to trust; (3) Tolerating exposure: Taking control; (4) Gaining perspective in new light: Changing the mind set; and (5) Shedding light on self: Discovering self as “good enough.”

The theory generated in this study contributes to an understanding of recovery from anorexia nervosa from the women’s perspectives. The theory provides a framework for understanding the unique experiences of women recovering from anorexia nervosa and direction for professionals and family members who are involved in supporting women’s recovery from...
this illness. This theory provides a basis for continued research to more fully develop our understanding of the process of recovery from anorexia nervosa.
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Chapter One: Introduction

Anorexia nervosa evokes many images and emotions in those of us who have cared for individuals with this disabling illness. Individuals who recover from anorexia have much to tell but the complexities of that journey continue to be encoded in mysterious language. Even Goldkopf-Woodtke, who underwent recovery from anorexia and works as a therapist in the field of eating disorders, finds recovery hard to explain, “The pain of recovery is difficult to describe, the raw exposure that comes from peeling away layers of feelings. Because no step-by-step approach exists, knowing exactly where to begin is difficult” (1994, p. 133). This study aims to “decode” that process of recovery because anorexia nervosa is a serious and persistent mental health disorder with the highest mortality rate of any other psychiatric illness (Sullivan, 1995; Theander, 1985). Compared to the general population, the suicide rate of this disorder is 200 times greater (Sullivan, 1995). Although this illness can be chronic, those who recover still undergo a lengthy course which tend to be variable and unpredictable, making it very challenging, frustrating, and frightening, to know how best to support the recovery process.

Purpose of the Study

The purpose of this study is two-fold. First, the study aims to describe the process of recovery from anorexia nervosa from the patient’s perspective. Second, to generate a theory that captures the process of recovery and make meaning of what influences the patient’s thoughts, perceptions, emotions or sensations, how actions and interactions occur, and how social processes interrelate to make recovery possible.

The frameworks used to investigate recovery from anorexia nervosa in outcome studies have mainly been researcher defined. Few attempts have been made to capture the patient’s
perspective. This study focuses on patients’ views of recovery as well as their experience of recovery. For the purpose of this study, individuals who have “recovered” from anorexia nervosa will be operationally defined as those who have previously received the clinical diagnosis of anorexia nervosa by a qualified practitioner and now consider themselves recovered.

Three assumptions underlie this study. First, it is assumed that many individuals who consider themselves recovered from anorexia will include those who have received multiple treatment interventions as well as those who have not received any treatment. Formal treatments may be in the form of hospitalization, individual, family or group psychotherapy, nutritional counselling, psychiatric care, residential programs, day programs, and psychopharmacotherapy. Second, it is assumed that the experience of recovery from anorexia will be unique to every individual, regardless of the types of treatment received, and that there exist some common threads to the recovery process that are yet to be understood. Third, it is assumed that relapse (the recurrence of anorexic symptoms which had been previously reduced or alleviated) is a part of the phenomenon of the recovery experience.

This chapter reviews the definition of anorexia nervosa, the history of theoretical perspectives, the etiology, the extent of the problem, the morbidity, and the unpredictability in the course of recovery. This information serves as the basis for further examination into the process of recovery and the purpose of this study.

Definition

The syndrome of anorexia nervosa was first coined by two prominent physicians in 1873, Charles Lasegue in Paris, and Sir William Gull in London, England (Pike, 1998). This psychiatric illness is characterized by an unrelenting drive for thinness, an over reliance on body
weight and shape for self-evaluation, a denial of the seriousness of the illness, an extreme fear of weight gain, and menstrual dysfunction. The word anorexia is derived from Greek—*an*, meaning *without*, and *orexis*, meaning *appetite* (Blinder & Chao, 1994). Clinically, the term anorexia is misleading because people with anorexia nervosa do not initially have a loss of appetite. Instead, the sensation of hunger is either deliberately ignored or forcefully controlled by means such as water loading, gum chewing or appetite suppressants. It is only in more advanced stages of anorexia nervosa that the appetite and hunger signals are significantly diminished, the person continues to starve, and may eventually die of cardiac failure, suicide or other complications.

The DSM IV (APA, 1994) is often used to make the diagnosis of anorexia based on four criteria that must be met. The DSM IV requirement is very stringent and often clinical diagnoses of anorexia nervosa do not include all four diagnostic criteria but focus more on the pathological thinking related to eating, self-concept, body image, and resultant low body weight. The DSM IV criteria also distinguishes between two subtypes of anorexia nervosa, the restricting subtype and the binge-purge subtype. The restricting subtype is characterized by very restrictive dietary patterns that not only limit the number of calories consumed but also the types of food consumed, and sometimes, even the way in which the food is prepared and eaten. The binge-purge subtype involves a vicious cycle of dietary restriction, binge-eating, and purging by means of self-induced vomiting, laxative abuse, diuretic abuse, or excessive exercising. The binge-purge subtype of anorexia nervosa is often confused with bulimia nervosa but the distinguishing

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1The four DSM IV (APA, 1994) criteria for the diagnosis of anorexia nervosa are: (1) refusal to maintain body weight at or above a minimally normal weight for age and height; (2) intense fear of gaining weight or becoming fat, even though underweight; (3) disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight on self-evaluation, or denial of the seriousness of the current low body weight; and (4) in postmenarchal females, amenorrhea (i.e., the absence of at least three consecutive menstrual cycles).
features for anorexia nervosa relate to refusal to maintain body weight at or above that which is expected for age and height, denial of the seriousness of low body weight, and amenorrhea.

**History of Theoretical Perspectives**

Over the centuries, there have been great debate and confusion as to whether anorexia nervosa should be deemed a medical or psychiatric disorder. The early literature on anorexia nervosa dates back to 1689, when Richard Morton published what is considered to be the first medical account of anorexia nervosa (Silverman, 1997). Morton’s approach relied on pharmacotherapy that had no demonstrated success. Still, more than a hundred and fifty years would pass before anorexia nervosa was clearly depicted in 1859, as a psychiatric illness with profound psychopathology, by another physician, Louis-Victor Marce (Silverman, 1997). And it was another fourteen years later before the term “anorexia nervosa” was coined by two physicians working independently of one another, Lasegue and Gull. Both made major contributions to the early understanding of the psychopathology of anorexia nervosa.

In 1914, a dramatic shift in theoretical perspective took place--turning attention from psychopathology to biological explanations of anorexia nervosa with Simmonds’ theory of pituitary insufficiency leading to severe weight loss (Silverman, 1997). It was not until 1930, that Berkman would re-direct emphasis to the psychogenic nature of anorexia nervosa. This perspective continues to be supported and underlies subsequent developments in this field. The theoretical perspectives of anorexia nervosa that guide clinicians to date stem mainly from the works of Bruch, Crisp, and Russell in the 1960's and 1970's. Silverman (1997) observed that treatments developed in the last twenty years are more or less refinements of these pioneers’ work.
Bruch (1973, 1978) viewed self-starvation in anorexia nervosa as a struggle for autonomy, competence, control, and self-respect. The underpinning assumption is that the child’s needs for independence are not recognized or acknowledged, that developmental experiences are faulty and the child experiences inner confusion. Subsequently, perceptual and conceptual disturbances manifest in the form of a distorted body image, lack of interoceptive awareness, and an all-pervasive sense of ineffectiveness.

Crisp (1967, 1980, 1997) theorized that anorexia nervosa was a “flight from growth,” a desperate subconscious attempt to maintain or return to a pre-pubertal weight, shape or hormonal status, as a way to cope with fears and anxieties related to psycho-biological maturity. Accordingly, he conceptualized anorexia nervosa as a panic disorder whereby the individual adheres rigidly to an avoidant stance from the feared object, that being puberty, which in turn is ascribed to food.

In the early 1970’s, Russell (1985) proposed that the morbid fear of fatness was the central psycho-pathology in anorexia nervosa. Russell (1985) conducted research which supported his hypothesis that people with anorexia nervosa have a distorted image of their body, that they perceive themselves to be unduly wide and fat, and that it is this cognitive distortion which drives them to further restriction of food intake and subsequent weight loss.

The works of Bruch, Crisp and Russell are echoed in Beresin et al.’s (1989) analogy of the childhood story of the Velveteen Rabbit and the inner struggles of individuals with anorexia nervosa:

Anorexia nervosa is a defensive retreat from the world of the living, which is viewed and experienced as exploitative, unempathic, dangerous, and untrustworthy. Like the Velveteen Rabbit, they do not feel real or understand the process of becoming a real, feeling person, but imagine it to be a mechanical activity and fear being hurt. They are
the ones, aptly described by the Skin Horse, who break easily, have sharp edges, and are carefully kept in their families. They do not experience being truly loved for themselves, and instead of withstanding the expectable bruises and failures in healthy intimate relationships, feel they must be beautiful, perfect, and compliant to be loved. Indeed, they feel ugly—intolerant of their inner hurt, envy, rage, and primitive guilt, ensconced in a world of people who do not understand (p. 104).

No treatment to date has been found to cure anorexia nervosa but the search for an effective treatment continues. As a result, we see a wide range of treatments being used, often several treatments in combination with one another (e.g., psychopharmacotherapy, nutritional therapy, individual therapy, family therapy, and group therapy). In addition, a variety of therapeutic approaches such as cognitive behavioural therapy, psychoanalysis, psychoeducation and solution focused therapy have been used with limited success. However, motivational enhancement therapy and narrative therapy are two approaches which have received the most attention due to recent research-based evidence that support their use in treating eating disorders (Blake et al., 1997; Geller & Drab, 1999; Serpell et al., 1999; Treasure & Ward, 1997; Ward et al., 1996).

Motivational enhancement therapy (M.E.T.) is particularly useful in addressing the ambivalence and resistance to treatment so characteristic of patients with anorexia nervosa (Ward et al., 1996). M.E.T. stems from Prochaska and DiClemente’s (1992) transtheoretical model of behavioural change which ascribes different stages of readiness for change as well as the processes of change. The stages of change include pre-contemplation (not ready for change), contemplation (thinking about change), action (commitment to change) and maintenance (sustaining change) (Treasure & Ward, 1997). Processes of change are the strategies that bring about change but the strategies selected depend on the stage of readiness. That is, in the pre-contemplation and contemplation stages, cognitive strategies such as providing information are
used to motivate and build confidence for change. In the action and maintenance stages, behavioural strategies to reduce problematic symptoms and increase positive experiences are used. Treasure and Ward have indicated that the goal of M.E.T. is to enhance the individual’s intrinsic motivation to change by bringing to light the existing discrepancy between the anorexic behaviours and broader goals, and between self-concept and actual behaviour. The general principles of M.E.T. focus on supporting self-efficacy, hope and optimism, and building self-esteem—all of which are especially important in working with individuals who experience a pervasive sense of ineffectiveness and lack of control.

Similarly, narrative therapy focuses on promoting a sense of personal mastery and reducing blame. White and Epston (1990) founded narrative therapy on the basis that problems such as anorexia are created within a social, cultural and political context. Narrative therapy emphasizes the use of language as a means of deconstructing the world of anorexia, unpacking the dominant stories which support anorexia, separating anorexia from the person and relocating anorexia within contexts such as “cultural trainings around perfection, safety, and control; gender trainings of body surveillance and less-than-worthy identities; religious beliefs regarding body-purity, self-sacrifice, and guilt; the cultures of self-help that promote the politics of condemnation” (Madigan & Goldner, 1998, p. 384). By externalizing the internalized problem of anorexia, the opportunity for change is created (White & Epston, 1990). The person struggling against anorexia is no longer the focus of blame, the person and problem are separate entities, and the person can be supported in mastering ways to fight against the problem. A narrative approach uses a curiosity stance to bring forth hope by asking questions to stimulate remembrance of past experiences of autonomy, competence, courage, appreciation and change.
These are considered important therapeutic goals for individuals recovering from anorexia.

**Etiology**

There is no singular known cause of anorexia nervosa. Although what is understood about the fundamental etiology of anorexia nervosa remains incomplete (Anderson et al., 1997), experts consider the etiology of eating disorders to be multidimensional. Garner (1997) conceptualizes the etiology of eating disorders in terms of predisposing, precipitating, and perpetuating factors. Predisposing factors relate to culture, family and individual differences in psychological and biological make-up. When an individual lives in a culture where the ultra-slim model is held up as the ideal of feminine beauty, an individual who has not developed a strong sense of "self" will turn to societal ideals, become dissatisfied with body weight and shape, and will succumb to the media messages of dieting in order to achieve a sense of self-worth and self-control. Thus, the roots of anorexia nervosa appear to begin in early childhood and not in adolescence or adulthood when formal diagnoses are made (Andersen et al., 1997). The precipitating factors of anorexia nervosa have been identified as body dissatisfaction, dieting, low self-esteem and feelings of lack of control. One of the perpetuating factors that maintain anorexic behaviours is the initial positive reaction from others who compliment the person with anorexia on weight loss. Another perpetuating factor has been identified as starvation symptoms which further reduce self-esteem, self-confidence, and impair judgment (Garner, 1997). Furthermore, Andersen et al. (1997) stress the "friend" and "foe" nature of eating disorders which sets anorexia nervosa apart from any other medical or psychiatric disorder. That is, anorexia is falsely used as a friend who provides a sense of control and autonomy when faced with developmental crises, distressing family dynamics or other life problems when in reality,
anorexia robs the person’s life, arrests maturational development and threatens physical well-being.

The Extent of the Problem

The incidence of anorexia nervosa is estimated at 0.3-0.7% (Kaye et al., 1999) among females in the general population. It is particularly prevalent among adolescent females and young female adults, although males are also affected at a rate of one in ten females. Jarman and Walsh (1999), however, have noted increasing reports of anorexia nervosa in a wider age range, including children as young as eight years old and women well into their forties and beyond. Using the prevalence rate suggested by Kaye et al. (1999), the number of Canadian females\(^2\) (all ages) affected with anorexia nervosa would range between 46,164 to 107,715. The number of British Columbian females\(^3\) affected would range from 6,072 to 14,167.

The mortality risk in anorexia nervosa increases with chronicity. Mortality rates after five to six years are 8%, increasing to 15% after twenty years (Deter & Herzog, 1994), and 18% or higher after thirty-three years (Theander, 1985). By contrast, Strober et al. (1997) claim that their study sample of juvenile-onset anorexia, followed no less than four years, show a zero mortality rate which is supported by others (Bryant-Waugh et al., 1996; Herpertz-Dahlman et al., 1996; Kreipe & Dukarm, 1996; Rastam et al., 1996). Not surprisingly, Sullivan (1995) undertook a meta-analysis of 42 published outcome studies to review the crude rate of mortality due to all causes of death in anorexia nervosa, with a length of follow-up ranging from two to thirty-three years. Sullivan showed that the mortality rate is 0.56% per year and 5.6% per decade. When


\(^3\)Statistics Canada (1999) show female population for all ages in British Columbia at 2,023,836.
compared with mortality rates amongst females in psychiatric inpatient populations, between ages 10-39, the annual mortality rate due to all causes of death in anorexia nervosa is more than twice as high. Even worse, the mortality rate in anorexia for younger females between ages 15-24 is twelve times that of the general population. In addition, Sullivan (1995) showed high mortality risks in anorexia related to suicide rates that were 200 times greater than that of the general population. Anorexia nervosa, undoubtedly, has the highest mortality rate of any other psychiatric illnesses (Garner, 1997).

The causes of death in anorexia nervosa are varied but mainly relate to suicide and complications of starvation. According to Herzog et al. (1988), of the 88 deaths noted in 13 outcome studies, 50% were related to complications, 24% were suicide, 15% unknown or unreported causes, 6% lung disease and 6% other disorders or accidents. Similarly, Sullivan (1995) reviewed 42 studies (3,006 individuals with anorexia nervosa) and found that 54% of deaths were related to complications of anorexia nervosa, 27% suicide, and 19% unknown or other causes, with 178 deaths during follow-up. Major complications of anorexia nervosa are mainly related to ventricular arrhythmias and heart failure (Cooke & Chambers, 1995).

Morbidity

Not only are the mortality rates with anorexia nervosa astounding, but the odds for long-term morbidity are unusually high. There is new evidence that osteopenia persists even after weight and menstruation recovery (Ward et. al., 1997), that cerebral gray matter volume deficits persist (Lamb et. al., 1997), and that there is high risk (8%-41%) for developing bulimia and its associated medical complications (Bulik et. al., 1997) as well as multiple long-term psychiatric problems, with common co-morbid issues such as depression, anxiety and obsessionality (Hsu et
al, 1992a; Pollice et al., 1997). With affective disturbances, Herzog et al. (1996) report a high lifetime incidence of 52% to 98% among individuals with anorexia, with depression being the most common. With anxiety disorders, there is a lifetime incidence of 65% for people with anorexia, compared with 21% for normal controls, the most prevalent being social phobias and obsessive-compulsive disorders (Herzog et al., 1996). Substance dependence is another co-morbid issue although lifetime incidence rates are lower than for affective and anxiety disorders (12%-21%), particularly for the restrictor subtypes of anorexia nervosa (Herzog et al., 1996). Finally, personality disorders are also prevalent among people with anorexia, particularly compulsive and avoidant personalities, with estimates ranging from 20%-80% (Herzog et al., 1996). The wide range of variability for personality disorders reflects disagreements in criteria for diagnosis.

Unpredictability, Relapses, Remission

Anorexia nervosa presents a complex clinical picture with medical and psychiatric co-morbidity. The co-morbid issues complicate the already variable course of recovery from anorexia. When recovery from anorexia is observed over longer periods, some individuals who respond to treatment still experience relapses and remissions, while others achieve full recovery after a prolonged period of many years (Herzog et al., 1999; Theander, 1995), some remaining chronic (Herzog et al., 1999; Pike, 1998; Steinhausen et al., 1991), and others dying from complications such as cardiac failure or suicide. Pike’s (1998) review of the literature focuses on the long-term course of anorexia nervosa in terms of response, relapse, remission, and recovery. Pike defines the “course” of the disorder according to changes in core features of anorexia nervosa over time, especially with regard to duration, severity, stability, and variability. While
Garrett (1997) defines recovery as an ongoing process, Pike (1998) refers to the long-term outcome as “the final destination of the pathological process” (p. 448).

Pike (1998) does not define relapse in anorexia nervosa. Instead, Pike focuses on predictors of relapse such as presence of vomiting as a core feature of diagnosis, low weight at time of referral, long duration of illness prior to seeking treatment, later age of onset, persistent attitudes regarding weight and shape, and the presence of co-morbidity such as anxiety disorders or depression. It is hard to predict who will most likely relapse or when. However, individuals who are in recovery are often advised to be alert for signs of relapse and to seek help if they are losing weight, losing their menstrual function, using compensatory behaviours for weight control, preoccupied with food, body weight or shape, sleeping poorly, losing appetite, losing enjoyment in life, experiencing crying spells, or are unsure about the need for additional therapy (Garner et al., 1997).

The unpredictability of the course of anorexia is also influenced by the significant number of spontaneous recoveries (Bassoe & Eskeland, 1982; Maine, 1985; Theander, 1992). Bassoe (1990) reported on two long-term prospective studies which showed 12% of individuals with anorexia nervosa who recovered spontaneously. In reviewing the literature on clinical studies, Garrett (1996) found repeated reports of spontaneous recoveries from anorexia, and that words like “mysterious” and “unpredictable” were frequently used to describe the recovery process. Others contend that these kinds of recoveries do not simply occur as part of the “natural history” of anorexia but are most likely triggered by life events (Crisp, 1997) or as a result of therapeutic impact from life experiences or meaningful relationships (Beresin et al., 1989).

Researchers have made significant contributions over the years to advance our knowledge
and understanding of anorexia nervosa. Much attention is focused on the outcome of the illness. However, outcome studies do not explicate the process of how individuals recover. The remarkable pioneer works of Bruch, Crisp, and Russell continue to provide an overarching guide to therapeutic approaches. Yet, the mortality rate and morbidity issues in anorexia nervosa are sobering to even the most seasoned therapist. A better understanding of the elements that support recovery from anorexia could provide direction for important changes in the way health care services are delivered.

Summary

This chapter provided an overview of the definition of anorexia nervosa, a historical review of the illness, the extent of the problem, and the purpose of this study. The next chapter is a literature review that summarizes what is already known about the process of recovery and what is still missing. The literature review shows the gaps in research leading to the premise for this study. The remaining chapters provide details of the methods, findings and discussion of this study.
Chapter Two: Literature Review

A review of the research literature was conducted to examine the current state of knowledge on the process of recovery from anorexia nervosa, and in particular, what is known about the experience of recovery from the patient's perspective. The review focused on how researchers have conceptualized and tracked recovery from anorexia nervosa, how recovery was measured, and what factors facilitated or hindered recovery. The purpose here was to summarize what is already known about the process of recovery from anorexia nervosa and the gaps in research that provide a context from which this study was proposed. As well, common themes which emerged from the literature specific to the patient's perspective of how recovery occurred will be identified and discussed.

Using the PSYCINFO, MEDLINE (R) ADVANCED, and CINAHL databases, the search terms "anorexia" and "recovery" were used to retrieve relevant literature, limiting the search to English only publications between 1979 and 1999. In the PSYCINFO database, this search yielded 182 articles but only those studies specifically relevant to outcome or recovery were selected for review. MEDLINE (R) ADVANCED yielded over 300 articles but many of those articles focused on specific medical measures related to endocrine, hormonal, genetic, and neurological studies. CINAHL yielded substantially fewer research studies (90). Duplicates were removed. Articles not found via this process were obtained from the reference lists of various research articles reviewed. This search resulted in 37 publications on recovery from anorexia which were reviewed for the purpose of this chapter. Only 5 studies were found that addressed recovery from the patient's perspective.
Tracking Recovery

Over 70 follow-up studies had been conducted on the course of anorexia nervosa by 1991 (Deter & Herzog, 1994; Gillberg et al., 1994). In early long-term studies, researchers focused mainly on measures of weight, menstruation, and mortality. Hsu’s (1980) review showed a large gap in measures of outcome relating to eating patterns, relationships, or social functioning. Subsequently, long-term studies have focused on various outcome measures including mortality, weight, menstruation, eating behaviour, social relationships, family relationships, psychosexual functioning (marital status, childbirths), and psychiatric symptoms such as anxiety, depression, obsessions, and compulsions (Bassoe & Eskeland, 1982; Deter & Herzog, 1994; Gillberg et al., 1994; Herzog et al., 1999; Herzog et al., 1993; Strober et al., 1997). Overall, researchers have defined recovery mostly in terms of physical well-being, although some have included measures of psychological functioning, social functioning, or both.

Recovery rates from anorexia need to be interpreted in light of the criteria used to identify recovery as well as the length of follow-up. For example, Herzog et al. (1993) operationalized recovery from anorexia nervosa using the Psychiatric Status Rating (PSR) scale to assess presenting symptoms. In this study, full recovery was defined as PSR rating of levels 1 or 2 for at least 8 consecutive weeks. Level 1 (usual self) included normal weight range, returned menstrual functioning, and no evidence of anorexia nervosa according to DSM IIIR (APA, 1987). Level 2 (residual) included no longer meeting DSM IIIR criteria, within 5% of ideal body weight and still spending a great deal of time thinking about food and weight. Using these criteria, Herzog et al. (1993) found only 10% of participants with anorexia nervosa recovered after one year, whereas 18% of those with anorexia/bulimia nervosa and 56% of those with
bulimia nervosa were recovered in the same time period. These findings need to be interpreted cautiously. Herzog et al.'s (1993) criteria for full recovery was limited to physical (weight and menstruation) and psychological (intense fear of weight gain and food preoccupation) recovery, and did not address social aspects of recovery. It has been suggested that full recovery may take 7.5 to 10 years (Herzog et al., 1999; Theander, 1992). Furthermore, when other researchers such as Strober et al. (1997) factored in the mental state of patients, estimates of recovery time lengthened to 10-15 years after initial diagnosis.

According to Herzog et al. (1993), recovery rates in anorexia range widely between 17% and 77%, reflecting great variability in study criteria, definition and length of follow-up (4 to 20 years). Studies have shown recovery rates hovering around 33% (Herzog et al., 1999), 40% (Beresin et al., 1989; Deter & Herzog, 1994), and 50% (Herzog et al., 1996; Norring & Sohlberg, 1993). Based on their review of eight outcome studies between 1973 and 1984, Beresin et al. (1989) reported a global outcome of 40% totally recovered, 30% improved, and 30% died or chronically affected. Deter and Herzog (1994), using the Morgan-Russell⁴ scale, reported higher recovery rates than others. Their findings indicate the likelihood of a higher “good” outcome was 54%, an “intermediate” outcome was 25%, and a poor outcome was 11%. However, when

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⁴The Morgan-Russell scale is oriented in terms of intensity of somatic symptoms where “poor” meant average body weight <85% or >115% and amenorrhea; “intermediate” meant one of the DSM IIIR criteria still applies; and “good” meant none of the criteria apply (Deter and Herzog, 1994).
psychosocial functioning, psychiatric and somatic comorbidity were factored in, the “good” outcome dropped to 41% after 12 years, similar to the findings of Beresin et al. (1989). Strober et al. (1997) conducted a prospective study of the long-term (10-15 years) course of severe anorexia nervosa in adolescents. Using the Morgan-Russell criteria for weight and menstruation as indicators of recovery, they found a high recovery rate of 86%. When the mental state of patients were factored in, the recovery rate dropped to 76%, which, however, was still high relative to other findings. Across the studies, it is difficult to determine an average recovery rate in anorexia nervosa because no standardized criteria for recovery have been used. In general, it seems that the more factors considered in measurements for recovery, the lower the recovery rate. Furthermore, evidence suggests that recovery rates have not improved dramatically despite ongoing developments in therapies and research on treatment effectiveness.

Defining recovery is a continual challenge. Pike (1998) defined the “course” of recovery in terms of changes in the core features of anorexia nervosa that occur over a period of time and which can be measured in terms of “duration, severity, stability, variability and impact on general health and suffering for the individual” (p. 447). Pike’s review of selected outcome studies between 1983 and 1997 showed that a commonly used operational definition of recovery is the Morgan-Russell scale which defines “good recovery” in terms of achieving weight and

5Psychosocial functioning included employment status, social relationships, and psychosexual functioning, which meant having a sexual partner, regular sexual contact, no sexual anxieties, married and/or have own children (Deter and Herzog, 1994).

6Psychiatric comorbidity included presence of phobic disorders, substance abuse, major depression, personality disorders, chronic psychosis, and obsessive-compulsive disorders (Deter and Herzog, 1994).

7Somatic disorders due to anorexia were related to bone and joint problems as well as chronic inflammation in various parts of the body (Deter and Herzog, 1994).
menstrual recovery, regardless of continuing psychological features of anorexia nervosa. Pike cited Strober et al.’s (1997) more stringent criteria of recovery, this being the absence of all criterion symptoms of the disorder for at least 8 consecutive weeks. Pike suggested that Strober et al.’s (1997) definition should be applied to the stage of remission, where the risk of relapse is still high. In refining the definition of recovery, Pike proposed that recovery from anorexia could be defined as an absence of symptoms, when the risk of symptoms returning is no greater than that of the general population. Absence of symptoms can be easily measured, but it remains unclear how one would assess the risk of symptoms returning.

**Gaps in Research**

The first section addressed the numerous outcome studies that tracked various somatic, psychological, and social indicators of recovery. The emphasis on the physical aspects of recovery (e.g., weight and menstruation) and other quantifiable measures (e.g., marital status, childbearing, employment status, or eating patterns) provide an important but incomplete picture of recovery. Other potentially important indicators of recovery from anorexia such as attitudes toward self-acceptance, positive body image, perceived effectiveness and sense of autonomy have been ignored. Jarman & Walsh (1999) have observed the limitations of using quantitative measures to understand qualitative changes in a person’s psychological functioning. It is paradoxical that researchers who seek to understand the complexities of recovery from anorexia often resort to a limited range of measures of recovery. As well, the patient’s perspective on recovery from anorexia is distinctly lacking (Herzog et al., 1988; Hsu, 1980; Jarman & Walsh, 1999; Pike, 1998; and Steinhausen et al., 1991).

Although Maine (1985) questioned the completeness of conceptualization of recovery
based on specific, narrowly focused measures almost two decades ago, it has been difficult for researchers to capture the complexity of recovery from anorexia nervosa. When recovery is conceptualized as giving up the "defensive retreat" of anorexia—the retreat that promises a safe haven of familiarity and control (Beresin et al., 1989), questions arise about how to recognize recovery. How does a person with anorexia transition to a new realization that living with anorexia does not bring the promises she or he had hoped for? How does one venture to leave the anorexia retreat to experience the unknowns of change, a new identity, or a new sense of autonomy, with the ever present fear of possible failure and weight gain? Consequently, when or how does one arrive at the journey to recovery, and when is the journey complete? These questions point to the complexities inherent in the process of recovery from anorexia and the difficulties of finding appropriate measures to signal when recovery is complete.

Garrett (1997) challenges researchers who are searching for a "uniform definition" or theory of recovery with findings from her qualitative study of 32 women’s perspectives of recovery from anorexia. Although the participants were all at various stages of recovery, most considered themselves to be fully recovered. The women’s insights about their own recovery suggest a complicated dynamic that is not reflected in most quantitative outcome studies:

I see the myth of recovery as part of the attitude which produces anorexia (Diana). The word recovery feels like too final a term and that there is an expectation...to always be perfect (Jacqueline)...I’m not sure if I’m still affected by it--I mean I always presume I’m normal! (Sue). One major aspect of recovery for me has been stepping outside the social norms; outside the stereotype of what’s appropriate for a woman in our culture (Diana) (p. 264).

These findings suggest that recovery may be a continual process that unfolds over time, with individuals healing in different ways and at different levels of completeness. There may be more clinical and theoretical significance in mapping the events and processes that facilitate recovery
than to define recovery in finite terms.

In seeking to understand recovery from anorexia, it may be useful to look at conceptualizations of recovery from serious illnesses that have been developed on the basis of patient perceptions of their experiences. Morse and Johnson (1991) developed an "Illness-Constellation Model" in which they describe how illness affects the ill person and his/her significant others, as well as how both parties cope, live through the illness and take charge again. This model describes the illness experience leading to recovery in four interrelated, dynamic and evolving stages: (1) uncertainty, (2) disruption, (3) striving to regain self, and (4) regaining wellness. First, the stage of uncertainty involves suspicion from the ill person and/or significant others that something is wrong, that the body is not functioning as usual, and both parties are overwhelmed by the ramifications of the experience. The illness experience with anorexia for the family or significant others is similar in that they do suspect something is wrong and become panicked with the person's deteriorating and emaciated state. However, individuals affected by anorexia in the initial stages are often in denial, ignoring body hunger and fatigue. They are usually reluctant to seek help because they are delighted by the prospect of further weight loss.

The second stage of the illness experience involves disruption (Morse & Johnson, 1991) and occurs when the ill person decides that there is something seriously wrong, seeks help and/or receives a medical diagnosis of the illness. This stage is characterized by crises whereby the ill person lets go of control, becomes dependent on health care professionals for care, and allows family members to take over household responsibilities. Family members suffer along as they come to realize the seriousness of the illness. These experiences are not common among those
diagnosed with anorexia. Unlike a diagnosis of cancer or heart disease, the receipt of a diagnosis of anorexia does not convince individuals of the seriousness of the problem despite the fact that this illness can be life-threatening. Even control over self-care is not relinquished, and anorexia continues to be viewed as something desirable.

The stage of striving to regain self refers to the experience of trying to make meaning of the illness, to piece together reasons for the illness, and to examine the impact of illness on future living. Meanwhile, family members pull together to support the ill person’s fight for life and health. As the person’s health improves, s/he attempts to resume previous roles and responsibilities while family members tend to protect the person from stressors and monitor his/her behaviours to ensure safety and wellness. The final stage, regaining wellness, is when the ill person decides s/he is “better” or is able to live with the changed level of functioning. The family responds by letting go of the person’s temporary passive role and allows the person to resume control over his/her life. These latter two stages could be thought of as the recovery experience. It remains unclear if this conceptualization of recovery can be applied to experiences with anorexia. Clinical observations indicate that recovery from anorexia is an extended process often covering 7.5 to 10 years that includes experiences of improvement and relapse.

It appears that the Morse and Johnson (1991) illness-constellation model may be best suited to explaining the illness experience for those with serious, potentially chronic and life-threatening medical disorders. Recovery from psychiatric disorders such as anorexia nervosa are sufficiently unique that other models are required to explain these experiences.

**Recovery from the Patient’s Perspective**

Within the parameters of the current literature review on anorexia, five studies (Beresin et
al., 1989; Garrett, 1997; Hsu et. al., 1992; Maine, 1985; Noordenbos, 1989) were found which addressed recovery from the patient’s perspective. Noordenbos (1989) made reference to de Bloois’ (1987) study which also addressed recovery from the patient’s perspective but it will not be reviewed here because it was written in Dutch.

In general, personal interviews were used to elicit the experiences of individuals who had recovered from anorexia nervosa. The participants in all five studies were almost all women, with the exception of Noordenbos’ (1989) study which included four men. The interview approach was generally semi-structured, using mostly open-ended questions. With the exception of the study of Hsu et al. (1992), research participants were solicited via local newspapers and/or newsletters of self-help organizations for people with eating disorders. The number of participants in each study ranged from as few as 13 to 108, with most studies in the 30 or lower range. All researchers were seeking to understand the process of recovery from anorexia nervosa.

Beresin et al.’s (1989) descriptive study explored the process of recovery in thirteen women who had responded to their advertisement in a newsletter of a local eating disorder support organization and who considered themselves recovered from a previous DSM III\(^8\) diagnosis of anorexia nervosa. A variety of measures were used in this study to substantiate the women’s claim of recovery. A series of pre-determined questions were used to interview participants about their recovery:

\(^8\)The DSM III (APA, 1980) criteria for anorexia nervosa included “intense, unrelenting fear of obesity; disturbance of body image; weight loss of 25% of body weight; refusal to maintain a normal weight; no underlying physical illness” (Maine, 1985, p. 49). In contrast, the DSM IV (APA, 1994) criteria no longer has the 25% weight loss criteria but instead emphasizes the psychopathology of the refusal to maintain weight at or above a minimally normal weight for height and age.
1. Do you have any idea what caused your anorexia nervosa?
2. How were you able to recover from anorexia nervosa? What experiences were most helpful and harmful in recovering (both treatment and non-treatment related)?
3. What features of the eating disorder are hardest to change?
4. What did you lose by giving up your anorexia nervosa? What took its place?
5. Do people ever fully recover from anorexia nervosa? What is left?
6. What advice would you give to others who are suffering from anorexia nervosa? (p. 106).

Several important assumptions about the recovery process were reflected in these questions, including that there were certain features of anorexia that are hard to change, that anorexia serve some purpose that could be replaced, and that perhaps recovery is not final. The interviews were focused on aspects of recovery which the researchers believed to be important. It is unclear whether participants were provided with an opportunity to focus on aspects of recovery that they believed were important.

Some insights offered by Beresin et al. (1989) related to key turning points in the participants’ recovery. For example, only when the anorexia felt significantly ego-dystonic (or when the participants’ perceptions of themselves no longer matched the anorexia goals) did the decision to change or let go of the anorexia occur. This transition was marked by comments like, “I am sick of this” or “I am bored of this” (p. 120). The turning points were described as periods of “psychological rebirth” in the process of recovery. In part, this rebirth was related to participants’ enhanced self-understanding via talking to themselves, journalling in their diaries, and reading their diaries repeatedly. The researchers suggested the self-discovery behaviours were similar to the “transitional phenomena” described by Winnicott (1958), in which “the talking or writing becomes a means of self-soothing, utilizing illusion to combat a pervasive sense of aloneness” (Beresin et al., p. 120). Other activities which participants deemed important
to recovery involved taking risks in interpersonal relationships, moving away from their family of origin, or examining family dynamics as a contributing factor to the development of anorexia, and being productive at work or school.

Although Beresin et al. (1989) presented new insights about factors which support recovery, there was limited exploration of the actual process of recovery. The semi-structured interview may have restricted participants from telling their recovery stories. Important insights can be revealed by paying attention to how individuals begin stories and what they focus on or emphasize when they are given an opportunity to tell their stories in their own way.

Hsu et al. (1992b) also used a descriptive approach to explore the process of recovery from the patients’ perspective. Informants were recruited from those included in the Aberdeen Psychiatric Case Register between 1965 and 1973 or those who had received care from the St. George’s Hospital Medical School in London between 1968 and 1973. Individuals were considered for Hsu et al.’s study on the basis of having previously been given a clinical diagnosis of anorexia nervosa, with massive weight loss ranging between 15 and 83 pounds, as well as obviously low weight at presentation of 63 to 93 pounds. Patient charts were reviewed and 63 cases met the study criteria for anorexia nervosa. The onset of illness for the 63 cases ranged from 17 to 44 years of age, and letters were sent to invite these individuals to participate in the study. Of the volunteers who responded to the letters, only seven women from the Aberdeen register, and nine women from St. George’s were interviewed based on their ability to meet at a mutually convenient time during the brief stay of the interviewer at each site. Participants agreed to a battery of psychometric testing and were encouraged to describe their experience of the illness as well as the factors that helped their recovery during an open-ended interview.
The most common factors related to recovery from the women's perspective were personal strength, self-confidence, being ready, and being understood. To illustrate how these factors supported recovery, Hsu et al. (1992b) presented six case scenarios under each of the following headings: 1) treatment and will power, (2) scared straight and husband, (3) fed-up with illness, (4) husband, (5) got out of family and leucotomy, and (6) psychotherapy and faith. Although Hsu et al.'s (1992b) findings add further to existing knowledge on possible key elements to recovery from the patient's perspective, they do not provide details of data analysis. It is unclear whether the six case presentations were representative of the entire sample. Finally, the six case scenarios do not provide an adequate explanation of the recovery process.

Maine (1985) examined the patient's perspective of the effectiveness of treatment for anorexia nervosa, how a successful outcome was achieved, and what phenomena facilitated recovery in or out of formal treatment. Participants in this study were volunteers who responded to an advertisement in local newspapers and circulated to self-help organizations for eating disorders. All 25 participants, by history, met the DSM III (APA, 1980) criteria for anorexia nervosa as well as Maine's (1985) criteria for recovery: (1) no hospitalization for anorexia nervosa, related sequelae or other psychiatric disorder in the last three years, (2) no acute medical or nutritional crisis in the last three years, (3) no longer attempting to lose weight, (4) weight stable for at least one year, and (5) able to identify problems leading to her eating disorder. Semi-structured interviews were content analyzed to identify themes describing the progression of illness and recovery process. The themes identified included the elements of positive therapeutic relationships occurring within and outside of therapy, adaptation to and acceptance of family problems, and the process of self-acceptance. Maine (1985) concluded that recovery
relies very little on formal treatment approaches and that many participants experienced relationships within their daily lives which contributed significantly to their recovery. The kinds of relationships which supported recovery had the ingredients of unconditional acceptance, making it safe to trust, explore, share, discover, and develop the inner self, which, for these participants, were experiences that had been sadly lacking in their family environments.

Maine (1985) contends that the process of recovery for all participants included realizing the impact of the pain they had endured within their families of origin, before they could let go of their anorexic self-destructive behaviours. Recovering individuals came to realize that shedding another pound would not make them more perfect, help deny their feelings, nor help them regain control over their lives. Personal responsibility and self-motivation were viewed as integral parts of recovery. Maine (1985) reported that the self-selection bias in her sample limits the generalizability of the findings in her study and the fact that the participants volunteered may indicate a more motivated, resourceful and insightful group. Her study nevertheless provided important insights to the recovery process.

Noordenbos (1989) used a questionnaire and interview to gather information from 104 women and 4 men who were considered to have improved or recovered from anorexia nervosa. The goal of the study was to understand the process of recovery in hopes of discovering earlier and improved treatments. Noordenbos’ (1989) criteria for recovery included: (a) no longer being obsessed by eating and slimming, (b) not underweight according to body mass index, and (c) no relapse for at least one year. The questionnaire consisted of 24 statements of treatment goals in which the participants were asked to rate their importance and if they received treatments that targeted these goals. Although 24 statements of goals were rated as important by the greater
majority (ranging from 70% to 98% of respondents), these goals were addressed in treatment only 12% to 47% of the time. Since all participants were considered recovered or recovering and apparently received treatment which infrequently addressed goals they deemed important, other factors must have contributed to improvements and recovery from anorexia.

Noordenbos (1989) attempted to broaden our understanding of the process of recovery by interviewing 37 of the 108 participants who completed the questionnaire. Interviews were structured to include questions that were expected to capture specific processes that lead to recovery (i.e., initial denial of illness with eventual transition to admission of ill health, seeking help, receiving education about illness, medical treatments, referrals to specialists, further recognition of ill health, number of treatments received, evaluation of different treatments and goals addressed in treatments received, and motivation to change before and during different treatments). Tabulated responses to each question provide some important insights. However, Noordenbos (1989) did not provide a description of the actual process of recovery from the patient’s perspective. Assumptions regarding the important components of the process of recovery may have precluded exploration of alternative perspectives.

To date, Garrett’s (1997) phenomenological study provides the most detailed analysis and interpretation on the process of recovery. Garrett’s newspaper report of her own recovery story resulted in 32 female volunteers for her study. All the women accepted for the study considered themselves to be recovered, although Garrett determined that they were at various stages of recovery. No criteria were provided to substantiate her claim. Garrett directed her study participants to tell their story of how they recovered. Study participants were also asked to define recovery from their point of view and to describe any stages of recovery, as well as any
influencing factors on their recovery.

Participants’ personal views of recovery were in direct contrast to clinical criteria for recovery. Some participants avoided using the word recovery because it suggested finality and closure, and did not fit with their conceptualizations of recovery. Nevertheless, five fundamental elements of recovery were identified:

(a) abandoning obsession with food and weight, concomitant with a critical understanding of social pressure; (b) having a sense that their lives were meaningful; (c) believing they were worthwhile and that the different aspects of themselves were part of a whole person; (d) believing strongly that they would never return to self-starvation; and (e) mentioning spirituality as a source of meaning (Garrett, 1997, p. 264).

Only the findings related to “spirituality” in the recovery experience were featured prominently. Garrett claimed that the participants’ stories of recovery reflected a quest for meaning, a spiritual quest that could be explained according to Durkheim’s (1976) position that religion or spirituality serves to show how we are connected to each other and to our environment, and the meaning of life. The participants’ definition of spirituality depended on a threefold connection: “connection of the many aspects of the self, especially of body and spirit/self/mind; connection with others; and connection with nature” (Garrett, 1997, p. 265). Garrett explained that the participants’ experience of strong emotions during recovery is part of the process of renewing such connections, which laid dormant during the anorexic period. Body-mind split, emotional numbness, and lack of presence in relationships are well-documented phenomena in anorexia nervosa.

Based on Durkheim’s (1976) analysis of rituals and van Gennep’s (1960) rites of passage, Garrett (1997) theorized that anorexia and recovery can be explained as parts of the same spiritual quest, and that anorexia and recovery can co-exist in the same society which supposedly
produced the anorexia.

As ritual, anorexia nervosa itself is the separation phase in the initiation of the individual into full selfhood. It is a chaotic liminal period; the apprehension of nothingness out of which the future must be created. As part of this ritual, the taboos on certain foods are purifying. They are attempts to pay homage to social proscriptions on fattening foods and to transform oneself, through self-control, into a more worthy person in the eyes of society. Recovery, and the rituals which accompany it, is the reconnecting part of the rite, when the individual is reincorporated into the community, strengthened through suffering (p. 265).

Garrett (1997) explained that rituals often symbolize death and rebirth, and that anorexia is like the donning of a “mask of death”, or shedding of the flesh, and then rebirth into a new life, a new way of being and connecting with the self and others. As well, Garrett described the rites of passage as a response to a developmental crisis (puberty or social maturity demands); followed by a preliminal phase whereby the one being initiated withdraws from society. During the withdrawal phase, there are symbolic gestures in the donning of a mask (the anorexic mask), the stripping of clothes (or flesh), dangerously facing one’s human vulnerabilities in life and death, and then being reborn as one with a “wider range of personae” (p. 266). Garrett also drew the analogy of dietary taboos and sexual prohibitions in many rites of passage as common rituals which symbolize the purification of the self in order to be accepted by society. She concluded by suggesting that fasting in the medieval era was considered to be a respected form of social suffering and that the current notion of anorexia nervosa as a psychiatric phenomenon may need to be challenged.

Garrett’s (1997) findings need to be considered cautiously. As indicated above, it is unclear why “spirituality” was presented as the main element to explain recovery. Furthermore, Garrett’s interpretation of the process of recovery from anorexia as a rite of passage is an analogy that does not appear to be derived from the data and maybe fraught with difficulty. Garrett
explains that anorexia is merely another ritual in a rite of passage into adulthood. However, rites of passage are usually endorsed by the society within which they are created and practised. In this case, Garrett claims that our society has created anorexia, yet only 0.3-0.7% of the female population has anorexia nervosa. In addition, the person engaging in any rite of passage is usually aware of the fact and has the conscious means to end the ritual. This, however, is not the case with anorexia nervosa. Unfortunately, Garrett’s study appeared to yield little evidence to support her theory on the recovery process.

Themes of Recovery from Previous Works

Despite efforts to understand the process of recovery from the patient’s perspective, only Garrett (1997) provided a detailed process-oriented description. Other researchers reported on factors or themes which were deemed important to recovery. The common themes which emerged from all five studies related to the importance of: (a) therapeutic relations, (b) experiences in and outside of formal therapy, (c) shifting perspectives on family, and (d) self-discovery. Thus, the next section presents an integrated discussion of these themes related to the process of recovery and implications for further research.

Therapeutic relations. With the exception of Noordenbos’ (1989) study, all four studies (Beresin et al., 1989; Garrett, 1997; Hsu et al., 1992b; Maine, 1985;) reported that recovery from anorexia encompassed some form of complete, unconditional acceptance of the self from someone. Noordenbos directed questions mainly at the effectiveness of certain treatments such as medical, behavioural, psychoanalysis, psychotherapy, family therapy and self-help. Thus, no opportunity was given to participants to speak freely of relationships which might have had therapeutic impact. Maine (1985) found that five participants reported psychotherapy as essential
to their recovery while thirteen others reported extended family members and friends to be a major factor. In all cases, either within or outside of formal therapy, the experiences allowed participants to feel validated, affirmed and unconditionally accepted. Participants in Maine’s study reported finally feeling “good enough,” having self-confidence and trust, reaching out, and then giving up the need to prove themselves.

Other researchers provided further support for the role of relationships outside of therapy that facilitated recovery. Hsu et al. (1992b) cited two case scenarios in which the husband of the person with anorexia was seen as the one who provided the emotional support and strength necessary to build self-confidence and develop new ways of coping. The participants in Beresin et al.‟s (1989) study reported that taking the risk of exposing oneself to others was a critical step to recovery. One participant stated, “I could finally accept myself, when friends got to see me as I really was, without acting, and that meant seeing all sides of me, the good and the bad” (p. 121). In addition, one-third of the participants in Beresin et al.‟s study reported that significant events in their recovery were falling in love, allowing oneself to be vulnerable in an intimate relationship, and experiencing sexual pleasure with one‟s body instead of disgust and hatred.

Unlike other researchers, Garrett (1997) found that spirituality was an important theme of recovery and that the participants’ search for meaning was often identified as a spiritual quest. “What they found in recovery was a sense of peace within themselves, of oneness with nature and with other people. As in religious conversion, they usually referred to a force beyond themselves as an active participant in their recovery” (p. 264). Although Garrett provided a very different perspective from other researchers, the thread of similarity lies in “unconditional” acceptance, whether it is with a friend, spouse, therapist, or spiritual force.
One participant in Hsu et al.’s (1992b) study also credited “faith and psychotherapy” as a main factor in recovery. This participant had been struggling with anorexia nervosa for 23 years and had been near death (weighing only 65 pounds) several times over the course of her illness. Finally, triggered by the threats of the rigid terms of hospitalization (contracting to gain to 115 pounds and bedrest) and out of desperation, she began praying hard for deliverance from her illness, and began attending church regularly with her husband. Subsequently, a friend told her about a psychiatrist whose only requirement of her was in maintaining her weight above 70 pounds. The conditions of the psychiatrist were acceptable to this participant and after one year in treatment, she was able to stop binging, vomiting, and abusing laxatives, alcohol and diazepam. This participant saw the psychiatrist as the answer to her prayers and was able to work through multiple family issues. As well, the participant gained insight into how her problems with her father translated into her choice to marry a man who was 22 years her senior, which she believed stifled her need to mature and perpetuated the eating disorder. Again, it appeared that unconditional acceptance from the psychiatrist and from God made recovery possible for this individual.

Experiences in formal treatment. The perceived effectiveness of formal treatment as part of the recovery process is mixed. Women who recovered from anorexia believed certain professional treatments were helpful while others were deemed harmful to recovery (Beresin et al., 1989). In Maine’s (1985) study, only 5 out of 24 participants saw their formal treatment (inpatient and outpatient) as essential to their recovery, while 3 believed their treatment (all inpatient) was harmful to their recovery. The remaining women believed that formal treatment made no difference and that they would have recovered without any treatment. Other women
have also reported that psychotherapy and other formal treatments had not helped them (Garrett, 1997). When the women believed formal treatment was useful, it was directly related to experiencing a strong relationship with the therapist.

Contrary to Maine (1985) and Garrett’s (1997) findings that hospitalization or psychotherapy were not helpful in many cases, Beresin et al. (1989) found that most participants in their study reported how relieved they felt that someone else was making decisions about their food and environment, even though they felt anxious and defiant about the experience. As well, the hospital experience, although intrusive, was seen as caring, providing safety and refuge from the daily demands of home, school, and friends. The participants also reported that the structured hospital setting offered a sense of security to confront their fears of food and being fat. Although Hsu et al. (1992b) also presented one case of a woman who found that her inpatient treatment was supportive and helpful to her recovery, they also presented a contrary case of another woman who found the hospital experience so frightening that she was “scared straight.”

Another aspect of formal treatment relates to therapy style. According to Beresin et al. (1989), participants reported that effective therapists were those who actively engaged in explanations about eating disorders, and coached and encouraged them without taking on the traditional therapist role of being formal and silent. One participant stated, “He was never judgmental. He saw me as a healthy person and always addressed that part of me. He addressed my strength and my healthy side and he did not let me be sick” (p. 115). Participants reported that it was difficult to build trust with therapists who practised the traditional approach because the silent stance reminded them of the hidden agendas within their family of origin which were frustrating and demeaning. Maine (1985) and Hsu et al. (1992b) also reported active therapists to
Shifting perspectives on family. There is no known singular cause for the development of anorexia nervosa although many professionals have laid blame on families. Sharkey-Orgnero (1999) suggested that the focus on blaming the mother for anorexia nervosa is increasing in the literature, and that discussions of the positive nature of that relationship or the family’s role in recovery are virtually absent. From the perspective of individuals who recovered from anorexia nervosa and whose families were enmeshed, rigid, controlling, domineering, or overly protective, leaving home was reported to be one of the main factors in recovery (Hsu et al., 1992b; Beresin et al., 1989). Others have found that learning to recognize “their family’s contribution to their pain, to their denial, and to the use of their bodies as battleground” (Maine, 1985, p. 53) was a major contribution to their healing. Either way, the few prior studies that capture the participants’ views on recovery provide some support for assumptions that relinquishing the chains of old family roles, expectations, and emotional burden, is a freeing experience that allows personal growth, maturity, and confidence for self-discovery and development.

Self-discovery. Research on anorexia nervosa from the patient’s perspective point to self-discovery and self-development as having potential importance to the recovery process (Beresin et al., 1989; Hsu et al., 1992b; Maine, 1985; and Noordenbos, 1989). Inherent in self-discovery is the task of acquiring greater self-awareness, self-understanding and self-definition which lead to ongoing self-development and self-acceptance. Adolescence pose a greater challenge toward the process of self-discovery in that there are many demands and uncertainties which threaten the youth’s sense of identity and acceptance. Demands and uncertainties during adolescence include pubertal changes, peer pressures, transitions from elementary to secondary school and to college,
being in romantic relationships, conforming with media messages for thinness and dealing with work and careers. Beresin et al.'s (1989) finding that maturity fears were overwhelming provides some support for this. According to these researchers, growing up requires the skill of tolerating uncertainties in relationships, the ups and downs of feelings, the struggles of defining oneself, being separate from the family, and the unknowns of adult responsibility and sexuality. Anorexia nervosa may provide, for some, a temporary escape from the challenges of growing up which implies that recovery requires some means of self-discovery and development that leads to a sense of personal effectiveness or competence in facing life's demands.

Various aspects of self-discovery and self-development were described as important goals to recovery by participants in Noordenbos' study (1989) and referred to by Maine (1985). These goals included becoming more satisfied with themselves, gaining more self-confidence, feeling more at home in their body, learning what is important for them, becoming more assertive, strengthening their sense of identity, learning how to resolve conflicts, and evaluating weight as being less important. Although these elements were significant to study participants, the researchers did not provide a clear explanation of how the closely related concepts of self-discovery and self-development contribute to the process of recovery from anorexia nervosa.

Implications for Further Research

Research exploring the experience of recovery from the patient's perspective is very limited. Nevertheless, research to date has provided some insight into the process of recovery. Important understandings have been gained about how recovery may be influenced by therapeutic relationships, the importance of experiences outside of formal therapy, shifting perspectives on family relationships, and the potential significance of self-discovery. These findings highlight
aspects of recovery that have not been captured in studies that are based on explanatory frameworks and assumptions about anorexia nervosa from the point of view of experts in the field. It is therefore important to continue to explore patient’s perspectives of recovery.

What is still missing is a complete understanding of recovery from anorexia nervosa as a process-oriented experience that may include periods of remission and relapse. Although qualitative approaches were used to study the patient’s perspective of the process of recovery from anorexia, multiple qualitative studies, using a variety of methods are required to fully explore the complexity of the recovery process.

Summary

This literature review highlighted the contributions and limitations of published research addressing the process of recovery from anorexia nervosa. Only a handful of researchers have looked at recovery from the perspectives of those who have journeyed from anorexia. Themes for clinical consideration have emerged from the stories of how people recovered. Given the limitations of these studies, it is important to continue building on such works in the hope of achieving further insights into the recovery experience.

Ryan (1994) have suggested that anorexia is a healing voyage of discovery, and she cited Marcel Proust, who so eloquently stated, “The real voyage of discovery consists not in seeking new landscapes but in having new eyes” (p. 91). Perhaps researchers need not look for new explanations or horizons of anorexia, but to listen to those who have made the voyage, and to see the journey with their eyes. The next chapter discusses the methodology of grounded theory in studying the phenomenon of anorexia nervosa and the process of recovery from the patient’s perspective. Grounded theory methodology aims to generate a theory which explain experiences
with such detailed conceptual richness that anyone having had that experience and upon reviewing the theory would be able to immediately embrace it as their own (Sandelowski, 1986). This kind of theoretical understanding of recovery from anorexia nervosa is a gap yet to be filled in research.
Chapter Three: Methods

Grounded theory methods were selected for this study for the purpose of discovering a beginning theory to explain the processes women undergo to recover from anorexia nervosa. This chapter begins with a brief description of the grounded theory approach. The main focus will be on strategies used to enhance methodological rigor during participant selection, data collection and data analysis. Ethical considerations are also described.

Grounded Theory Approach

Grounded theory is designed to capture the social realities of human experiences and aims to develop a theory that encompasses the experience as a whole. Since the aim of this study was to understand the basic psychological and social processes of “how” women make change to recover from anorexia, grounded theory was the best fit.

According to Morse and Field (1995), grounded theory stems from symbolic interactionism. Symbolic interactionism explains human behaviour in terms of how people respond to others in their environment through active and ongoing interactions. In order to make meaning of experiences, people actively engage in the process of constructing their own realities from the symbols in their environment rather than merely reacting to them. Grounded theory methods in this study extend our understanding of how individuals make meaning of the symbols in their environment, what influences their thoughts, perceptions, emotions or sensations, how actions and interactions occur, and how social processes interrelate.

Grounded theory is known for its systematic approach to qualitative inquiry but it is also characterized by its evolving and inductive nature (Glaser, 1978). For example, this study began with interviewing four participants (Anna, Betty, Cathy and Diana), transcribing the audio-taped
interviews verbatim, checking the transcripts for accuracy, using open coding analysis with each transcript to form initial categories, generating memos, and as questions arose from the analysis, they were used to further direct data collection (i.e., in selecting the kind of individuals who were interviewed as well as using questions arising from the analysis to focus subsequent interviews). This iterative process of data collection and analysis was repeated with another set of three interviews and then two more interviews, until a minimum of new information was obtained from the interviews, major categories were developed, relationships between categories were identified, and the theory that emerged provided a preliminary explanation of the basic psychological and social processes of recovery from anorexia.

Grounded theory was originally advanced by Glaser and Strauss in the 1960's (Dey, 1999). However, since that time, Glaser and Strauss have gone in different directions in terms of their philosophical approaches. To reduce confusion, this study will follow grounded theory methods as advanced by Strauss and Corbin (1998). The following sections provide details of their methods that were used in this study.

Selection of Participants

Purposeful sampling was used for participant selection in the initial phase of this study. Purposeful sampling refers to the selection of participants based on their first-hand knowledge and experience of the phenomenon under study (Sandelowski, 1995). This study initially began with interviewing four women who met the study criteria. Further sampling was directed by the theoretical needs of the study.

In grounded theory, the term “memos” refers to the process of documenting the researcher’s thoughts, analysis, interpretations, questions and decisions that direct subsequent data collection (Strauss & Corbin, 1998).
**Selection criteria.** Only females were recruited for this study because it was believed that the recovery experience would be gender specific. The fact that 90% of those affected by anorexia nervosa are female suggest that it is predominantly a woman’s health issue. Goldner et al. (1997) argued that, “Anorexia nervosa is simply one of many choices that women can make to express themselves within a dominant gender order where women’s power is unequal to men’s” (p. 455). MacInnis (1993) argues that patriarchal societies rank women according to how closely they approximate society’s narrow definition of body ideal and beauty. Women who “measure up” are rewarded with more dating and job opportunities, marry earlier and are ultimately given the “attention and admiration of males” (p. 74). The current cultural message that the power, success and worth of women can only be achieved through the thinness of their bodies results in women competing against one another with respect to weight, what they wear or how they look.

Other criteria for participant selection included: (1) previous diagnosis of anorexia nervosa by a qualified practitioner such as a family physician, psychiatrist or psychologist; (2) a self-report of being “recovered”; (3) no other existing eating disorder; (4) English speaking; and (5) willingness to participate in one or more separate audio-taped interviews either in person or by telephone. Women of all ages were included because the recovery process may be prolonged.

**Selection procedure.** Recruitment of women for this study came from various sources. An advertisement (see appendix A) was posted free-of-charge in the community column of newspapers in various locales such as Vancouver Island, the Lower Mainland, and the Okanagan area. The same advertisement was distributed in a flyer format to self-help organizations and advocacy groups such as the Association for Awareness and Prevention of Disordered Eating (ANAD) and the British Columbia Eating Disorders Association (BCEDA), as well as to over 20
eating disorders programs and services in British Columbia, excluding the program in which the researcher worked as a nurse clinician.

All twenty-four individuals who responded to the advertisement or heard about the study via word-of-mouth were provided with details of the purpose of the study. Almost all respondents expressed interest in participating and were then screened according to study criteria. Twenty women who met the study criteria were informed of the procedures for interviewing, assured of confidentiality, asked to sign a consent form (see appendix B), and to complete a brief background information checklist (see appendix C). Consent forms were sent by mail to seventeen women, who were then contacted by telephone to assure that they had the information necessary to provide informed consent. Once the respondents had this information, they were asked to sign the consent form and return it to the researcher using the postage paid, self-addressed envelope. Thirteen consents were returned via that process. Consents from three other women were obtained in person which made up a total of sixteen potential candidates to draw from.

It is important to note that the sixteen women who volunteered and met study criteria were of different ages between 19 and early 50's. There were no intentions to exclude anyone because of age although the final sample showed that women between the ages of 24 to 40 were not interviewed in this study. The two main reasons why this may have happened relate to the few numbers of women who fell within 24 to 40 years of age, and the way theoretical sampling occurred. To explain, the number of women in their forties and early fifties made up 50% of the total pool of interested participants, while 5 women were under 24 years of age and only 3 women were in their late twenties and early thirties. During purposeful sampling, two women in
their early twenties and two women in their early forties were interviewed. Theoretical sampling was then used to guide sampling decisions. During analysis, age did not emerge as an important factor that influenced recovery and it was by coincidence that the age group in question was not included in the study. As well, all volunteers for this study were Caucasian.

Data Collection

Grounded theory makes use of various sources for data collection (Strauss & Corbin, 1998). In this study, data was obtained from interviews, field notes, and theoretical memos. The women in this study were considered experts in terms of their own experience, and the researcher’s objective was to capture that experience as accurately as possible.

The interview setting was mutually agreed upon, in advance, to ensure confidentiality and to put the women at ease. Six interviews were conducted by telephone and three women chose face-to-face interviews in their homes. All interviews were conducted by the researcher, audio-taped, and then transcribed verbatim by an experienced transcriptionist. Field notes were recorded immediately after each interview to capture the researcher’s impressions and observations of the essence, subtleties and context in which the interviews unfolded.

For the first four interviews, open-ended, sensitizing questions were used to ask the women to describe their experience of recovery in their own way, with as few prompts as possible. The main questions were: (1) Tell me as much as you can about your recovery experience from anorexia, (2) What would you say are some of the highlights of your recovery process? (3) Why were those important or significant? and (4) What is it like now without anorexia? As the women told their stories, it was important to listen actively, respond with empathy and sensitivity, and encourage as necessary. Trigger questions that helped jog the
women's memory, refocused the interview, or clarified the information being sought included:

1. What or who supported your recovery? What changed? What helped? What was different? Who were the significant supports? Were there significant events or experiences?
2. What or who hindered your recovery?
3. Tell me about your recovery, with all its ups and downs. What were the high points? What were the challenges? How are both important to your recovery?
4. How or when did you know you had recovered from anorexia?

Other questions that arose during the interview depended on how the women told their stories, what points required clarification, and what more needed to be understood. Another important aspect of interviewing for this study, specifically with telephone interviews, was that the researcher had to be more conscientious in offering verbal encouragements to express listening and active engagement.

Theoretical memos generated during the coding and analysis procedures were used to determine the theoretical needs of the study. They were reviewed for developing hypotheses and questions that needed to be addressed in subsequent interviews. Questions arising from that process highlighted the need to compare and contrast recovery experiences in several ways that directed theoretical sampling. For example, informants (Emily, Fiona, and Grace) were selected in the second set of interviews to further understand those who experience anorexia as something that will "always be with them" (Grace) versus "no longer a part of them" (Emily, Fiona), those who developed anorexia in their adolescence (Grace, Emily) versus later in life (Fiona), those who recovered with limited support (Grace, Fiona, Emily) versus a variety of support (Anna, Betty, Cathy), and those who were recently recovered (Grace) to those who had been recovered for many years (Fiona, Emily). Thus, keeping theoretical memos and using theoretical sampling were important methods for data collection and analysis.
The quality of data gathered for this study was highly dependent on the types of questions asked of the women. During analysis, there were recurring concepts such as the length of “time” it took for recovery to occur, the “hard work” of recovery, and “recovery for self” that needed to be further explored and clarified. Thus, subsequent interviews included questions such as, “Explain what you mean by ‘hard work’, and what was ‘the work’ that was involved?” Furthermore, the first four interviews revealed an absence of information on “how” the women began to eat during recovery. Thus, data gathering became more focused, using practical and structured questions such as, “How did eating or difficulties with eating change during recovery?” Other questions used by the researcher to draw further comparisons amongst developing concepts, as well as to determine similarities and differences, began with, “Some women have talked about....” and ending with, “what was your experience with that, if any?” Theoretical questions were repeatedly used throughout, “What did you do when that happened?” or “How is that related to what you said before?” to help move the analysis beyond mere descriptions to conceptualizations (Strauss & Corbin, 1998), thereby addressing the processes, variations, and relationships among developing concepts. These data gathering methods along with theoretical sampling and theoretical memoing enhanced the process of constant comparisons of incidents, events or happenings, which facilitated the analysis and development of concepts that were foundational building blocks to the emerging theory.

Data Analysis

In grounded theory, data analysis and data collection are systematic, interrelated processes. This process flows between data collection to data analysis, whereby one advises the other, in a fluid and iterative process that continues until data saturation is reached (Strauss &
Corbin, 1998). In this study, data analysis began on completion of the first interview, writing the first field notes, asking questions of the data and keeping track of those questions in memos which were systematically organized alongside relevant data. Data analysis came to an end when the major categories were sufficiently filled to provide an explanation about “what’s going on here?”

Throughout the course of this study, data analysis involved the rigorous application of constant comparison, a distinguishing feature of grounded theory methods (Strauss & Corbin, 1998). That is, the data from each interview were constantly compared to one another and to subsequent interviews in order to stimulate theoretical thinking and generate higher order codes or categories. Other analytical methods that were critical to this study included the three specific procedures of open coding, axial coding, and selective coding. The use of these analytical methods of constant comparison and coding procedures provided direction for further data collection, which then moved this study from concrete to abstract concepts, and the eventual emergence of a theory to explain the process of recovery from anorexia. The following is a closer examination of the three coding procedures and how they contributed to theory development.

**Open coding**

Open coding was the first step in this study toward building a grounded theory. Open coding refers to the process of “taking apart” and analyzing a large volume of raw data to identify concepts and their associated properties and dimensions (Strauss & Corbin, 1998). In this study, open coding involved a detailed line-by-line review of all interview transcripts, underlining or circling the incidents or facts (represented by a word, a phrase, or a paragraph), and rewriting
those concepts in an abstract form in the margins of the transcript (e.g., commitment, work hard, power, control, shifting perspective, and sense of self). During this process, incidents were compared with other incidents to determine whether they fit within similar or different concepts. Concepts that seemed to relate to a similar phenomenon were grouped into categories and labelled with more abstract conceptual names. For example, the concepts of commitment, caring, nurturing, connectedness, believed in me, and affirmation were initially categorized under “support.” Some of the other categories identified through this process were trust, being ready, hard work, ways of coping, having control, challenging thinking, new insights, start of recovery, slow process, and sense of self.

Categories are the “conceptual elements” of the theory to be generated, where the relationships between categories form the basis of the theory. Like the theory with its component parts, a category has “properties” as its component parts. Categories must not be viewed merely as labels of events but are valued for their analytical and sensitizing features that capture the complexities of the experience under study (Dey, 1999). The basic operations which supported this process of coding and categorizing were grounded in the asking of questions of the data and using theoretical comparisons to unveil the properties and dimensions of categories. For example, analyzing the category of “support” showed that some of the properties referred to the length of involvement, strength and quality of the support. And the dimensional variations of those properties included important components such as, ever present, unconditional, committed, non-judgmental, caring, and encouraging. Thus, the properties of “support,” constituted the conceptual elements that gave depth and meaning to that category. Open coding in these early stages of data analysis had to be done systematically and carefully in order to form a solid
foundation toward theory building.

**Axial coding**

By contrast, axial coding is the process of putting back together what was taken apart during open coding. In this study, categories and subcategories were pieced together and analyzed for their relationships to one another so that a more comprehensive explanation of the phenomenon could be found. Axial coding was termed as such because "coding occurs around the axis of a category, linking categories at the level of properties and dimensions" (Strauss & Corbin, 1998, p. 123).

Four basic tasks of axial coding (Strauss & Corbin, 1998) were applied. First, the properties and dimensions of the categories that were identified during open coding, were clearly laid out. For example, the category, "worthiness", revealed the properties of *extrinsic* and *intrinsic* worth and the dimensional variations related to *being deserving, entitled to recognition, and some sense of distinction*. Second, the different conditions, actions, interactions, and consequences associated with a phenomenon were identified. For example, comments about "looking good" (the action) from strangers (the condition) were sometimes more valued than comments from loved ones (the condition) because the latter was believed to mean "gaining weight" (the interaction) which would cause a "set back" (the consequence) during recovery. Third, the relationships between categories and subcategories were deduced and proposed, which then gave further direction for theoretical sampling and obtaining further evidence toward theory building. For example, one subcategory of "worthiness" was "self-approval" was hypothesized as a contributing factor to the "emerging sense of self." This hypothesis was then tested in subsequent interviews to reveal the intimate relationships among self-approval, self-acceptance,
sense of worth, and being “good enough.” Lastly, cues in the data that pointed to how major categories might relate to one another, how they were similar or different, were explicated (e.g., encountering support, learning to trust, and discovering self as “good enough”).

The four basic tasks of axial coding provided a systematic way of thinking about the data, identifying the intricate and complex nature of the data, and explicating the conceptual depth and richness within the data. As hypothetical statements were made during axial coding, further theoretical sampling was done to gather evidence that would either validate or dispute those statements. As the study progressed, a diagram was developed to help organize and examine the emerging relationships between categories and subcategories. Memos were written to explain the logic behind the diagram. The process of axial coding guided this study toward determining the phenomenon of “what’s going on here?”

**Selective coding**

Following open and axial coding, selective coding was used to integrate what had emerged from the first two coding procedures. Selective coding focused on three main processes (1) discovering the central or core category, (2) using specific techniques to aid integration, and (3) refining the theory (Strauss & Corbin, 1998).

**Discovering the central or core category.** The central category condenses the main theme of the research into a few key words. Sampling at this stage of analysis became even more focused so that data obtained would further fill out and saturate the major categories. As categories were further analyzed for their properties and dimensions, and then integrated with other categories, there was a story or explanation that evolved which seemed to logically and consistently relate all the categories, without forcing the data to fit. The core category also
appeared frequently throughout the data, in the form of various indicators pointing to that concept. The central category, “becoming the real me,” was eventually identified as having the analytic power to account for the many variations within categories, as well as explain how all categories and subcategories interrelate as a whole, to explain how the women in this study recovered from anorexia.

Techniques to aid integration. Strauss and Corbin (1998) described several ways of facilitating integration of concepts and identifying the central category. Techniques included writing the storyline, making use of diagrams and reviewing and sorting memos by hand. In this study, writing the storyline was perhaps the most useful tool that forced the researcher to pull together her interpretations and insights, and to answer the question of “what is going on?” Reading and re-reading interviews to answer questions such as, “What is the main issue or problem with which these women seem to be grappling?” and “What keeps striking me over and over?” as per Strauss and Corbin’s (1998) suggested approach facilitated writing the storyline which guided the remainder of the analysis.

Using diagrams was another helpful tool to integration because it focused on working with concepts rather than details (Strauss & Corbin, 1998). Drawing a diagram forced the researcher to think specifically about how concepts interrelate and how that can be depicted pictorially. The diagrams drawn for the purpose of this study were mainly used to organize the overwhelming number of categories and subcategories, as well as make sense of the dynamic interplay amongst categories. No satisfactory diagram was produced during this analysis that captures the complexity or essence of the recovery process, becoming the real me.

Another tool to integration involved reviewing and sorting through memos (Strauss &
Corbin, 1998). As the analysis progressed, memos became more abstract, provided more descriptions of properties and dimensions of various concepts, and thus, pointed to clues for integration. These three techniques were used throughout the integration process of selective coding.

Refining the theory. The last process to selective coding, in this study, was refining the theory. The theoretical scheme of *becoming the real me* was reviewed for internal consistency and logic. Where there were poorly developed categories, further data analysis was done to more fully develop those categories. As well, extraneous categories were trimmed. And finally, four women from the study were invited to review the theoretical scheme with the researcher and to give feedback on how accurately the findings reflected their story. One woman reported, “You allowed me to tell you my story, and then you gave it back to me in a form that got to the essence of what it was all about.”

Ethical Considerations

The women who volunteered their time to participate in this study were regarded with the utmost respect as they allowed the researcher to delve into their personal lives. Thus, ethical considerations for this study were observed, first and foremost, in the strictest sense, with the goal of protecting the rights of the women. Six items were identified for consideration.

First, approval from the University of British Columbia Behavioural Research Ethics Board (R.E.B.) was received prior to conducting this study. Second, participation in this study was completely voluntary. Third, written informed consent from all study participants were signed by the participant and witnessed. Fourth, all participants were informed of their right to withdraw from the study at any time— that they had a right not to participate, to end the interview
early, or to only give as much information as they felt comfortable. Fifth, confidentiality and anonymity were assured. All written materials, transcripts, and labels on audiotapes made use of fictitious names and number codes which protected the identity of each participant, and all tapes and files have been kept in a locked cupboard in the researcher's home. The actual names of the participants were known only to the student researcher. Lastly, if, during the interview process, it became clear that the participant had relapsed into eating disorder behaviours, then it was the researcher's responsibility to identify her concern to the participant and to refer her to appropriate services (see appendix D). No such need arose during this study.

Summary

This chapter provided a brief overview of how grounded theory methods were rigorously applied during data collection and analysis that led to the generation of a beginning theory. Ethical considerations underpinning this study were also described. Although the process of grounded theory methods were presented here as separate components, the actual, intricate nature of grounded theory relied on flexibility, fluidity and creativity in order to discover the depth of meanings and relationships of incidents, concepts, categories, dimensions and properties. Strauss and Corbin's (1998) grounded theory methods made it possible to make sense of the underlying conditions, experiences and processes of recovery from anorexia nervosa.
Chapter Four: Findings

Nine women shared their experience with anorexia nervosa and their story of recovery in great depth and with much passion. The findings here offer only a glimpse into the complexity of their recovery process. These findings must be taken within the context of these women’s lives. Thus, this chapter begins with a brief summary of the women’s background and their history of illness. The central category or the main theme of this study, Becoming the Real Me, will then be presented along with the five-stage process of recovery. Included in this discussion are verbatim statements from interviews with these women that give rise to the major findings and explain similarities and differences in their recoveries.

Context of the Participants’ Lives

Nine women, age 19 to 48 years, were interviewed for this study. Five women were in their forties and the rest were under twenty-five years of age. All participants resided in British Columbia with three each from the Lower Mainland, Vancouver Island and Central Okanagan. All were Canadians with predominantly European heritage (i.e. French, German, Scottish, Irish, British and Croatian). One participant also had a part mix of Native origin from her mother’s side. Their educational backgrounds ranged from completion of high school to university degrees; two were college students, three were employed, two were in contract/consultant work, one was self-employed and another was not employed due to medical complications of long-term effects from having had anorexia. Five of the nine women have never been married, two were divorced, and two were married. Both husbands of the two married women met their partners during the illness stage of anorexia and were instrumental in their recovery.

All but one woman struggled with the restricting sub-type of anorexia nervosa while the
other had the binge-purge sub-type. The onset and duration of their illness varied. Most of these women had an early onset of illness either in their mid or late teens while only one had a late onset at age 27 (see Table 1).

Table 1: Participant Characteristics

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Age</th>
<th>Age when anorexia began</th>
<th>Age when diagnosed</th>
<th>Age when recovered</th>
<th>Length of time since recovery</th>
<th>Education</th>
<th>Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna</td>
<td>46</td>
<td>14/15</td>
<td>29</td>
<td>38/39</td>
<td>8 years</td>
<td>Post-secondary training</td>
<td>Divorced</td>
</tr>
<tr>
<td>Betty</td>
<td>19</td>
<td>15</td>
<td>15</td>
<td>19</td>
<td>6 months</td>
<td>3rd year university</td>
<td>Single</td>
</tr>
<tr>
<td>Cathy</td>
<td>23</td>
<td>14</td>
<td>19</td>
<td>21</td>
<td>2 years</td>
<td>Bachelor’s degree</td>
<td>Single</td>
</tr>
<tr>
<td>Diana</td>
<td>41</td>
<td>15</td>
<td>29</td>
<td>33</td>
<td>8 years</td>
<td>Post-secondary training</td>
<td>Divorced</td>
</tr>
<tr>
<td>Emily</td>
<td>42</td>
<td>17</td>
<td>17</td>
<td>27</td>
<td>15 years</td>
<td>Bachelor’s degree</td>
<td>Married</td>
</tr>
<tr>
<td>Fiona</td>
<td>48</td>
<td>27</td>
<td>30 (Self-dx)</td>
<td>35</td>
<td>13 years</td>
<td>PhD (Psychology)</td>
<td>Married</td>
</tr>
<tr>
<td>Grace</td>
<td>23</td>
<td>20</td>
<td>20</td>
<td>22</td>
<td>1 year</td>
<td>Bachelor’s degree</td>
<td>Single</td>
</tr>
<tr>
<td>Nina</td>
<td>45</td>
<td>16</td>
<td>22</td>
<td>33</td>
<td>12 years</td>
<td>Bachelor’s degree</td>
<td>Single</td>
</tr>
<tr>
<td>Lisa</td>
<td>19</td>
<td>15</td>
<td>15</td>
<td>18</td>
<td>7 months</td>
<td>2nd year college</td>
<td>Single</td>
</tr>
</tbody>
</table>

Eight of nine women were diagnosed by a physician and one woman, with a doctoral degree in psychology, made a self-diagnosis. Three women gave a family history of anorexia nervosa. One woman reported a co-morbid history of obsessive compulsive disorder. The majority experienced depression to the severity of becoming suicidal:

I sat on the floor and cried really quietly to myself...whispering out loud...how much I...didn’t want a body....I just wanted to be a little head floating around....I could deal with things on that...wave....I went through about fifteen or twenty minutes of this and then a moment of silence, and this is the turning point for me was I said to myself, even out loud, I can’t leave my daughter without a mother, I can’t do that because that’s where I was heading....It was just a life or death moment for me....Am I really going to give in and let go and die or am I gonna...recover? Am I going to get over this somehow? (Diana)
All women in this study experienced denial of their illness. For most of these women, anorexia represented having a sense of control and identity that was important to them. Denial offered an escape from acknowledging anorexia as an illness, to themselves or others. Thus, women tended to discount and ignore concerns expressed by family members and significant others. However, being hospitalized sometimes forced women to look at the seriousness of their illness:

It took me a long time to believe that I was actually sick (laughs)....One part of me...understood it but...I couldn't believe that I was as thin as I was...and...somehow when I was in the hospital, it sort of finally hit me....It was like...oh, (laughs) I am actually sick....This isn't something...people have made up. (Lisa)

Four of the nine women (Betty, Emily, Grace and Lisa) received treatment within the same year their illness began but two others (Cathy and Nina) who lived away from home did not receive treatment for at least 5 years. Even when women were no longer in denial of their illness, they continued to deny their need for help, especially those who seemed to excel at school or work, despite their illness. As well, denial to others was a common means of keeping “a sense of control” and keeping others from “interfering.” Two women (Anna and Diana) kept their eating problems secret for fourteen years before reaching out for help. Diana recalls finally going to her physician when the illness became desperately out of control:

I didn’t want anyone to find out [about my anorexia]....I was so out of control....The scariest time in my life was that two months there where I dropped down into the nineties [pounds] and I really felt out of control and still managed to keep it quite secret. (Diana)

Denial was a barrier to seeking timely treatment. However, those in denial sometimes received treatment because of outside forces such as parental insistence, medical authorities, and/or hospitalization:

So I first started seeing doctors...because my mom kind of made me....She really wanted
me to go to the doctor and I honestly thought that I would go to the doctor and they would say...you don’t have a problem. (Cathy)

Cathy and Nina were immediately hospitalized by their physicians because of their dangerously low weight and medically compromised state. Although their hospitalizations were technically voluntary, both Cathy and Nina were “threatened” with involuntary status due to their denial of the illness and resistance to medical treatments. Occasionally, external forces were absent, but internal forces were sometimes sufficient to mobilize women toward seeking help:

I think the knowing [that I had anorexia], the knowing moved [me]...from thinking maybe to...being certain....It was a progression because it was so difficult for me to acknowledge this [the anorexia]....I remember when my period stopped, that...the hammer had come down....It was also an indication to me that I needed to do something about this. (Fiona)

Often, there was a combination of internal and external forces at play. For Diana, internal forces related to her “being tired” of the behaviours driven by anorexia i.e., of being obsessed with weighing herself multiple times per day and always striving to be at a lower weight even when severely underweight. But it was the external force that pushed Diana toward recovery. Diana’s daughter was becoming aware of her mother’s malnourished physique and abnormal eating patterns:

[Recovery] became just as much for my daughter if not more....She was getting older, she was becoming aware, and then it started to be a fight for her. I couldn’t let go of that last little bit of thread of hope for her [not to have anorexia]. (Diana)

Although internal and external forces that motivated women to change varied, they all came to realize they were “sick of being sick”:

I would say that [the threat of prozac] was probably one of the first steps, that and just being so tired....That and having so many tests done....I was so tired of having tests done like so sick of it and so tired of...people wanting to poke me and prod me and do all these stupid things....I hate it....That really got to me. I'm so sick of being like this. (Grace)

At the time of the study, all of the women considered themselves fully recovered although
three women who were recently recovered spoke of their ongoing challenges with food and
anorexia:

It’s a constant day by day struggle....There’s not one day that goes by...that food doesn’t
cross my mind....It’s knowing how to cope with that and just understanding...it will never
be completely out of my life....This will be something that you will have to everyday face
and choose everyday to not let it control your life. (Betty)

I guess most of what I want from recovery is to be able to not have it run my life,...not be
my religion,...not to be my God....I think that's what I really strive for....I think it’s
something I have to work at all the time...and some days I miss the mark and some
days...I get it and that's...what you have to do....Live day by day and that's...what I'm
trying to attain. (Grace)

I'm sure that...I'm never going to get sick again, I guess for me that's what...recovery is
about....I don’t fight it all the time and...I know I’m not going to get sick again...and it’s
not going to take over....Although now I catch it right away....Anorexia is sort of...sitting
there and it will start to come back a bit. (Lisa)

The rest of the women in this study spoke of recovery in terms of anorexia being “gone” or “no
longer a part” of them. For several, although anorexia was behind them, they acknowledged it
would always be a part of their lives, “Anorexia...is something in my history, it never goes
away....There's still this awareness....But it’s more of an awareness....It’s not that I'll become
anorexic again” (Fiona). Another woman reflected on the way anorexia continues to influence
her life, although anorexia was “gone”:

I believe that our experiences all contribute to the person that we eventually become so
that...the disease is no longer affecting my life to the degree it once did, but it will always
be a part of who I am and in some ways for the better because I think that I...understand
things differently than what I would otherwise understand had I not experienced what I
experienced and I have maybe more patience for people going through certain things....I
definitely have more insight into...weight matters...just things that affect body weight and
health and so on....It definitely will always be a part of my life because...it’s a part of who
I am....But...it definitely doesn’t...control my life the way it did....It’s not affecting me
anymore because it’s gone. (Emily)

A variety of themes emerged from the interviews with participants as they gave detailed
accounts of what they experienced as significant to their recovery from anorexia. These women initially used anorexia as a way to cope with the many challenges and stresses in their lives. For these women, anorexia provided a solution to perceived problems in gaining control, having an identity, feeling worthy and being “good enough,” much of which was first documented by Bruch (1973). As the illness progressed, however, the women began to lose control of anorexia. Under the influence of the illness, they felt tortured by the multiple expectations they created and demanded of themselves. No matter how much weight had been lost, it never felt good enough. With recovery, the women now define anorexia as a maladaptive way of coping with their emotional issues which “stunted” and “stamped out” their emotional growth. During illness, they were not “free” to be themselves. Thus, recovery for these women involved a “discovery” of the sense of self that had not been well developed, learning to believe they had value just for who they were and, consequently gaining the confidence to becoming who they were meant to be, without the guise of anorexia. In essence, recovery was all about “Becoming the Real Me,” and this became the main theme or central category of this study. The remaining discussion will examine this theme along with the related processes, strategies and factors that explain recovery for these women.

**Becoming the Real Me: Process of Recovery**

The women in this study underwent a complex, five-stage process to recover from anorexia. The work of recovery in each stage of *becoming the real me* was in direct contrast to the illness experience. During anorexia, the women experienced a drastically reduced sense of self. One woman described this experience as a “huge sense of no sense of who I was” (Anna). With this reduced sense of self, women felt they had no “power” or “control” in their lives, and
they looked to anorexia to combat their helplessness. In order to recover, these women aimed to
discover and define their sense of self. Diana recalled her search for self-understanding by
attending a group for women with anorexia, "What we’re all trying to find is...that sense of
self....Who am I? What are my boundaries? I didn’t know. I wasn’t going to find it through
other sick people. I was going to find it through getting to know myself.” As well, these women
had to find their own worth independent of anorexia. One woman explained,

The process for me also involved...in a big way,...issues around self worthiness, being of
value--of me being of value as a person just for whom I am....And not for how I looked or
what I was able to do....That was part of the recovery process for me. (Fiona)

And finally, becoming the real me also included the process of becoming an individual with a
separate identity:

I never felt like my own person....I guess recently too it’s just been developing...my own
person....Just sort of branching away from my parents in terms of the whole...adult
process....Just becoming my own individual person and not having to live under the
shadow of anyone else. (Betty)

In describing the process of recovery, two women in this study used a metaphor of
coming out of the darkness and into the light which symbolized, for them, their transformative
experience in becoming the real me. Fiona and Anna both explained:

When I was in the darkness, the darkness was the anorexia but there was no light within
because there was...no sense of self then. So coming out of that darkness into being...
coming out of the darkness into...the light of what I was becoming, that was the
process....In fact...that really describes the recovery....And the...step forwards and step
backwards is...that coming out of the darkness and then you slip back a bit and then you
move forward and you slip back....I wasn't out but I could see the light and that signified
hope...and I could hold onto it. (Fiona)

I envisioned myself as this black metal ball...and there was no light inside and I didn’t
know what was on the outside....Like I realized there is life up there. There is something
else in this and I truly in my being experienced it. And that just came....I was doing the
doing and going through programs and doing everything there and I didn’t see a lot of
result but along the way these things would happen which I’m sure all that stuff
contributed...Some more sense of life coming into my death experience like there was some light coming in. (Anna)

In keeping with this metaphor, the five-stage process of becoming the real me involved 1) catching glimpses of light: seeing the dangers, 2) inching out of darkness: encountering supports, learning to trust, 3) tolerating exposure: taking control, 4) gaining perspective in new light: changing the mind set, and 5) shedding light on self: discovering self as “good enough.” Although presented here as five sequential stages, recovery from anorexia was not a linear step-by-step progression. There is overlap within and between stages that suggests more of a transformation from having no sense of self to becoming the real me. It was characterized by a forward and backward struggle where slippage with progress made in one stage affected the ability to sustain progress made in other stages. For all women in this study, recovery was experienced as slow, gradual, long, and requiring a lot of hard work.

Stage One: Catching Glimpses of Light: Seeing the Dangers

Stage one of recovery for the women in this study involved the beginnings of gaining insight into their illness. These insights were often fleeting and it was like catching glimpses of light. As the women began to see the light, they saw the guise of anorexia and the harm that it posed. This created discord in their perceptions of anorexia and what anorexia actually was. Women perceived anorexia as something which helped them feel better about themselves. They believed that losing weight was a “good thing” and it gave them a greater sense of control. Learning about anorexia opened the women to new possibilities.

For most of the women, the insights came as a result of education that helped them understand what they were experiencing. “Learning about the starvation syndrome gave me more trust that, okay, well maybe I am not abnormal. Maybe I will be able to be a normal
weight” (Cathy). These unexpected insights offered hope along with a sense of danger:

My mom came into my room with this Reader's Digest and she just was crying...and she said, you need to read this. And I read it and I knew that's what I had immediately and it scared me and yet it was a huge relief to know that I wasn't just going crazy. That there was actually a name for it....And that there was...something that maybe could even be done about it. (Emily)

I didn't understand prior to reading that chapter...that I was actually harming myself...I thought I was doing a good thing when I lost another pound. When I read that information and understood that I was, in fact, harming my body, there was a shift in my thinking because I didn't want to harm my body....By not eating, I'm harming it. So that was...one of those shifting moments...that supported my recovery. (Fiona)

For Anna, who was so deeply entrenched in anorexia, it was not until someone reached out and connected with her that she began to see anorexia for what it was:

I was just sitting in the mall, just not looking well at all in my jogging clothes and eating a muffin like I did everyday, that's all I ate. And...she [high school acquaintance] just... brought some flowers and came up to me. She brought me some freesias, and she said, you know, if you'd like to be a friend, I would be your friend....Do you want my phone number? And by the time I got home I phoned her crying....That's really a huge part of my recovery is her commitment....Her friendship [and] commitment to me...for no reason because everything in my life was for a reason. (Anna)

In this early stage of recovery, the kinds of insights that demanded attention from these women related to the inherent dangers of anorexia and health risks associated with weight loss. Learning about the starvation syndrome helped the women understand why they had extreme preoccupations with thoughts of food, impaired memory and concentration, pervasive sense of ineffectiveness, and depression. Having that understanding reassured them that they were not "going crazy" but how they were feeling and thinking were attributable to not eating. With these critical insights, the women began to realize the real possibility of dying from the disorder. These insights prompted them to examine how anorexia had personally affected them:

I was cold all the time...and tired, like I'd fall asleep. I'd be sitting there on the bus going to school and I'd just fall asleep at the drop of a hat for no reason....I could barely stay
awake....I'd fall asleep in class. I'd fall asleep...watching TV. The only time I didn't fall asleep was when I was eating. And...it's just tiring and you're cold and...it's uncomfortable like it hurts to sit...on the bus....The seats are too hard, it hurt to sit at school because the seats were made of plywood. (Grace)

As the women began to internalize their problems with anorexia, they were forced to reflect on their need to change, “I was almost thirty and I thought I am not going to go through the next thirty years of my life like this. I can’t do it. I won’t live through it” (Diana). For Anna, cycling through an extended period of drastic weight loss, weight gain and hospitalization finally helped her face what anorexia was doing to her:

Just keeping going back to my old way, hospitalize, gain weight, lose weight and keep going back, and...each time I did it, it became more difficult. I’d have to work harder at it and I would...feel like so awful and I, just this frenzy ball of anxiety and activity and I couldn’t stop and I wanted to stop. I wanted to have a break. I wanted to be able to sleep. I couldn’t do it and just, I guess out of a desperation...realizing that this is not working....What I’m doing is not working....I’m getting back less from it than I used to and yet I can’t let it go. (Anna)

For others like Fiona, beginning insights also represented hope:

It was just a picture of the process that came to me like a vision of where I had been in this black pit and, and seeing...this glimmer of light and with the light there was hope that I was going to be able to come out of the darkness. I wasn't out but I could see the light and that signified hope to me....I think it...was part of the process and it was getting to a point in the process where...everything came together in that moment that I could have that awareness...and hold onto it. (Fiona)

With this hope, some women began searching almost obsessively for “answers” in books on anorexia, texts on how the body works, and even self-help books unrelated to anorexia.

Although the women’s initial efforts seemed futile, it was the beginnings of contemplating change:

I’ve read anything I can get my hands on just to validate my experience partly and confirm that...if this is true for me, then how do I get over it? I was always looking....So where’s the answers?....And [I] never found anything really satisfactory. (Diana)
This stage of recovery, *catching glimpses of light and seeing the dangers*, began when the women started to see anorexia differently. That is, they began to see the dangers of anorexia, to examine what it had done to their lives, to find some glimmer of hope, and to look for a different way of living. Depending on how entrenched in anorexia these women were, some were able to begin recovery sooner than others.

**Stage Two: Inching Out of Darkness: Encountering Supports, Learning to Trust**

In stage two, the women slowly began to move away from anorexia, *inching out of darkness* and into a new way of living. A key component of this stage was learning to trust—in others and in themselves. Trust was not possible, however, until they encountered people who would offer unconditional and unwavering support, people who would not judge but accept them as they were, people they could count on. These encounters did not occur readily and when they did, trust still needed to develop over time. Thus, *inching out of darkness*, occurred over a long period of time and in very small steps, “To find your way out of that little by little by little, by little, by little....It’s the tiny baby steps....For some people it’s longer than others but there’s often long periods of time when it’s a...battle of life and death” (Anna).

Part of the “battle” or struggle of anorexia related to the forces that held these women back. One was strongly related to the significance that anorexia held for them, in terms of having a sense of control, “The control of abstaining from food and the high I got off that gave me a sense of power, a huge sense of power” (Anna). This insatiable need for control grew out of their experience of having “no control” in other parts of their lives, “One thing I could control no matter what else happened....And [while] other things in my life...were going kind of crazy....I could control what I was eating...and how much I weighed” (Lisa). For all women in this study,
“not eating” was a means of regaining a sense of control as well as feeling “good at losing weight and...being [the] best” (Lisa). For some women, anorexia was inextricably linked with their sense of identity:

Even as a...really young girl, I always had...low self-esteem...I wasn’t allowed to associate with other people...I wasn’t allowed to play sports or do any sort of extra curricular activities because those again were supposed to be part of the religion...so there was nothing else in my life that I was good at...my only other identity was grades and my body...I was always known as the skinny one...so that was kind of given to me as my identity. (Cathy)

Because anorexia gave the women a sense of control and identity, they had to work hard to “let go” of their false belief that control and identity could be effectively achieved in that way. In order to recover, they also had to work against the multiple societal messages that upheld thinness as something to aspire to.

Lastly, and perhaps the strongest force that held these women back, was the “not good enough” self-perception which continually perpetuated anorexia, making it necessary to ignore and neglect their own needs:

I was really depressed....I know a lot of anorexia for me was just...I didn't feel like I was good enough to eat and I felt so guilty every time I...took in anything....I thought I shouldn't feel the feelings but I did...so I decided I was a bad person....I didn't think I deserved to eat....Again, as I said at first...for a long time I was doing it [recovering] for the kids [Natalie and Ron’s kids], I couldn’t do it for myself because I still didn't believe that I deserved it. (Lisa)

Part of Lisa’s experience of not feeling deserving or “good enough” stemmed from her father’s emotional neglect during a traumatic period in early adolescence when her mother died, and the many mixed grief reactions that were not addressed but were ascribed to “being a bad person.” For some of the other women in this study, not feeling “good enough” stemmed from family environments that were verbally and emotionally abusive. Perceived favouritism of parents
toward other siblings added to the “not good enough” self-perception. As well, having “controlling parents” or “controlling boyfriends” who dictated a narrow range of acceptable standards added to the self-doubt of being “good enough.” Even when none of these conditions seem to be present, one woman in this study described feeling “overshadowed” by her parents and boyfriend, because she held them in such great esteem but believed she could not measure up or be “good enough.”

The “not good enough” self-perception also gave rise to distortions in thinking about the body and self, “Now [with] the anorexia, I knew I needed to be smaller...because that would make me less bad or I could think smaller....So I had been minimizing, I was becoming less and less and less and less” (Fiona). The body represented something of themselves that they despised and wanted to be separate from. Having to work against these forces made recovery extremely “hard work.” And inching out of darkness was only possible when these women encountered supports they could trust.

Encountering supports was a factor that helped women take small steps and endure the hard work of giving up their dependence on anorexia. Who was considered by the women to be a primary support in their recovery varied, and included family members, spouses, friends, therapists, ministers, church members, God, and, for one woman, a stranger who offered her friendship. For Lisa, it was her billets who became more like parents to her:

Natalie and Ron are really sincere....You can always count on them...if they make a promise, they will keep it, right?....I guess that's the big one....I can count on it. Now if I say...I really need to talk, I'm really having a hard time...I can count on the fact that Natalie is going to make time for me. (Lisa)

Having unwavering support that was ever present created a level of emotional safety necessary to make change and inch toward becoming the real me. What touched these women was the depth
of caring and commitment they began to recognize in their relationships, especially to them as individuals. It was through these special relationships that the women were learning to trust and to begin understanding how damaging past relationships were to their sense of security, “My fear was fed by the fact that I wasn’t given a sense of, I’m here for you, I will be here for you as long as you need me” (Anna). The trust experienced in those special relationships gave the women greater confidence in seeking out other relationships that eventually added to further self-understanding.

Finding safety in not being judged was another important factor that supported the women in *inching forth* and risking being seen without the veil of anorexia:

[She was] committed to me. She did not judge me in any way. She never said anything about my eating or my behaviour, she just didn’t go there. All she did was love me and be a committed friend...and listen to me. (Anna)

These supportive relationships allowed the women to *develop trust* and become more open to addressing the problems with anorexia. As the women gained insight into their illness, they experienced shame in having the illness and they kept it secret until they found someone they could trust with this information. Trusting that others would be understanding enough to help and sensitive enough not to react in ways that would harm or destroy their fragile selves was critical to the recovery process. Burke and Stets (1999) describe trust as “an expectation of goodwill and benign intent,” which is exactly what the women in this study looked for. They relied on the trusted individuals to not further shame them, and to continue to accept and care for them as they were:

Trust was...such a big part [of my recovery]....Because I always had a fear...that I couldn’t trust people, they would betray me somehow...if they knew the real me....And having trust in therapists...made a big difference to being very open and honest about whatever was happening. (Diana)
When the women experienced unconditional acceptance from trusted others, the underlying message of being valued just for who they were, helped move them that much closer to becoming the real me:

The most important aspect of recovery for me and...continued recovery for me...is surrounding myself with people who see value in me for being who I am....It feels to me as though that was the essential ingredient that I needed to begin this process....And that was my husband initially and in what I've done as the years have gone by....Without that, I don't know what might have happened. (Fiona)

Sustaining progress was also easier when the women found reassurance and guidance that they were heading in the right direction. It was not uncommon for the women to lose sight of where they were heading. Having regular reminders of what they were capable of doing and how they were contributing to life, in general, supported them in their journey to recovery. One of the factors that sustained progress, especially with respect to eating, was the “outside voice” and presence of someone they trusted. That outside voice served to balance off and counteract some of the “inside voices” of anorexia by distracting them from the non-stop, self-destructive thoughts that they did not deserve to eat:

Basically it was somebody just being there, somebody sort of outside of me, so again...your mind is sort of just taken over by these voices saying you don't deserve to eat....So if there's somebody outside, then...it gives you an opportunity to focus on something else....Obviously you're still intensely focused on food and everything but at least there's a glimmer of sort of outsideness, you're not just stuck there with your obsession (chuckles)....There's somebody outside saying hey, remember...life out here and...most of it was...just chatting....Especially at the beginning of meal support...[having someone say] you can do it, remember what you're doing this for....It was important to have somebody there and especially that sense of somebody is watching me, I have to do this....Because my brain said...you don't...have to do this, you don't need it or whatever....There was somebody there that was watching me so...I had to. (Lisa)

There were many events that created extreme fear and ambivalence for women in this study that caused them to retreat to the safety of their anorexia. Their ambivalence centred
around gaining and not gaining weight. Thus, in response to instances where their clothes fit a
bit tighter, or if others commented they had gained weight, their still fragile resolve to get better
would be shaken. Even comments about the women “looking better” created uncertainty because
it meant they had gained weight. Gaining weight created great fear in these women because their
sense of identity and control still depended on being thin, and even when they had insight into
this, it was difficult to cope with any additional weight as Betty recalled, “And if it’s two pounds
more than you want, for some reason you become worthless in your own eyes. And if it’s two
pounds less than you want, you feel great.” Knowing her self-esteem revolved around numbers
on her bathroom scale, she coped by making a conscious effort to avoid weighing herself. The
ambivalence around weight gain contributed to the forward and back movement of recovery as
the women struggled with fears of unknown and feelings of being exposed and vulnerable:

That’s what characterized the struggle for me...the forward and the back...the forward and
back...it felt as though as I moved forward, I was moving into territory that was
unknown...an identity...that was unknown....into behaviours that felt unfamiliar....So it
wasn't a comfortable place. It was more comfortable even though it was torturous, there
was some kind of comfort in...knowing how to restrict my diet....Trying to let go of that I
felt so vulnerable....And that's where the scariness came from, that vulnerability. I don't
know what's going to happen. (Fiona)

*Inching out of darkness* was a tentative, forward and back struggle with many challenges but the
work was necessary in *becoming the real me*. In order to continue inching forward, the women
in this study also had to begin tolerating exposing themselves without their anorexia. They had
to learn new ways of coping.

**Stage Three: Tolerating Exposure: Taking Control**

When women in this study began to let go of anorexia, they were still uncertain about
their sense of identity, sense of worth and level of acceptance if seen for who they were. This
made them feel vulnerable and out of control. When that feeling became intolerable, they were susceptible to falling back into anorexia—where it was familiar, predictable and safe. Thus, continuing the process of recovery demanded tolerating exposure while they began to learn how to take control of their lives in new ways. The women in this study took risks in experimenting with various strategies such as: setting boundaries, making choices, facing fears, and taking back power. However, during this process, the women were often tested with ongoing challenges around weight gain and appearance as they attributed much of who they were to those qualities:

Because it was real scary to...gain weight....For some reason....I just went on this...okay, I trust you but I'm not going to fully let go (laughter) control here but I...did trust him. Um, oh God, (laughs) I just...remembered it was so hard....It was that conflict between letting go and holding on...and...that became another thing that got added to the obsession about food and what I’m eating and what I’m not....There was then this conflict about I want to let go but I don't. (Fiona)

In experimenting with the strategies described, the women discovered that they could attend to their own needs, voice their opinions, and still feel effective and accepted. In fact, these life experiences taught the women that they have power and control over their lives regardless of their body weight.

Setting boundaries was an important first step to taking control and tolerating exposure. For women in this study, their boundaries around what they wanted were fragmented because they were unclear about who they were and what worth they had as human beings. For some women, these boundaries had been broken because they were violated by either sexual predators, and/or verbally abusive individuals who left them with deep, emotional scars. Other women with less traumatic histories, described being “overshadowed” by their parents or boyfriends which resulted in difficulties in distinguishing where their own boundaries ended and others began. During illness with anorexia, the women coped by catering to everyone else’s needs but their
own, which usually took the form of assuming caregiver roles or pleasing others. Eventually, the women lost sight of their own needs, desires and personal boundaries. Thus, recovery required a re-learning of what their own boundaries were. A critical component to that re-learning, was to see others validating the boundaries they set as something to be respected:

If I wasn’t a hundred percent certain it was okay, she [therapist using therapeutic touch] wouldn’t proceed....She let me be in charge....She said...it’s your body, you have to be comfortable with it, you have to be ready for it and it was always okay....She gave me that feeling [that] whatever I said was okay...and she would honour...[and] respect whatever my boundaries I set. (Diana)

In learning to set boundaries, women in this study began to experience a sense of who they were, what they wanted and what was acceptable to them. They were beginning to feel a sense of wholeness and thus found courage in speaking up for themselves. Diana had a very traumatic experience with a therapist who breeched her trust as a client, and violated her boundaries as a woman. With much support from another trusted individual, she found her own means of staking claim to what was acceptable and what was not acceptable in her relationships with others:

It was a victory....I felt like I had given away [a part of myself]...that he [therapist] had taken something [trust] from me....And this was me reclaiming myself....Going through that process allowed me to reclaim and even discover maybe a sense of self because for the first time in my life I actually set some boundaries....I felt for the first time...I actually could speak up for myself and say this was okay or that was not okay...I’d never done that before about anything. (Diana)

Taking control of their lives by setting boundaries supported women in tolerating the exposure of being seen “as is.”

Making choices about one’s life was another important means of taking control. In making choices for themselves, women had to acknowledge and attend to their own needs and desires independent of others. For some, this occurred only when they were away from their
families and on their own:

I think it's just a lot of learning....It's becoming mature...[and] deciding what you want....I had just gone by what everyone else did. Even when I went to...see Kathleen, it would be what Kathleen told me to eat....I have to decide to be healthy for myself....Being out on my own...[and] spreading my wings...made me choose what I want to do....And reaching points of just very, very, very low points of unhappiness and wondering why that I'm so unhappy....It was the low points that just made me realize...what it is that I'm doing wrong....and [then]...really deciding what I wanted out of life. (Betty)

Learning to make choices was another aspect of honouring their own needs and becoming the real me. As they became more comfortable in making choices for themselves, and understanding better who they were, they became more able to tolerate being seen for who they were.

Facing fears of “doing anything” outside of the world of anorexia taught women in this study about where they had control and where they did not. Facing their fears posed great threat and risk to what they believed they might lose. Diana reported having great fears of losing control if she were to give up anorexia. Whereas, Anna, who desperately wanted to recover, believed that her psychiatrist was the only person who could help her and she feared losing him. However, she never felt secure in that relationship as there was no sense of commitment from him, and she felt that he had all the “power and say” while she had none. Her psychiatrist represented her only hope for recovery and she feared that loss. Eventually, she began to see the futility of that relationship and took control by parting ways with him. By facing that fear, she discovered other more therapeutic relationships that taught her about equality, commitment and respect, which were critical to her understanding that relationships can be predictable and trustworthy.

Facing fears of being controlled by family members were even more difficult considering the vested interest in the life-long nature of those relationships. For the women in this study,
losing the love of a parent was devastating because it fueled their belief that they were not worthy or deserving of love. Diana grew up being afraid of being controlled by her mother. In standing up to her mother, and resisting her demands, Diana finally realized that she held the power to changing that situation:

She [mother] was yelling at me out the door, don’t you go anywhere, don’t you walk out on me. And...it was so scary....Yet it also helped me a lot because I did face my biggest fear with her...that she could control me....And because...she had so much controllingness about her when I was growing up...so that was also an important point in my process with her. (Diana)

As women triumphed over their perceived fears, they were able to continue taking more steps toward living freely and becoming the real me.

*Taking back power* was a conscious strategy used by the women to acknowledge the power differential that perpetuated anorexia in their lives. For Betty and Emily, preoccupations with thinking about food made them feel powerless over food and anorexia. Emily managed to take back power by denouncing anorexia as something that was “stupid” and a “waste of time,” and she used this power to interrupt her habit of spitting out food. Diana also took back power by personifying anorexia and confronting its presence in her life:

Understand what’s driving me, that there is a part of me that is destructive and hateful....I confronted him [anorexia] in writing, I confronted him in dreams...to take his power away...that shadow side that was killing me. It [anorexia] controlled my mind, and it was this very gradual fading away process....He’s [anorexia] still there but I befriended him....I took control in that dream where I confronted him....It took his power away....He doesn’t control my life anymore....Now it’s just a gentle sort of dialogue....what’s going on with you? (Diana)

There were other situations in the women’s lives that replicated a “perceived” power differential that perpetuated anorexia. When it seemed that her mother’s religion dictated her every move, Cathy believed the only thing she could control was “not eating” and “being thin.”
Betty saw her parents as pillars in their community and in striving to live up to their ideals, sought her own identity through anorexia. Both Cathy and Betty took back power by re-examining their perceptions and realizing that they possessed the power to choose who they want to be, and still be accepted as worthy. For others like Anna, taking back power involved finding the courage to disengage from power struggles with her psychiatrist and walking out on him. Taking back power was a necessary part of taking control without using anorexia.

As the women took back power and exercised control over their lives, they began to deal with their misperceptions of helplessness. They became more confident as they gained greater insight into the power they possessed. These strategies helped the women feel more secure in tolerating exposure of being seen for who they were.

The strategies the women used were interrelated processes that built upon one another toward taking control in new ways. In doing so, women experienced a stronger sense of who they were in terms of their boundaries, their limits, their thoughts, their desires, their fears, and their feelings. All this emerging sense of control and effectiveness increased their tolerance for exposing themselves without anorexia. Working through this stage, women developed greater confidence toward becoming the real me.

Stage Four: Gaining Perspective in New Light: Changing the Mind Set

While women in this study underwent the processes of learning to trust and taking control, the misperceptions perpetuated by anorexia continued to work against them. However, the more they worked through stages two and three, the more they were able to gain perspective on their erroneous anorexia thoughts. In gaining perspective and seeing things differently, they began changing their mind set about food, body weight and, most importantly, themselves as
worthy beings. Building on previous stages, women used several strategies to change their mindset: "undoing wrong thinking," changing focus, and gaining distance.

"Undoing wrong thinking," for the women in this study, required undoing distorted thoughts that eating made them "bad" persons, that they were not deserving of food, and being smaller meant making smaller mistakes. As well, they had strongly held beliefs and misperceptions that anorexia was the only means of achieving a sense of control, a meaningful identity, and significant self-worth. These kinds of "anorexia thoughts" or "wrong thinking" were pervasive in "all areas" of their lives. This mindset was so strong that it limited their ability to see their lives from a broader perspective.

There were internal and external factors that supported this process of undoing wrong thinking. External factors involved having someone they trusted constantly question and challenge their anorexia thoughts. "My own personal therapist...she was very nurturing and constantly... questioning my irrational beliefs....And slowly, like very slowly, that took years [to undo]" (Cathy). Undoing the irrational beliefs of anorexia was a process that required nurturing from others, and softly spoken words rather than direct confrontations. Anna spoke of the importance of being nurtured, having a connection and developing trust as part and parcel of the process of undoing wrong thinking. The women could only "accept" and "receive" feedback about their ways of thinking when the people who shared this were those they trusted. In essence, caring and commitment fostered the development of a trusting relationship that allowed the women to begin trusting what others said to them.

Another common external means of obtaining and receiving trusted information was reading textbooks or other credible sources of information on anorexia. Reading helped the
women examine how anorexia drove their thoughts and behaviours. By comparing what they read with what they experienced daily, the women exposed their wrong thinking for what it was. Cathy recalled competing to be the sickest and feeling very inadequate or “not good enough” when others were worse off. She explained, “The book really explained it [for me]....Because that [anorexia] had become my identity...that’s who I was. And because of me being very competitive and being a high achiever...I was going to strive at...[being] the sickest anorexic.”

For many women, journalling was yet another concrete and reflective process that helped them gain perspective on their anorexia thinking, “What my mind was saying was really irrational and I knew that. But just to have it put...on paper...[helped me] to see...how irrational it really was” (Cathy). Journalling also helped women become more open and honest with themselves in examining and undoing their “wrong” thinking:

Have journals where they have two columns and it’s like this is my thinking....That’s wrong thinking, and this is correct thinking....So it was really a process of challenging my thinking and going there....Not just having somebody say it to me but really accept that as part of my process. And I did that exercise...honestly within myself to say...this is not truth. This is not right thinking. This is distorted. (Anna)

Some women in this study also needed to have proof that there was value in eating before they were able to undo their misguided thinking about food and weight:

I remember feeling like that and thinking...if eating makes me feel like this everyday...I could do it....I remember running across the...road thinking...I feel so strong, I love running, I feel so good....Maybe eating isn’t that bad because it makes me feel better....If I can feel like this, maybe putting on a little weight isn’t that bad. (Grace)

Internal factors that supported undoing the anorexia thoughts related to making conscious choices against those thoughts. Thoughts that they were not deserving of eating and that eating was bad were so entrenched that the women had to deliberately “force” themselves to do otherwise:
I was very conscious of...what the eating disorder behaviours and thought patterns were and I made a significant effort....If I was going to chew something up and spit it out, for example, I would force myself not to do that. You either eat something or you don’t eat it, this is it. (Emily)

Another internal factor that facilitated undoing wrong thinking was consciously acknowledging and “attacking” irrational thoughts as they occurred:

I’m able to attack it right away...Just because my negative mind was telling me all day like twenty-four hours a day...just berating...everything whether it has to do with food or whatever....So it was really important...to have thought attack things for everything that was going on in my life. (Cathy)

Even while attacking these thoughts, women continued to experience a forward and backward struggle:

For me it was somebody again bringing that hammer down and declaring that I wasn’t good enough. Now that was...during the recovery process. The effect...that had...after the hammer coming down and making that declaration that I really, really wasn't good enough and I had suspected it all along....This was the hammer coming down saying no, you're not....There was something inside of me that said, wait a minute....I don't think that would have happened...if I was still, if I hadn't been in that recovering phase process....There was enough there that...was shifting my ideas about myself...It was actually an event that...flung me a couple of steps back but then quite quickly...I'm saying in weeks, saying, hey, wait a minute, no, this isn't okay. So that was...back and forth. (Fiona)

Thus, undoing wrong thinking was an important strategy to gaining perspective and changing the mind set. Again, this process was characterized by hard work, “You have to work hard at it. It just doesn’t happen because you need to re-program your brain to think different. And you have to be well enough to be able to do that” (Anna).

Finding that inner strength to work against anorexia also required changing focus. Instead of focusing on external appearances of weight or body shape that triggered anorexia, all women in this study had to learn to choose a different focus. For some, it involved distracting themselves from food and focusing on other activities, “Just getting...out of your own little
shell...visiting the elderly...getting involved in things that don’t have to deal with food” (Betty).

For Cathy, it was important to distract herself from the negative messages of anorexia by doing crafts. Diana re-focused on the “spiritual” side of herself through meditation in yoga. Still, for others, re-focusing on physical activities they enjoyed was important to finding motivation to achieve physical wellness:

And I tried...to focus....It is hard because I still deal a lot with it everyday like I really don't like [certain] parts of me or whatever....But I try to look at...things like how I feel when I run....I feel this strong when I run because of what my body is now....It feels good to get out and just move...and be a strong person and a healthy, active person....Whereas I couldn’t really be an active person when I was falling asleep all the time. (Grace)

For all women in this study, re-focusing on what was important in life was necessary in moving away from anorexia:

When your friends just stick by....Just keep telling you how much...they value you and your friendship. You just realize what’s really important and what’s not, and really realize...what’s inside....You realize people don’t like you for your body. They don’t appreciate you for your looks. They like you for who you are. (Betty)

As women continued in this process of changing focus, they began shifting their focus to their purpose in life and how they could contribute as human beings:

I think it’s really important to consume oneself with... things that are really of value....And recognizing that the eating disorder itself is of no value to anyone especially to one's self. It’s destructive, but when you...think about it and...I thought about this a lot....What is it that I will accomplish by consuming my mind with food...all the time? And what am I going to eat for breakfast, lunch and dinner?...What value do I contribute to the world by doing that? And...what are the consequences in the end? And I thought, nothing that does any good for anyone, not even for me. (Emily)

Lastly, gaining distance was an important strategy the women used to gain broader perspective on themselves. The women found it difficult to change their anorexia mind set about their own body weight and size in relation to being accepted or valued. Therefore, instead of evaluating their own immediate situation with weight gain, it was easier to step back, gain some
distance, and observe how others of various body sizes were viewed:

I remember beginning to observe people and to see how regardless of their size, their mistake wasn't any bigger or smaller....I was in psychology so I was in a place of learning about human behaviour and research. So...that probably (laughs)...contributed to me taking that approach....It wasn't someone from the outside that helped me observe that....That's simply what I needed to do. (Fiona)

Another means of gaining distance was to observe others who were not as far along in recovery, “She’s been in and out of hospital like crazy and...it’s such a reinforcement to me...to realize that’s not what I want at all. Like that does not bring happiness at all....[It] keeps me on track” (Betty). Finally, taking a look at oneself from the position of another further broadened the women’s perspective on themselves:

What difference, when someone looks at me, do they look at me and say, wow, she's only a hundred pounds? She must have a lot of will power....I actually went through those thought processes and I said, no, people look at me and say,...I really pity her, she's got an eating disorder....And she might die from it....They don't look at me and think, wow...she's the thinnest of the thin. (Emily)

As women in this study used various means to examine anorexia, they became more able to gain perspective and change their mind set on anorexia, “The time that you dedicate to an eating disorder is time that is totally wasted and robbed from you and everyone you love. It’s just such a useless...thing....And I realized how stupid it was but I had to go through all of those processes” (Emily). More importantly, women were able to gain perspective and change their mind set about who they were as people and what they were capable of. Again, this contributed to the women’s emerging sense of self, seeing their bodies differently, and becoming the real me.

Stage Five: Shedding Light on Self: Discovering Self as “Good Enough”

Women in this study spoke extensively about their self-perception of being not good enough, not worthy, not deserving--to the point of having “no voice.” In being silent, they tried
to protect themselves from criticism, but in doing so, denounced their worth, abandoned themselves, and neglected their needs. For recovery to occur, these women had to reclaim what they had abandoned. In reclaiming themselves, they had to experience and see themselves as having value. The factors and strategies which supported this process involved: *seeing others see value in them, seeing value in themselves, and, finally, accepting themselves as they were*. This stage reflected the metaphor of *shedding light on themselves* and the phenomenon of *discovering themselves as “good enough.”* It is important to keep in mind that this stage does not stand alone. This stage occurred in concert with all other stages and the emergence and transformation of self during their *discovery of themselves as good enough* were interwoven in the processes of *seeing the dangers, encountering supports, learning to trust, taking control, and changing the mind set*. The following discussion attempts to isolate what was characteristic of this particular stage of *discovering self as “good enough.”*

*Seeing others see value in them* began the process of building self-confidence and seeing themselves as worthy. Fiona explained how her self-worth was initially dependent on how others saw her, and what she needed from them:

I was living with a focus that was outside of myself, so my worth was dependent on what others thought or said about how I behaved or what I accomplished...and how well I did a thing....Whether I was good or bad, whether I was right or wrong, the authority was always outside of me. And my choices were...based on...what they wanted me to do or what they thought was right or wrong. (Fiona)

Therefore, in discovering their own worth, the process needed to begin with other people who genuinely valued them for who they were so that they could experience being valued. These experiences often came unexpectedly:

He [the teacher] just was so positive. He wrote beautiful, lovely things about me and said I was so sensitive and caring...and that made me feel good about myself. And all of the
people that made me feel really good about myself, that helped me a lot even though they might not have realized it because then it made me value myself more. (Emily)

As well, opinions and attention from others, even strangers, especially if it came spontaneously and unsolicited, helped the women see how others saw value in them:

Moving to a town...you’re meeting all these new people....You’re the new girl, so you get all this attention from other people....That made me feel like, oh wow, maybe I am worthy, maybe I do have something to contribute to these other people....Maybe I am...worthy of getting to know....It gave me more confidence. It gave me more self-esteem. It gave me more happiness and...more motivation to fight the disease. (Cathy)

Seeing others see value in them was also experienced as seeing others believe in who they were and what they were capable of. Anna had the gift of a beautiful singing voice, and her pastor “believed in” her but he also valued her for much more and Anna experienced that from deep within. For the women to eventually believe in themselves, they needed to experience others believing in them:

He [husband] would say to me at that time that he really believed that his calling in life, his role in life...was to be in a relationship with me...and that was...at the top of his list....I think I needed that, that's what I needed....It gave me value but there again the value was still coming from outside but it...helped. (Fiona)

The women also noticed that others were interested in them and valued them as individuals, independently of the anorexia or being a certain weight, “They never talked about it [anorexia] with me. So...all of a sudden [I] was...given this new identity that had nothing to do with the eating disorder” (Cathy). As the women continued to experience seeing others see value in them, they began the long and slow process of understanding how they might be “good enough” as they were. Sometimes, even when there were lots of affirmations and approval from others, women like Diana “always doubted” what was being said and somehow, it was “never enough.” Instead, she needed to “go inside” of herself, and begin seeing value from within.
Seeing value in themselves was a process of learning that occurred and evolved in different ways. Being competent and being able to contribute were important factors that supported the process of seeing value in themselves and believing in their own worth:

Most of the time...starting to believe in myself, and I guess a lot of that came from doing things, being able to see ways I could affect other people in positive ways....So...I think that was a big part of it being able to start to do things and feel like, oh, okay...I did something. (Lisa)

This learning took place in therapy and in everyday life. Emily found that she had value just for being herself—sensitive and caring, and was appreciated by the many different people she cared for in her clinical placements. Cathy recognized that she was appreciated by her new roommates whenever she did things like baking cookies and cleaning the house, which helped remind her that she was a capable and competent person, who was worthy and deserving. Diana’s experience with yoga, where the breathing exercises were coupled with visualizations from her instructor such as, “I value myself and I am deserving” eventually helped her change her negative self-talk toward seeing value in herself. Fiona attended a group that helped her learn and experience how to value herself:

And so I didn't go to the group because I was anorexic....I never thought of the reason for me going was that....But now on reflection, it [anorexia] was the reason I went to the group which [was where] I needed to learn to value myself more. That is exactly what I needed to do for that recovery. (Fiona)

Again, experiencing unsolicited and genuine feedback about themselves was important to developing their own sense of worth. This occurred more often for some than for others. Either way, it was an important component to beginning to see value in themselves, “So part of the recovery was becoming more. Whether it was more in, well, it included more in pounds, but it became, it was also needed to be more in self” (Fiona). Becoming “more in self” included
expanding all aspects of oneself. As already mentioned, becoming more in physical self was an important aspect to recovery. Other aspects of self important to recovery included emotional and spiritual components, and the women emphasized the significance of finding “balance”:

It can’t just be the weight or it can’t just be dealing with your issues or it can’t just be only spiritual....These things really need to be...in balance....I probably didn’t emphasize enough how important that was for me and just having that balance. (Anna)

As women experienced seeing value in themselves, they were also developing a greater sense of self, which spurred them on to finding courage in relinquishing anorexia, “The other part of me was beginning to grow. The real sense of me and life in that part. So I think I was ready to begin to let go a little bit more of the anorexia” (Anna).

Finally, in addition to seeing others see value in them and seeing value in themselves, women in this study learned that accepting themselves as they were contributed to the overall goal of discovering themselves as being “good enough.” Many of the factors and strategies that were previously discussed in stage two where women encountered real support and learned to trust laid the ground work for this aspect of recovery. Seeing value in themselves evolved over time and accepting themselves as they were required freeing themselves of the encumbrances of anorexia. Accepting themselves as they were allowed them to emerge and be seen for who they were. Whether others accepted them or not, was no longer an issue--more important was whether they accepted themselves. Diana described this experience as coming out from the protective layers of a cocoon, of being an ugly worm transformed into a beautiful butterfly:

My whole past melted down to this little puddle at my feet....And there I was finally emerging just like I’d been in a little cocoon for years...forming and then it fell away. And I was re-born. It was like a re-birth....At that point I felt like I was about fifteen again. (Diana)

The factors that supported women to accepting themselves as they were involved having
repeated experiences of unconditional acceptance. Because there were no conditions on who or what the women had to be, they were finally able to conclude that for themselves. That is, they were "okay" the way they were, and they did not have to improve to have value or be valued:

A lot of people think, well, my parents support me and...my boyfriend supports me or whatever, but...there's something else when someone just...values you for who you are without conditions on that....And that's not something we get in society...but that's...what I needed to experience, to even begin opening the possibility that I had value....But I can't go out and get it [unconditional acceptance] from somebody if I don't even get what it [unconditional acceptance] is....And that was...being able to experience it with my husband initially. (Fiona)

As the women experienced unconditional acceptance, they were then able to transfer how others treated them to how they treated themselves. This process also included being able to express themselves without being criticized, to have their opinions and thoughts accepted and validated, especially because that was the part of themselves that did not involve what they looked like. These experiences contributed to how the women saw themselves:

I needed to begin to hear my own voice...so I could find out who I am....And I could also discover that some of the things I said weren't being criticized...because the things that we were talking about were things that were deep inside of us. And...I guess...I needed to be accepted when I said those things in order for me to begin to think that maybe there's some value in me. (Fiona)

This process evolved over time as a continuation from stage two. The final internalization of unconditional acceptance for oneself materialized when the women had clarity of boundaries, identity and self-worth that was separate from their body weight:

I needed to discover that I was more than my weight and I was more than [my] mistakes, and I was more than either good or bad...and so if I was more than those things, then who was I? And I didn't have a clue (laughs). When I look...back, I was so...focused on...being the good girl and doing what I was told to do that I didn't know what I wanted to do. I didn't know what I thought because all I would say were things that I thought the other person wanted to hear....So I had to discover what do I want? What do I need? What do I think? And, and in discovering those things to also discover how that makes me more than my weight or being good or bad....So it expanded...for me who I was....Because I had
come so far...I remember...being eight years old...I was this...outgoing, fun loving person that got lost...So...very out of touch with what I thought and what I felt. (Fiona)

Thus, re-connecting with one’s desires, needs, emotions and thoughts grounded these women in a strong sense of who they were, which then opened the way to accepting themselves as they were. Being valued by others and learning to accept themselves as they were contributed to the overall process of discovering themselves as “good enough.”

Becoming the real me allowed women in this study to finally live in the open, out of the darkness of anorexia. Because these women accepted themselves as “good enough,” they were free to be themselves, and were no longer rule-bound by anorexia. They were free from their own mis-conceived expectations of who they thought they should be, “There was nothing to prove anymore, I had my own approval. [Before] I was seeking it always in others...and once I gave [it] up...I did the healing around that” (Diana). They were free to make choices. They chose to be themselves, “I have value just for who I am...in this very moment, and...I don’t need to improve to have value” (Fiona). They no longer feared losing control, they could “let things be”:

Becoming able to appreciate that wonderful things happen if you just allow things to flow and that...trying to exert control prevents some of those wonderful things from happening....Because you’re not allowing it to happen. So...somehow, I have had to become aware...that good can come out of just allowing things to be the way they are. And that includes me (laughter)...as well as events...and will have value. (Fiona)

Thus, becoming the real me was the main theme or central category that explained the process the women underwent to recover from anorexia nervosa.

Summary

The study findings presented here offer a glimpse of the process of recovery from anorexia nervosa from the women’s perspective. The women used anorexia as a solution in coping with life’s developmental demands and challenges. Through self-starvation and weight
loss, the women attempted to find a sense of control, an identity of being special and worthy. This solution initially helped the women feel better about themselves but as their illness progressed, they felt out of control. The main theme of recovery for these women revolved around leaving behind the veil of anorexia and \textit{becoming the real me}.

\textit{Becoming the real me} consisted of a five-stage process that included: 1) catching glimpses of light: seeing the dangers; 2) inching out of darkness: encountering supports, learning to trust; 3) tolerating exposure: taking control; 4) gaining perspective in new light: changing the mind set; and 5) shedding light on self: discovering self as “good enough.” This process was characterized by a lot of “hard work” in undoing and working against the self-destructive and self-defeating thoughts of anorexia. There were many forward and backward steps during recovery in which the women became ambivalent and petrified about leaving anorexia behind. The women triumphed over their struggles through a process of empowering themselves, using strategies that aimed at taking control. Although they began recovery with a diminished “sense of self,” they encountered supports that were unconditional and unwavering, with a level of caring and commitment that taught them to trust. Trust in others and trust in themselves paved the way toward further self-understanding, self-development, and self-acceptance which contributed to increasing their competence and confidence in managing life’s developmental challenges. In doing so, the women learned to value themselves for who they were, regardless of their body weight or shape and they finally recognized their selves as “good enough.” Being “good enough” gave them the courage to \textit{becoming the real me}, to give voice to their opinions, thoughts, and feelings, without hiding behind anorexia. The women can proudly proclaim, “This is finally me” (Diana).
Chapter Five: Discussion

The purpose of this study was to capture the process of recovery from anorexia nervosa from the women's perspective. The findings revealed a five-stage process of complex, interrelated strategies and factors which aimed at *Becoming the Real Me*. *Becoming the real me* is the central category of this study which explains the similarities and variations that underlie the basic psychological and social processes of recovery from anorexia. This chapter begins with a summary of those findings, the significance of this study, and a critique of the methods used. The most salient aspects of the findings in this study will be explored in relation to relevant published literature on the process of recovery. Implications for nursing practice, education and research will be addressed throughout.

**Summary of Findings**

The study findings provide a description of the process of recovery from anorexia nervosa from the women's perspective. During illness, all women in this study appeared to use anorexia as a solution in managing the many different challenges, uncertainties, and demands of various life stressors. It was, therefore, common for anorexia to manifest during adolescence. Although volitional intent with anorexia was absent during illness, the women, now recovered, were able to reflect on how they used self-starvation and weight loss as a means of regaining a sense of control, to have an identity of being special, and to feel worthy. When anorexia no longer served its intended purpose, the women struggled to regain control of their lives by engaging in various strategies that revolved around the central category of this study, *becoming the real me*.

In *becoming the real me*, the women underwent a complex five-stage process that supported them toward relinquishing anorexia and finding alternate solutions in facing up to the
unpredictable nature of life. These five stages consisted of: 1) catching glimpses of light: seeing the dangers; 2) inching out of darkness: encountering supports, learning to trust; 3) tolerating exposure: taking control; 4) gaining perspective in new light: changing the mind set; and 5) shedding light on self: discovering self as “good enough.” Each of the five stages built upon one another toward the common goal of becoming the real me. However, slippage in one stage would affect the women’s ability to progress within other stages. Thus, recovery was characterized by a forward and backward struggle that required a lot of “hard work.”

Recovery from anorexia began with discord in the women’s perceptions and hopes of what anorexia would provide and what they were actually experiencing. As the women’s health deteriorated, they struggled with their diminishing sense of control and they searched desperately to understand what was happening. Their search led them to seeing the dangers inherent in their illness, which also gave them hope that their life could be different. This beginning stage of recovery relied heavily upon encountering supports that were ever-present and genuine, with a level of caring and commitment that they could count on, identify with, and connect to. Supportive individuals taught the women how to trust and it was only with that trust, that women felt secure enough to begin “accepting” and “receiving” the kind of information and guidance offered by these trusted individuals. With these supports, women took small steps away from anorexia but their uncertainty about themselves made them feel vulnerable, out of control, and afraid. They gradually learned that there were ways of taking control without anorexia. Their strategies involved setting boundaries, making choices, facing their fears, and taking back power. Taking control of their lives empowered them to question and challenge the way anorexia made them think. By gaining perspective on the influence of anorexia in their lives, the women were
enabled to *change their mind set* about themselves and move toward recovery. They used strategies such as “undoing wrong thinking,” changing focus, and gaining distance to challenge the mind set that gaining weight was bad and they were undeserving of food. Going through this process led to greater self-understanding and further self-development that were necessary for meeting up to the demands of everyday life.

In the final stage of recovery, the women *discovered themselves as “good enough”* through an array of experiences where they began seeing others see value in them. In turn, they learned to see value in themselves. Over time, they finally arrived at accepting themselves as they were without the need to prove anything more. Arriving at self-acceptance was part of the process of discovering themselves as “good enough.” Being “good enough” freed the women from self-criticism and misperceived fears of weight gain. All five stages supported the women toward gaining and developing the life skills they needed to feel like competent and effective individuals who no longer needed anorexia as a solution to life’s challenges. *Becoming the real me* was finally celebrated as being “good enough,” and more.

**Significance of Study**

There is very little published research that describes recovery from anorexia nervosa from the patient’s perspective. The current study filled part of that gap by offering a glimpse of the process of recovery from nine women’s perspectives. Five stages of the recovery process along with related strategies and factors were explicated from the recovery stories told by the women. Although researchers in other areas of mental health illness have been shifting their focus of study from the “cause” of illness to “recovery” (Jacobson, 2001), it is not as prevalent with studies in anorexia, and even less with regard to the patient’s perspective.
Although there have been previous research done from the patient’s perspective in the past twenty years, our understanding of the process of recovery continue to be obscure. Garrett’s (1997) study offered a new perspective in understanding recovery from anorexia from the patient’s perspective, but her study focus was on the phenomenon and meaning of that experience. Analyzing that phenomenon from a Durkheimian perspective offered a social analysis of myths and rituals present in recovery, rather than the process of recovery. Thus far, the literature on recovery from the patient’s perspective has brought forth some important themes but they remain scant in describing the actual process. Themes such as interpersonal relationships, family relationships, job or school experiences and becoming a person (Beresin et al., 1989); essential ingredients of the therapeutic relationship, adaptation to and acceptance of family problems, and self-acceptance (Maine, 1985) all add to our understanding of recovery. This study re-captures many of these themes and extends our understanding of their contribution to the process of recovery from anorexia.

This study illustrates the complexities of the recovery process, explains what the “hard work” of recovery was about, why there were frequent forward and backward struggles, and what made recovery seem so “long, slow, and gradual” for these women. Since recovery from anorexia tends to be lengthy and the mortality risks tend to increase with time, the insights gained from this study emphasize ways to conceptualize and manage lengthy recoveries. As well, this study offers more focused direction for practice, education and research.

The remainder of the chapter will highlight the recovery process from anorexia as compared to recovery from other mental health illnesses. However, the findings must be taken within the context of the methods used. Thus, the following is a discussion of the rigor and
limitations of this study.

Critique of Research Method

Grounded theory methodology was conceived as a “way of thinking about data and the world in which we live” (Strauss & Corbin, 1998, p. 8). Grounded theory methods were designed to explicate the social realities of human experiences within the context of people’s lives, thereby capturing the conditions, processes and consequences of their behaviours to generate a theory of the explanatory whole. Since the objective of the current study was to understand and describe the intricacies of the process of recovery from anorexia, from the women’s perspective, grounded theory was decidedly the best fit. The use of grounded theory facilitated identification of the central category, Becoming the Real Me, which explained the psychological and social variations in how the women in this study recovered from anorexia. Detailed analysis of the process of recovery from anorexia resulted in the framework of the emerging theory that is reported in this study. The following offers a critical analysis of the means employed to ensure methodological rigour, as well as the resultant limitations of this study.

Adhering to the procedures of grounded theory (Strauss & Corbin, 1998) and attending to the four generally accepted criteria used to judge the trustworthiness of any qualitative research (Morse & Field, 1995) provided direction for ensuring methodological rigour in this study and, hence, recognizing its limitations. The four criterion measures of rigour include credibility, applicability, consistency, and confirmability.

Credibility is also referred to as the “truth value” (Morse & Field, 1995). The truth value of a study is not predetermined by the researcher in qualitative research but is determined by the
research participant because it is the participant who is considered the “expert” of his/her own experience being studied. As well, credibility in qualitative research is related to internal validity in quantitative research. Whereas quantitative research aims to measure “one tangible reality,” qualitative research aims to capture “multiple realities” (Morse & Field, 1995). Therefore, the credibility of this study depended on the researcher’s ability to report the women’s perspectives of how they recovered from anorexia, as clearly as possible.

Throughout the interview process, starting with initial contact, the researcher used many trust building strategies to engage the women in open and candid conversations about their recovery. These strategies included use of empathy, acknowledgement, validation, honesty, openness, genuineness and intuition to draw out the rich descriptions of the women’s experiences of recovery. On initial contact, the incident that probably had the most powerful impact on gaining trust from the women who volunteered for this study was in answering one very pressing question asked by all respondents, “How do you define recovery?” And when they realized that the definition depended on them, they immediately felt at ease and validated. By the same token, having women share their own definitions of recovery actually helped to reveal the various stages of recovery, which facilitated greater understanding of the entire process. This approach gave the researcher the privilege of becoming involved in such a way as to be able to see and interpret recovery, as a process, from these women’s eyes.

Another factor that helped to capture the women’s experiences of recovery was the researcher’s openness about her own interest in her work as nurse clinician with individuals who continue to struggle with eating disorders. This knowledge, however, also posed as a potential threat to this study because the women often shortened their description of recovery experiences
when they assumed that the researcher already had that understanding. Thus, the researcher had to consciously encourage further descriptions by using probing statements like, "tell me more about that" or "describe more of what you mean." There were also times when it was the researcher who made assumptions because of her clinical work in this field. In order to avoid prematurely attaching meaning to the women's descriptions, the researcher engaged in ongoing discussions with her supervisor, as well as, regular journalling to identify and reflect on personal biases. Another possible limitation of this study is the researcher's inexperience in conducting research interviews which may have influenced the way women shared their recovery experiences.

Additional means to minimizing bias during data gathering and analysis involved repeated review of the interview data across all participants and events, along with seeking validation from participants during interviews. That is, participants were involved in commenting on the researcher's interpretations and hypotheses about the relationships among the categories being formed. Such formulations were then revised to reflect, more accurately, the women's recovery experiences, and to finally arrive at a rich and descriptive theory to explain recovery from anorexia.

The final major threat to the credibility of the findings of this study was the small sample of nine women. Although in qualitative research the adequacy of a study is not judged by the size of its sample, there may have been additional new data and insights obtained had further interviews been conducted. Strauss and Corbin (1998) describe data saturation as an important means to filling out major categories, developing a full range of properties and dimensions to demonstrate variations, as well as, relationships between categories. Data saturation was not
achieved in this study and only nine women were interviewed because limited time and resources interfered with the researcher’s ability to continue. However, since the women provided such a conceptually rich and descriptive database of information to draw from, the nine interviews were sufficient to develop a preliminary grounded theory of how recovery from anorexia occurred for these women. Nevertheless, the full range of recovery experiences is unlikely to be reflected in the findings of this study, and further research may yield a more conceptually rich theory.

Applicability refers to how well the findings of the study “fit” in other contexts or with other groups (Morse & Field, 1995). The findings of this study are very specific to the small group of women who participated. That is, the participants in this study were all predominantly Canadian women of European heritage, who all had the privileged opportunity of receiving post-secondary education and attaining various degrees, certifications, and specialties, or were in the midst of doing so. The ages of these women were also coincidentally similar in that they either fell within the ages of 19 to 23 years, or were older than 40 years. The backgrounds of these women excluded other groups by virtue of ethnicity and the age group of women between 24 and 40 years of age.

Women of different ethnic origin and those within the age range between 24 and 40 hold potential importance to continued theory development. Women between 24 and 40 are in a very challenging stage of life where career development, life-long relationships and having children pose great uncertainty and stir up self-doubt that may affect how women experience their sense of self and body image concerns, both of which may be significant aspects in recovering from anorexia. Ethnicity may also influence the process of recovery in ways yet to be understood. For example, women of Asian, Indian or African backgrounds, growing up within a North American
society where beauty ideals relate to being blonde, blue-eyed and white in skin colour have additional challenges in feeling “good enough” or “accepted.” Other issues that may be culture-specific relate to values such as humility and self-sacrifice which remain highly prevalent in cultures such as traditional Asian families even when the affected individual may be born in North America. Since values of humility and self-sacrifice are intimately related to neglecting one’s own needs, it is uncertain how those values may influence the process of recovery from anorexia. Although the researcher recognized the significance of including women with these characteristics, limited resources and time, again, deterred from fully exploring their potential effects on the process of recovery. Therefore, the generalizability of the theory generated from this study is limited to the unique characteristics of this group of women. Further research that addresses issues of ethnicity and sample across age groups may yield valuable information to compare and contrast with the current study.

Consistency refers to whether the findings will be consistent if the same questions were asked of the same participants or in a similar context (Morse & Field, 1995). Consistency is usually judged by the “auditability” (Sandelowski, 1986) of the study. Auditability of this study was achieved through the rigorous process of keeping memos that generated a decision trail of how the codes, categories and theory evolved during this analysis. Memos of the decision trail also included telephone discussions held with the researcher’s supervisor. However, even though auditability was achieved, it is unrealistic to believe that the same study could be “replicated” because the qualitative aspects of human experiences and conditions are so complex and variable. As well, depending on the researcher-participant dynamic, the participant may choose to recall only certain aspects of their recovery experience with one researcher as opposed to
Confirmability or neutrality is enhanced with prolonged field contact or observation of participants because it increases data accuracy and freedom from bias (Morse & Field, 1995). For this study, participants were encouraged to take as much time as they needed to tell their stories of recovery, and to explain similarities or variations in their experiences. Women usually took between 2½ to 3½ hours to describe their recovery experiences. All women were anxious about not being able to tell their stories fully but were reassured that the researcher would not end the interview unless there was mutual agreement. As well, all women were offered the opportunity to call back with further information that they believed to be important but neglected to describe during the interview. Thus, there were subsequent discussions with three women to further enrich the researcher's understanding of their experiences.

Furthermore, four participants were invited to review the findings and give feedback on how accurately the collective story of nine women captured their actual experience of recovery. Three participants were able to offer feedback either by telephone or e-mail. All three women expressed, for the most part, the accuracy in which their recovery experience was captured in the findings. Their comments were considered and incorporated into the final analysis. One woman reported, "You described the five stages that 'feel' incredibly accurate and fit my experience, even though I could not have given it to you myself. You made sense of my experience and process" (Fiona). The second respondent, Diana, offered her perspective of the findings with great excitement and enthusiasm in a one and a half hour telephone discussion that was audiotaped. The third respondent, Lisa, provided feedback via e-mail. Both Diana and Lisa saw their own experience in the quotes from the other women in the study. Diana confirmed, "Most
of it I experienced...almost verbatim.”

Credibility, applicability, consistency and confirmability are the general criteria used for evaluating the trustworthiness of qualitative research (Morse & Field, 1995). For judging grounded theory methods, Strauss and Corbin (1998) also address issues of credibility, validity and reliability of the data and the adequacy of the research process, most of which have just been discussed using Morse and Field’s (1995) criteria. The remaining two criteria for evaluating the validity of the theory generated examine how well grounded conceptually and, how well grounded empirically, the theory stands up to scrutiny.

A theory that is well grounded conceptually must explain the relationships between concepts systematically and clearly. Furthermore, the theory generated should have the “explanatory power or predictive ability” (Strauss & Corbin, 1998) to explain what is going on, given certain situations. In this study, it was possible to formulate a beginning theory from the findings that offered an explanation of the conditions that gave rise to the phenomenon of anorexia, the related problems and issues, and the use of strategies or actions/interactions to address those problems or issues. As well, the theory formulated explained the consequences of what the actions or interactions were.

What remains ambiguous in this study is “how” the process of recovery began or ended. For example, several women in the study seemed to begin recovery by seeing the dangers of anorexia. However, there were other women who were very close to death, who did not begin recovery because of the dangers of their illness, but more so through other motivating factors such as encountering someone trustworthy or realizing parental responsibilities. Therefore, the theoretical formulation of the five stages in the process of recovery from anorexia must not be
misconstrued as having a “beginning” point i.e., stage one. Because of the dynamic interplay, between and within the stages of the process of recovery, the beginnings of recovery must be conceptualized as potentially having different entry points for some than others. Another aspect of this study that remains unclear is “when” recovery is considered complete. Some of the women have suggested “being free” or “this is finally me” as important indicators to recovery. As well, the belief that anorexia is “gone” or “no longer there” are further indicators. However, there are other women in this study who consider themselves fully recovered but still describe anorexia as being “a part” of them. Although the five interrelated stages of the recovery process seem to explain how the women in this study recovered from anorexia, perhaps recovery is better understood as an evolving and unfolding process and becoming the real me remains highly subjective.

In judging the empirical grounding of a study, Strauss and Corbin (1998) list eight criteria: (1) Are concepts generated? (2) Are the concepts systematically related? (3) Are there many conceptual linkages, and are the categories well developed? Do categories have conceptual density? (4) Is variation built into the theory? (5) Are the conditions under which variation can be found built into the study and explained? (6) Has process been taken into account? (7) Do the theoretical findings seem significant, and to what extent? (8) Does the theory stand the test of time and become part of the discussions and ideas exchanged among relevant social and professional groups? In short, how well a theory is grounded empirically can be judged by whether the theory has a “fit” or offers an adequate account of the evidence that was produced. Although there were limitations to this study, the theory generated does appear to have a “fit” between concepts and what was observed. As well, the data in this study are consistent with, and
have a “fit” with findings from previous works on the process of recovery from anorexia, from the patient’s perspective (Beresin et al., 1989; Hsu et al., 1992b; Maine, 1985). The current study supports Beresin et al.’s (1989) theory on “becoming a person,” which shows that their theory has stood the test of time. However, grounded theories are always considered provisional and limited in time (Strauss & Corbin, 1998). That is, the preliminary theory generated from this study will always be subject to continued elaboration and qualification.

Finally, Strauss & Corbin (1998) clearly indicate that substantive theories generated from grounded theory research do not have the kind of explanatory power of a larger, more general theory but “the real merit of a substantive theory lies in its ability to speak specifically for the populations from which it was derived and to apply back to them” (p. 267). Although the theory generated from this study had a number of limitations and is unlikely to have the kind of explanatory power expected of a fully developed grounded theory, it was at least able to capture the nine women’s recovery experience from anorexia in a way that felt “accurate” for them.

Throughout this research process, various strategies as described above were used to ensure methodological rigor in applying grounded theory methods. Although efforts were made toward that end, there were still limitations identified which have implications for further research. The following is a discussion of the process of recovery from anorexia as compared to previous research in this area, how this study extends that body of knowledge and how it is different. Included in this discussion will be implications for practice, education and research, in light of the findings, and how those findings relate to some of the major theoretical and/or therapeutic models that are currently embraced by expert practitioners in the treatment of anorexia.
The Recovery Process: Some Distinct Differences in Anorexia

Each woman in this study offered a unique account of her experience in recovering from anorexia. Although each experience was unique, all women described the process of finding themselves and becoming the real me, as the main theme of their recovery. Findings from this study reveal similarities that correspond with previous works in this area as well as recent studies in the general field of mental health on recovery processes. The concept of “recovery” is a new paradigm shift from illness models in mental health services in the past decade (Jacobson, 2001). Recovery must be viewed as more than just an outcome with objective measures whereby the person aims to return to the pre-illness state. Recovery processes are complex, difficult to measure, and must be captured through narrative means (Garrett, 1997; Jacobson, 2001; Young & Ensing, 1999). The women in the present study, through their stories, offer a way of conceptualizing recovery from anorexia as having some distinct differences from recovery from other mental health disorders and extend our current knowledge of that process from their perspective. The following examines implications of the similarities and differences found in other recovery experiences to the present study.

The theme, Becoming the Real Me, was reflected in Beresin et al.’s (1989) study of 13 women who were considered recovered and no longer met the DSM III criteria for anorexia nervosa. Those researchers also concluded that recovery from anorexia was a process of “becoming a person.” Although they did not describe the stages or phases of that process, they presented the significance of how women in their study used various strategies such as journalling and repeatedly reading their diaries as a means of “self-understanding” and “self-discovery.” Self-understanding and self-discovery were themes that predominated throughout
this grounded theory study, as women worked toward becoming the real me.

In the stage of inching out of darkness, the women in this study began learning more about themselves through a process of encountering supports and learning to trust others as well as themselves. The factors that contributed to progress in this stage held similar themes to what was previously described as important to recovery i.e. some form of complete, unconditional acceptance by someone, and/or a higher spiritual being (Beresin et al., 1989; Garrett, 1997; Hsu et al., 1992b; Maine, 1985). What was further emphasized in the current study was how the strength, commitment and unsolicited nature of these supports demonstrated to the women that others could be trusted. Although not explicitly explained by the women, what they seemed to be experiencing may be closely related to Burke and Stets’ (1999) conceptualization of the interrelated nature of trust and commitment. Burke and Stets (1999) explained that “when another person verifies one’s self-view, the process of trust is activated” (p. 348). In terms of self-view, the women, while ill with anorexia, could only “hope” to be accepted, and when others showed that they accepted these women and saw value in them, the process of trust was “activated.” According to Burke and Stets (1999), the process of trust continues to build when, “The self begins to see the other as predictable and dependable, and responds by developing trust in, and dependence on, the other. If the other responds benevolently (is trustworthy), then commitment to the relationship is fostered” (p. 348).

For the women in this study, having a sense that others were “committed” to them offered the emotional safety they needed in terms of being able to count on relationships that were dependable, absolute, and predictable, to the extent that they could begin to move away from anorexia. In essence, the trusted individuals in the women’s lives offered a commitment whereby
there was an “unwillingness to consider alternative relationships even if the current relationship [was] not optimal” (Burke & Stets, 1999, p. 348). This was the kind of affirmation the women needed to trust in others and then eventually in themselves.

Implications for practice rest heavily on the development of a trusting, caring, and committed therapeutic relationship. Inherent in building therapeutic relationships are the critical use of empathy and validation. Vitousek et al. (1998) emphasize four principles that are critical to developing sensitivity and empathy toward individuals with anorexia: 1) appreciate the fully ego-syntonic nature of thinness and self-control; 2) recognize the desperation that drives symptom “choice”; 3) do not attach surplus meaning to resistance; and 4) acknowledge the difficulty of change. These are some of the underlying principles that drive the work of motivational enhancement therapy which appear to have much recent empirical support (Geller & Drab, 1999; Treasure & Ward, 1997; Vitousek et al., 1998; Ward et al., 1996). Further discussions on this approach will be described later. Since there is much anecdotal evidence that women with anorexia have had many non-therapeutic encounters with health care professionals (Vitousek et al., 1998) and the women in this study have emphasized the significant impact of other informal relationships, further research into the development and maintenance of trusting and committed therapeutic relationships will offer important clinical insights that may improve the course of recovery.

Education of all students and health care professionals who come into contact with individuals affected by anorexia nervosa must address the paramount importance of building trust and maintaining therapeutic alliance that do not repeat the damaging and non-therapeutic encounters already prevalent in the lives of those individuals. As well, health care professionals
need to understand that no matter how well a therapeutic intervention is applied, its effectiveness will be limited by the foundational nature of their therapeutic relationship with individuals with anorexia nervosa i.e., trust.

In the stage of tolerating exposure, women began taking risks of being “exposed” without anorexia which Beresin et al. (1989) have described as a critical step to recovery from anorexia. That critical step was related to revealing oneself without the anorexia—being real, being authentic—but how the participants took that step remained unclear. The current study captured that process in the latter three stages of recovery. In the third and fourth stages, the women spoke extensively about taking control of their lives and gaining new perspective to help them tolerate “exposure.” The themes of taking control and gaining perspective were also found in recovery processes from other mental health illnesses, such as Young and Ensing’s (1999) grounded theory study of people with various mental health disorders (e.g., schizophrenia, major depression, anxiety disorder, bipolar disorder, and borderline personality disorder) who continue to maintain independent living.

Young and Ensing (1999) identified three phases of recovery from other mental health illnesses in which the middle phase was “regaining what was lost and moving forward” (p. 224). The main themes in that phase aimed at discovering and fostering self-empowerment, as well as gaining insight about self and the illness, which sound very similar to the third and fourth stages of recovery described in the present study. Young and Ensing (1999) described the strategies toward self-empowerment as requiring a willingness to take control, by shedding the role of victim, shifting to a new attitude of personal responsibility and efficacy, assuming responsibility (e.g., self-monitoring and self-care), recognizing destructive behaviours, making a commitment
to minimize those behaviours, and developing other empowering attitudes (e.g. learning to believe in oneself). The women in the current study also underwent a process of taking control and empowering themselves in the process. Taking control was preceded by a process of encountering supports which taught them to begin trusting that they were capable and competent of doing so. The strategies the women used to take control had some distinct differences from recovery from other psychiatric illnesses because these were specifically directed at minimizing factors that influenced the development of anorexia. For example, participants in Young and Ensing's (1999) study had to regain a sense of power in their lives because their psychiatric illness “shattered” their sense of self, control and power that resulted in the feeling of being “victimized.” In contrast, the women in this study did not describe being victimized nor did they initially recognize that their illness was problematic. In fact, it has been well documented that those affected by anorexia tend to experience “pride” in being seen as distinctly different and envied by those who diet ineffectively at weight loss (Vitousek et al., 1998). Instead, the women looked to their illness for a sense of power, control, identity, worth and distinctiveness that they believed were missing in their life. It was only over time, that the women’s sense of self became further diminished by the illness. Recovery demanded self-empowering strategies that specifically addressed finding alternate solutions to life’s many challenges, which is different from having to adapt to life with other mental health disorders that are mainly explained from a biochemical and organic perspective.

Differences in the process of recovery from anorexia and other psychiatric illnesses can also be understood from Strober’s (1997) model on the development of anorexia. Strober’s (1997) model suggests that anorexia originates from “inherited extremes of personality that
severely restrict a young woman’s adjustment to the challenges of pubertal growth and development” (p. 232). According to Strober (1997), inherited personality traits along with the kinds of parenting, trauma or other psychological experiences that inhibit or interfere with the development of the self, situated within a culture that is pre-occupied with body weight and shape, and when faced with developmental demands such as puberty, lead to the development of anorexia nervosa. Strober’s (1997) model shows how the interference with self-development and specific personality traits,\(^{10}\) leave the individual with few skills to face the nature and demands of puberty. Strober (1997) suggests that anorexia is used as a “solution” in facing such demands. No other psychiatric illness manifests in this way. It was not surprising, then, that the women in this study reported mainly on self-development as the key to their recovery, with limited reference to the context in which they live or work. Further research to explore the social and familial contexts of recovery, from women’s perspectives, may broaden our understanding of the recovery process from anorexia nervosa.

Implicit to self-development strategies are the women’s quest toward greater self-understanding, clearer self-definition and consequent self-empowerment. The women in this study reported feeling most empowered while losing weight or not eating, which is a common phenomenon reported by many others with eating disorders (Kearney-Cooke & Striegel-Moore, 1997). During the stage of tolerating exposure, the women aimed at taking control, and using specific strategies of setting boundaries, making choices, facing fears, and taking back power that

\(^{10}\)Inherited personality traits that Strober (1997) attributes as having causal influence in the development of anorexia include, “High emotional reserve and cognitive inhibition; preference for routine, orderly, and predictable environments, and poor adaptability to change; heightened conformity and deference to others; risk avoidance and dysphoric overarousal by appetitive or affectively stressful events; and excessive rumination and perfectionism” (p. 233).
resulted in reinforcing and empowering the self. These strategies are reflected in Kearney-Cooke and Striegel-Moore’s (1997) descriptions of “intrinsic power” whereby the women experienced a “sense of mastery, of competence, of potency in [their] dealings with the world of things and with the world of people” (p. 300). Discovering the sense of power from within, rather than from achieving external measures of feminine ideals was the work of recovery for the women in this study.

Learning to set boundaries was a critical component to achieving a strong sense of self, given that the women in this study had a tendency to conform and attend to others’ needs over their own, one of several personality traits described by Strober (1997). Furthermore, Strober (1997) suggests that individuals with anorexia tend to “perceive” others as they see themselves i.e., being very sensitive to change and vulnerable to psychological trauma, making personal boundaries unclear. In order to avoid bringing hardship and suffering that may be too much for loved ones to bear, individuals use anorexia to silence their own needs, yearnings, and emotional tensions. And perhaps more importantly, anorexia is used to shield underlying fears that loved ones will fail to recognize their real needs and emotions, leaving them potentially exposed to unbearable disappointments (Strober, 1997). The women in this study spoke of using anorexia as a means of “numbing” themselves, to the extreme of having a “huge sense of no sense of who I was.” Anorexia was like their protector. Given the kinds of personality traits the women and others with anorexia tend to have, more work is needed not only in the area of genetic research, but more in how these traits can be moderated toward healthier living. As well, education for significant others of newly diagnosed individuals that addresses how personality traits predispose individuals to and perpetuate anorexia may enhance their empathy, understanding and
acceptance.

The women in this study were able to risk exposure when they encountered committed and trustworthy individuals who would support them in their daunting task of taking control and setting boundaries. Instead of portraying the “self-less” image of someone who needs nothing, the women proclaimed that they were “sick of being sick.” The strategies they employed to change their lives were reminiscent of narrative therapy approaches (White & Epston, 1990). The women used strategies such as “externalizing” the problem of anorexia (recognizing that anorexia was not what defined them), discovering their own influence over anorexia’s control (facing fears of losing control), attending to their own needs (making choices), and re-defining who they were (setting boundaries) independent of anorexia. The women’s strategies for recovery support the use of narrative therapy which relies mainly on techniques of externalization, relative influence questioning, and re-authoring of lives to help individuals begin viewing themselves as separate from the problem. Although most women in this study did not refer to professional therapy as significant to their recovery, it appears that they acquired skills outside of therapy which enabled them in taking control and following the path toward greater self-definition, self-understanding, and self-confidence. Further research into how we can maximize the benefits of experiences outside of therapy and combine those with formal therapy may prove to have greater effectiveness in reducing severity of symptoms, and duration of

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11 White and Epston’s (1990) narrative approach uses relative influence questioning that consists of two main sets of questions. One set of questions helps the person to “map” the influence of the problem in their lives and the second set of questions asks the person to map his/her own influence on the “life” of the problem. This technique helps the person become aware of and to describe his/her relationship with the problem. The technique also aims to reveal that the problem is not static, that there is room for change and the person in relationship with the problem has opportunities to make change.
illness. Thus far, few research studies (Serpell et al., 1999) have been conducted on the effectiveness of narrative therapy although anecdotal evidence support its use. The strategies used by the women in this study also imply merit for its use.

The fourth stage of recovery for the women involved gaining perspective and changing the mind set. Young and Ensing (1999) also found that participants in their study underwent a process of learning new perspectives about themselves, and their relationship to the illness and the world, during recovery. Young and Ensing (1999) showed that gaining insight about self and the illness helped participants progress more rapidly in their recovery in terms of reconstructing “a stable sense of self” that incorporates the illness as one of many complex parts of their self. In the present study, some of the women also spoke about anorexia as being “a part of” their self. However, those further along in their recovery described anorexia more as being a part of their “history,” as something that “was” a part of them, but that the illness was “gone” and no longer held the threat of returning. Although this is not the case with participants in Young and Ensing’s (1999) study, it is worthwhile to examine the similarities and differences in each study.

Participants recovering from other mental health illnesses underwent the process of re-discovering their sense of self by realizing that the illness did not define them as a whole, that there were many aspects of their self that remained intact, and recovery required them to acknowledge their illness as a “part” of them (Young & Ensing, 1999). In contrast, the women in this study considered themselves recovered only when they no longer identified with anorexia as being a part of who they were. As one woman (Anna) described, the “other parts” of herself were growing, that then those parts were able to “push out” the anorexia. On the other hand, how the illness contributed to the women’s understanding of themselves, reflects, in part, what Young
and Ensing (1999) propose as an important process during recovery. Recovery from anorexia also brings a new sense of "freedom" that is different from living in the world of anorexia. The women seemed to approach life in a more "carefree" fashion that allowed them to relinquish the need to control. Although Strober (1997) indicated that personality traits such as poor adaptability to change, risk avoidance, and perfectionism tend to persist after "weight" recovery, the women in this study describe recovery as being able to "let go" and "let things be." Young and Ensing (1999) also found that recovery encompassed a new found sense of "peace" as participants gained insight about themselves and their relationship to the world they live in. They gained insight about becoming more assertive, making use of resources, and being productive in new ways. Again, there were some similarities in this study as women learned to take control of their lives, they too were able to find and give "voice" to their own needs and desires as well as tapping into outside resources and finally acknowledging that they, too, were deserving of help.

The most salient aspect of the fourth stage of the recovery process for women in this study was their "perseverance" and "hard work" in "challenging" and "undoing" the negative mind set of anorexia that would constantly "berate" them, and perpetuate the nagging self-doubt that is so characteristic of anorexia as described by Strober (1997). The women in this study used specific strategies during recovery that enabled them to gain perspective i.e., undoing wrong thinking, changing focus, and gaining distance. Many of these strategies the women used support the application of cognitive therapy that have been adapted for use in the treatment of anorexia nervosa (Garner & Bemis, 1985). For example, one woman (Emily) referred to the need to look at herself from the position of another in order to gain further insight about herself and her behaviours with anorexia. Another woman (Fiona) experimented with observing whether others
of various weight and shape would make larger or smaller mistakes. These strategies the women used illustrate the cognitive strategy of “de-centering” which is commonly used by clinicians to encourage individuals with anorexia to examine whether they evaluate others with the same rigid criteria that they have for themselves (Garner & Bemis, 1985; Treasure & Ward, 1997). Decentering serves as one of several means to altering weight-related self-schemata and expanding the perception of self that incorporates more than body weight. As one woman (Fiona) explained, she needed to know that her worth was more than just her weight, “it...needed to be more in self.” It was almost two decades ago that Garner and Bemis (1985) suggested the key ingredient to recovery is to help individuals recognize the serious limitations of seeing themselves as “unidimensional” beings and progress toward expanding their perception of self as a “complex, multidimensional” being. *Becoming the real me* supports that observation.

The fifth stage of the recovery process aimed at working toward *discovering oneself as “good enough.”* The women underwent a process of internalizing the belief that they were capable, competent, loveable beings that were “deserving” of life, nurturing and caring, by others and by themselves. Through that process, they gained the confidence to know themselves as “good enough.” The participants in Maine’s (1985) study, who were considered recovered from anorexia nervosa according to the researcher’s criteria, also reported feeling “good enough,” having self-confidence and trust finally helped participants give up the need to prove themselves through anorexia.

The current study revealed “how” the women eventually believed themselves to be “good enough.” Aside from experiencing unconditional support, regaining control and shifting perspective, one of the factors the women emphasized was their initial need for external approval
because how they saw their own worth was dependent upon "outside authority" and it was therefore significant to first see others see value in them before they began seeing value in themselves. Garner and Bemis (1985) have identified that gradually modifying the "cognitive appraisal system" from self-acceptance that rely on extrinsic factors, to self-acceptance that is contingent upon intrinsic factors are important to the discovery of self that is "complex and multidimensional." That self-discovery for the women occurred throughout their recovery experiences, in all stages, of working toward becoming the real me. Implications for practice relate to sequencing of therapeutic strategies that enhance the process of internalizing self-worth based on the readiness of the individual i.e., validating experiences of self-acceptance from external factors before attending to internal factors. This study has shown the importance of unconditional acceptance and commitment, from at least one person in the women's lives, as external factors that helped them make progress in their recovery despite other environmental conditions that were not always supportive. What remains unclear is how other women recover from anorexia when environmental conditions do not support recovery. For example, further research is required to explore how women and teens in abusive home environments recover when anorexia is their "solution" for survival.

Attention to other sequencing or matching of therapeutic strategies relate to the stages of change, which have been well documented in recent works on motivational enhancement therapy (Geller & Drab, 1999; Treasure & Ward, 1997; Vitousek & Watson, 1998) for the treatment of eating disorders. Motivational enhancement therapy (M. E. T.) stems from the previous works of Prochaska and DiClemente (1992), and Miller and Rollnick (1991). Recovery from anorexia as a process of change was embedded in the main theme of this study, becoming the real me.
Becoming the real me was also described as a process of slow “transformation” in which various forces initially sparked the women’s interest to begin thinking about change, and then eventually acting upon and sustaining change. The five stages of recovery identified in this study parallel some of the stages of change described in motivational enhancement therapy. The five key stages of change presented by Treasure and Ward (1997) are: 1) pre-contemplative i.e., not ready for change, 2) contemplative i.e., thinking about change, 3) preparation/determination i.e., ready to change but not sure how, 4) action i.e., commitment to change, and 5) maintenance i.e., sustaining change.

During the first stage of recovery in this study, the women began seeing the dangers of anorexia, which created discord in their perception of anorexia and prompted them to “contemplate” change. Although this first stage of recovery focused mainly on seeing the need for change, there were factors that moved the women from the pre-contemplative to the contemplative stage of change. According to Treasure and Ward (1997), offering information during the pre-contemplative stage, rather than advice, provides the base for an informed choice that is non-threatening. In fact, that was what happened for the women in the present study. The women either acquired or were given information which motivated them to consider the need for change. While “contemplating” change, the women also moved toward “preparing and determining” what they needed to do to make change, even though they did not find satisfactory answers at that stage. Comparing the process of recovery with the process of change, the first stage of recovery for the women (catching glimpses of light) encompassed the first three stages of the change process. However, the process of change, like that of the process of recovery, is not a “linear progression.” According to Treasure and Ward (1997), there is an oscillation
between stages and the key to applying M. E. T. is locating the position of individuals in the process of change so that M. E. T. strategies effectively match their needs. Using strategies that do not match the position or readiness of individuals will generate resistance to change.

Similar analysis can be applied to the remaining four stages of recovery from anorexia as a process of change. In fact, all remaining stages can be considered "action" oriented stages in the process of change, and progress during recovery requires "maintenance" of those new actions. As well, the oscillation between action, contemplative and sometimes pre-contemplative stages still continue, which reflect, in part, the women's experiences of ambivalence, fear, and anxiety toward change that generate a "forward and back" struggle during recovery, within the various stages of change. That struggle may be further magnified by the personality tendency of having poor adaptability to change (Strober, 1997).

The process of recovery for the women seems to go beyond the "maintenance" stage of change. According to Treasure and Ward (1997), relapse prevention techniques are important interventions for the maintenance stage of the change process. However, most women in this study portrayed recovery from anorexia as something that is "no longer" a part of them or a threat to them. This suggests that recovery from anorexia took the women beyond the stage of mere "maintenance" of the change. Recovery was about leaving the illness behind. The women in this study explained the process of change in terms of becoming the real me, but it remains unclear as to what therapeutic strategies would move the women from the maintenance stage of change, encumbered by relapse prevention strategies, toward finally being "free." Research that concentrates on the latter processes of change and recovery may yield new insights to further our understanding of how the last hold of anorexia is relinquished, and relapse is no longer a
concern. There are clinicians who believe that anorexia “never” truly goes away. However, six of the nine women in this study have proclaimed otherwise, and their experience of recovery speaks for itself.

Summary

The women in this study extended our understanding of the process of recovery from anorexia, from their perspective. What was explicated from their recovery experience was a five-stage process that unveiled the “work” of recovery. The “work” involved many complex social and psychological processes that were interrelated and intertwined in building toward becoming the real me. Becoming the real me required a number of eclectic strategies which were reflected in several different therapeutic models such as motivational enhancement therapy, narrative therapy, cognitive therapy, and developmental psychology approaches. Other researchers (Manley et al., 2001; Vitousek & Watson, 1998) have alluded to the benefits of combining therapeutic models such as motivational enhancement therapy and narrative therapy. In the general field of psychotherapy, integration of various therapeutic models and the movement toward eclecticism have a long history but the trend in eating disorders has been “to reflect a particular orientation” (Garner & Needleman, 1997, p. 50). What the women in this study were telling us is that integration of various therapeutic means was a necessity because there is no singular approach to addressing the complexity of their recovery experience.

Although this study described the five stages of recovery from anorexia, the full range of recovery experiences may not be reflected here, given the methodological limitations of this study. However, this description provides an emerging theory that maps out the necessary work of recovering from anorexia, from these women’s perspective. The women have offered many
insights that have practice, education and research implications.
REFERENCES


Appendix A
Recovered from Anorexia?

A UBC student in the Masters of Science in Nursing Program seeks females who have recovered from anorexia nervosa to participate in a research study.

Participation in this study will help health care professionals to better understand and support recovery from this complex and life-threatening illness.

For more information, please contact Mary Lamoureux collect at 1-250-860-3834 or E-mail to lamm@mox.interiorhealth.ca
Appendix B
Title of Project: Recovery from Anorexia

Principal Investigator: Dr. Joan Bottorff, Professor
School of Nursing
University of British Columbia (UBC)
(604) 822-7438

Co-Investigator: Mary Lamoureux, Graduate Student
UBC School of Nursing
(250) 860-3834

Purpose: The purpose of this study is to extend our understanding about recovery from anorexia from the patient’s perspective. This research is for Mary Lamoureux’s graduate thesis. You have been invited to participate because of your personal recovery experience from anorexia nervosa.

Study Procedures: Participating in this research study means that:
1. You will be asked to participate in 1 to 2 separate tape recorded interviews of up to 1 hour duration either in person or by telephone, depending on your preference.
2. At the beginning of the interview, you will be asked to answer questions that will provide the researcher with general background information about yourself.
3. The main portion of the interview(s) consists of questions about your experiences with anorexia and recovery.
4. The interviews will be typed out and reviewed to identify important ideas related to recovery from anorexia.
5. Some individuals will be asked to provide their comments on initial findings of the study.
Risks/Benefits: No risks are expected from participating in this study although some women may find recounting their experiences emotionally difficult. You will receive no direct benefits, although your participation in this study will help increase our understanding of recovery from anorexia. You may request a summary of the study results at no cost.

Confidentiality: Any information resulting from this research will be kept strictly confidential. All documents will be identified by code number and kept in a locked filing cabinet. You will not be identified by name in any reports of the completed study. The computer files containing interview transcriptions will be password protected.

Contact: If you have any questions or desire further information with respect to this study, you may contact Dr. Joan Bottorff at (604) 822-7348.

If you have any concerns about your treatment or rights as a research participant, you may contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley at (604) 822-8598.

Consent: Your participation in this study is entirely voluntary. You may refuse to participate or withdraw from the study at any time without any consequence to you or your continuing health care.

You will receive a copy of this consent form for your own records.

By signing this form, you are agreeing to participate in this study.

Signature of Research Participant __________________________ Date ______

Signature of a Witness __________________________ Date ______
Appendix C
BACKGROUND INFORMATION

I. Demographic Information

Informant I.D. # ______

Date of birth?

Marital status?

Any children?

Country of birth?

Ethnic background?

What is your first language (mother tongue)?

Do you live alone or with others?

What is your highest level of education?

Are you employed?

If yes, what kind of work do you do?

II. Information About Diagnosis & Treatment of Anorexia Nervosa

1. How old were you when you were first diagnosed with anorexia nervosa?_____

2. What type of anorexia nervosa were you diagnosed with?

   _____ Restricting subtype
   _____ Binge-purge subtype

3. Who gave you this diagnosis?

   _____ Family physician
   _____ Psychiatrist
   _____ Psychologist
   _____ Other______

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4. What kind of treatment did you receive for anorexia?

Medications (if any):  Past: Y  N  list types: 
Present: Y  N  list types: 

Medical treatments (if any):
   ____ psychiatrist:
   Past: Y  N  Present: Y  N
   ____ other medical specialists:
      ____ cardiologist
         Past: Y  N  Present: Y  N
      ____ gynaecologist
         Past: Y  N  Present: Y  N
      ____ gastrointestinal
         Past: Y  N  Present: Y  N
      ____ endocrinologist
         Past: Y  N  Present: Y  N
      ____ nephrologist
         Past: Y  N  Present: Y  N
      ____ neurologist
         Past: Y  N  Present: Y  N
      ____ other
         Past: Y  N  Present: Y  N

Counselling (if any):
   ____ individual therapy
   Past: Y  N  Present: Y  N
   ____ family therapy
   Past: Y  N  Present: Y  N
   ____ group therapy
   Past: Y  N  Present: Y  N
   ____ nutritional counselling
   Past: Y  N  Present: Y  N

Support group: Y  N
Past: Y  N  Present: Y  N

Hospitalizations
   - How many times? _________________
   - How long each time? _________________
   - What reasons? _________________

Specialized eating disorders services
Outpatient? Y  N
Day program? Y  N
Residential program? Y  N
Hospital inpatient? Y  N

5. When did you consider yourself fully recovered? ________ (age)
Appendix D
Resources in British Columbia

Eating Disorders Services:

Provincial: The Eating Disorder Resource Centre (EDRC): 1-800-665-1822
Provincial: St. Paul’s Hospital (Vancouver): (604) 806-8347
Provincial: B.C.’s Children’s Hospital (Vancouver): (604) 875-2200
Local: Contact your local Mental Health Centre (see blue pages) for Eating Disorder Services near you.

Eating Disorder Support Groups:
ANAD (Vancouver) (604) 739-2070
BCEDA (Victoria) (250) 383-2755

Crisis Lines (also see White Pages for services in your area):
Vancouver (24 hrs/day): (604) 872-3311
Surrey (24 hrs/day): (604) 951-8855
Coquitlam (24 hrs/day): (604) 540-2221
Chilliwack (4 pm-Midnight): (604) 792-7242
Richmond (8:30 am-Midnight): (604) 279-7070
Kelowna (24 hrs/day): (250) 861-4359
Penticton (24 hrs/day): (250) 493-6622
Vernon (24 hrs/day): (250) 545-2339
Victoria (24 hrs/day): (250) 386-6323