

UNDERSTANDING WOMEN'S EXPERIENCES OF  
NORMALIZATION OF EATING IN RECOVERY FROM  
ANOREXIA NERVOSA

by

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## **Abstract**

Research into recovery from anorexia nervosa has been limited to determining the typical course and long-term outcome of people diagnosed and treated for anorexia nervosa. No attention has been given to understanding the process of changing and normalizing eating behaviour during recovery. This study describes the process of eating normalization as experienced by 13 women who perceived themselves as having recovered from the disorder. Participants who worked with a dietitian also commented on the significance of the dietitian's role in their recovery.

This study used a qualitative research design to elucidate the themes underlying the process of eating normalization. Data were collected through semi-structured interviews and the Eating Attitude Test-26 questionnaire. Grounded theory methods were used in data analysis, generating a contextually grounded central theme of having the freedom to enjoy all foods. The central theme consisted of four phases: 1) Acknowledging the disorder (awareness of physical complications, decline in social activity, disliking the type of person one became, and finally becoming tired of the anorexic game); 2) Accepting support and deciding to change (being ready, deciding to change eating patterns, accepting weight gain, and engaging support); 3) Confronting old patterns and learning new ways (mentoring healthy eating, experimenting with new foods, and making incremental changes); and 4) Food becoming a non-issue (eating whatever/whenever one wants, reaching a balance, creating an identity without an eating disorder, and gaining freedom to enjoy food and life).

Six participants who worked with a dietitian reported mixed feelings about the significance of the dietitian's role in their recovery. Three women found nutrition

intervention beneficial, while three were dissatisfied with their interactions with a dietitian. Three themes emerged from the data describing the role of the dietitian: education, support, and mentoring. Based on these findings, the study provides recommendations that dietitians who wish to work with individuals affected by anorexia nervosa must have a good understanding of counselling skills on the issues underlying an eating disorder, and be able to function as educators, nutrition therapists and mentors in assisting clients with normalizing their eating behaviour during the recovery process.

## Table of Contents

<b>Abstract</b>	ii
<b>Table of Contents</b>	iv
<b>List of Tables</b>	vi
<b>Acknowledgements</b>	vii
<b>Chapter 1: Introduction</b>	1
1.1 <i>Background of the Study</i>	1
1.2 <i>Statement of Purpose</i>	3
1.3 <i>Summary of Chapters</i>	3
<b>Chapter 2: Literature Review</b>	5
2.1 <i>Features of Anorexia Nervosa</i>	5
2.2 <i>Diagnostic Criteria</i>	7
2.3 <i>Etiology of Anorexia Nervosa</i>	8
2.4 <i>Treatment of Anorexia Nervosa</i>	10
2.5 <i>Recovery from Anorexia Nervosa</i>	13
2.6 <i>Clients' Perception of Recovery from Anorexia Nervosa</i>	15
2.7 <i>Normalization of Eating in Recovery from Anorexia Nervosa</i>	19
2.8 <i>References</i>	21
<b>Chapter 3: Normalization of Eating during Recovery from Anorexia Nervosa</b>	
3.1 <i>Introduction</i>	27
3.2 <i>Research Design and Methods</i>	29
3.2.1 <i>Sample selection criteria</i>	30
3.2.2 <i>Data collection</i>	31
3.2.3 <i>Data analysis</i>	33
3.2.4 <i>Issues of trustworthiness</i>	34
3.3 <i>Participants' Description</i>	38
3.4 <i>Findings</i>	39
3.4.1 <i>Phase one: Acknowledging the disorder</i>	41
3.4.2 <i>Phase two: Accepting support and deciding to change</i>	44
3.4.3 <i>Phase three: Confronting old patterns and learning new ways</i>	47
3.4.4 <i>Phase four: Food became a non-issue</i>	50
3.5 <i>Discussion</i>	56
3.6 <i>Strengths and Limitations of the Study</i>	63
3.7 <i>Implications of the Findings</i>	64
3.8 <i>References</i>	67
<b>Chapter 4: Role of the Dietitian in the Process of Recovery from Anorexia Nervosa</b>	
4.1 <i>Introduction</i>	76

4.2 <i>Research Design and Methods</i>	80
4.2.1 <i>Selection and recruitment of participants</i>	80
4.2.2 <i>Data collection</i>	81
4.2.3 <i>Data analysis</i>	82
4.3 <i>Findings</i>	83
4.3.1 <i>Education</i>	85
4.3.2 <i>Support</i>	88
4.3.3 <i>Mentoring</i>	89
4.4 <i>Discussion</i>	90
4.5 <i>Implications for Dietetic Practice</i>	94
4.6 <i>Future Research</i>	95
4.7 <i>References</i>	97
<b>Chapter 5: Conclusion</b>	102
5.1 <i>Summary of Findings</i>	103
5.2 <i>Discussion</i>	105
5.3 <i>Future Research</i>	108
5.4 <i>References</i>	109
Appendix A: Recruitment Notice	110
Appendix B: Participant's Consent Form	111
Appendix C: Ethics Approval Form	113
Appendix D: Demographic Data Form	114
Appendix E: Interview Guide	115
Appendix F: Eating Attitude Test (EAT)-26	116
Appendix G: List of Open Codes	117
Appendix H: List of Axial Codes	121

## **List of Tables**

Table 3.1 Description of Participants.....	38
Table 3.2 Participants' Diet Type.....	53

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## **Chapter 1: Introduction**

### *1.1 Background of the Study*

In my fifteen years as a dietitian working with anorexia nervosa sufferers, I have seen many (though not all) clients get better and appear to move on to a normal and healthy lifestyle. From my professional perspective, I have watched the continuous struggle they experience as they vacillate between letting go and holding on to their eating disorder behaviour.

I have observed that most clients progress through a series of stages as they work on changing their eating behaviour. In the initial stages of recovery, their fear of gaining weight and lack of trust in the body for regulating weight outweigh the benefits of changing. But through many nutrition education sessions, gradual addition of foods to their diet, and countless group and individual therapy sessions, many clients decide in favour of change. Most of my time is spent exploring patients' cognitive beliefs regarding food (as good vs. bad, unhealthy vs. healthy) as well as challenging their ritualistic eating behaviours such as: cutting food into small pieces, mixing foods in order to hide fear foods, and excessive condiments to mask the flavour of food. I find that they progressively work on developing a normal eating pattern by challenging and incorporating many of their fear foods into their diet. As they begin to trust their bodies in their experience of hunger and fullness, their cognitive thinking slowly shifts to recognizing physical fullness as a function of digestion rather than as feeling fat. If clients are prepared and ready to work on their recovery intensively, and begin to normalize their eating behaviour, they gradually move away from restricting and other maladaptive anorexic behaviours.



During the treatment process, whether with inpatients or outpatients, my goal is to help clients move towards what I consider to be a normal eating pattern, based on my training and many years of clinical observation. What follows is my personal interpretation of normal eating.

Normal eating means:

- The ability to eat a variety of foods from all food groups comfortably and without guilt, thereby expressing control and power over food choices;
- The ability to listen to and respect the body's cues for hunger and satiety;
- The absence of ritualistic eating patterns such as mixing different foods in order to mask flavours or to hide certain foods;
- The ability to attend social gatherings and to eat with others comfortably, without feeling anxious about the food or the amount of calories consumed;
- The absence of the obsessive need to be thin and some degree of comfort about their current weight;
- The ability to separate thoughts and feelings during difficult times and ability to manage distress without needing to restrict food or purge.

Overall, then, my professional experience and training has given me some understanding and beliefs about the process of normalization of eating during recovery from anorexia nervosa. But this understanding is very much an outsider's professional perspective. Once clients leave our treatment program, I am left to wonder how they perceive their experiences and the process of recovery. Do they feel they have normalized their eating behaviour? What was the process like for them? Did they find that working with a dietitian assisted them in their recovery?

Although some researchers have begun to look at clients' perspective of recovery from anorexia nervosa, no one has looked specifically at clients' experience of normalization of eating during this process. Therefore, I developed the study reported in this thesis, which examines eating normalization during recovery from anorexia nervosa from clients' perspectives.

### *1.2 Statement of Purpose*

The purpose of this research is to understand how women who have had anorexia nervosa experienced changes in their eating behaviours during their process of recovery.

The specific research questions are:

1. How did individuals who have had anorexia nervosa experience making nutrition changes in their process of recovery?
2. What concepts or themes were most important to them in a normalization of their eating behaviour?
3. Who or what were the major sources of support for them in normalization of their eating behaviour?
4. For those who had an opportunity to work with a dietitian, what was the significance of the dietitian's role in helping them normalize their eating?

### *1.3 Summary of Chapters*

This thesis is organized as follows. Chapter 2 provides background information about anorexia nervosa, including diagnosis, etiology, treatment, recovery and normalization of eating. Chapter 3 is a journal-style manuscript describing the study methods and findings regarding the study participants' experiences of the process of

normalization of eating behaviour during recovery from anorexia nervosa. In Chapter 4, I present the methods and findings related to participants' experiences of working with a dietitian during their recovery. Finally in Chapter 5, I provide an integrated discussion of the study findings, present the conclusions and discuss implications for practice and future research.

## **Chapter 2: Literature Review**

In this chapter I provide background information about key features of anorexia nervosa, its diagnostic criteria, etiology, treatment modalities, recovery, and normalization of eating.

### *2.1 Features of Anorexia Nervosa*

Today, anorexia nervosa is recognized as a serious mental disorder with debilitating physical and psychological consequences, which if untreated, can result in death. Physical complications that can develop from anorexia include cardiac abnormalities (hypotension, edema, and arrhythmias), gastrointestinal dysfunctions, metabolic and endocrine related complications, dermatological dysfunctions (dry skin and thinning scalp hair, or growth of lanugo hair), and musculoskeletal system dysfunction (osteoporosis), all of which are related to starvation (Birmingham & Beumont, 2004). Nutrient deficiencies in minerals such as zinc, magnesium, iron, calcium, phosphate, and vitamin B12 are commonly observed in affected individuals (Birmingham & Beumont, 2004). Many of these complications can be corrected through adequate nutrition and a gradual restoration to a normal weight (Garfinkle & Garner, 1982; Goldbloom & Kennedy, 1995; Birmingham & Beumont, 2004). Cognitive and behavioural changes that are frequently encountered in anorexia nervosa are: a diminished capacity to concentrate, depression, preoccupation with food, impaired sleep, decreased libido, and a predominantly isolative lifestyle (Fairburn, 1985).

Although anorexia primarily occurs in adolescent females, it can also affect males. Research indicates that 5% to 15% percent of all anorexia cases occur in males,

giving a male-to-female ratio of approximately one in ten (Anderson, 1995). Anorexia is also becoming more common in women in their middle to late years, especially in those who have a long history of dieting and self-dissatisfaction with their body image (Hall & Driscoll, 1993). Nevertheless, anorexia remains predominantly a young woman's disorder, with the age of onset generally ranging from 12 to 25 years (Mitchell, 1985).

The prevalence rate of anorexia nervosa is between 0.3% and 0.5% in females 16-35 years old (Brownell, 1995; Hoek & Hoeken, 2003; Birmingham & Beumont, 2004). The epidemiological literature that examined the incidence of anorexia nervosa from 1956 to 1995 showed an increase of the incidence rate of the disorder (Eagles, Johnston, Hunter, Lobban, & Millar 1995; Jarman, & Walsh 1999; Hoek & Hoeken, 2003; Milos, Spindler, Schnyder, Martz, Hoek, & Willi, 2004). Researchers suggest that the reported increase in the previous studies was reflective of social changes taking place between 1930 and 1980, as well as a better and earlier diagnosis of the disorder and the increase of treatment services (Milos et al., 2004). Milos et al., (2004) examined the incidence of anorexia nervosa in Switzerland among females 12-25 years old over a total period of 40 years presented in five sampling periods: 1956-1958 (0.33), 1963-1965 (0.55), 1973-1975 (1.12), 1983-1985 (1.43), 1993-1995 (1.17) and noted an increase in the incidence rate for the total population. However from 1990 on the authors of retrospective studies conclude that the incidence of anorexia nervosa remains steady at the rate of 1.17 (Hoek & Hoeken, 2003; Milos et al., 2004).

## *2.2 Diagnostic Criteria*

Anorexia nervosa appears in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (1994) and is classified as demonstrating the following essential features:

- “Refusal to maintain body weight at or above the minimal normal weight for age and height (weighs less than 85% of normal weight);”
- “Intense fear of gaining weight or becoming fat, despite being underweight;”
- “Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or a denial of the seriousness of the current low body weight;”
- “Evidence of amenorrhea or an absence of at least three consecutive menstrual cycles in postmenarcheal females;”
- Binge-Eating/Purging Type: “During the current episode of anorexia nervosa, the person has regularly engaged in binge eating or purging behaviour (i.e. self-induced vomiting, misuse of laxatives or diuretics or enemas);”
- Restricting type: “During the current episode of anorexia nervosa, the person has not regularly engaged in binge eating or purgative behaviour” (pp. 544–545).

### *2.3 Etiology of Anorexia Nervosa*

There is no one comprehensive theory that can explain the development of anorexia nervosa. It is generally regarded as multidimensional involving numerous factors that may contribute to the etiology such as: sociocultural factors, identity formation and personality traits, role of the family, biological and genetic factors (Crisp, 1980; Hsu, 1990).

The emphasis on slimness, a socio-cultural phenomenon in Western culture in which ultra-thin models are perceived as the ideal of feminine beauty, may be a precipitant for the onset of an anorexia nervosa and eating disorders in general. In pursuit of thinness, a large proportion of the female population has dieted in Western countries at some point in their lives (Ogden, 2003). Nevertheless, not everyone who embarks on dieting will develop anorexia nervosa and therefore, the development of the disorder must be moderated by other factors such as a fragile foundation of self-concept and body concept (Hsu, 1990).

Some literature suggests that an individual who decides to go on a diet is more likely to develop anorexia nervosa if she is experiencing chaos and confusion during the adolescent years, has a poor concept of self and a high dissatisfaction with her body and is having difficulty with identity formation (Hsu, 1990). Strober (1981) states that the core personality disturbance of individuals' with anorexia nervosa may be central to the pathogenesis of the disorder. Individuals affective over-control and poor tolerance of change, lack of self direction and personal effectiveness, and relative absence of adaptive mechanisms to the maturational responsibilities of adolescence have been identified as possible contributing factors to the development of anorexia nervosa.

Some researchers suggest that there are certain family characteristics that may be specific to the condition of anorexia nervosa such as issues of enmeshment, meaning that there is a high degree of involvement that contributes to the poor differentiation between oneself and other family members (Hsu, 1990). Other factors such as: over-protectiveness, rigidity and a lack of conflict resolution that could result from family's low conflict tolerance, may provide the context for a child to use anorexia nervosa as a way of avoiding family issues and as a way of communicating her distress (Crisp, 1980; Hsu, 1990).

The biological research into neurotransmitter systems, the dopamine reward system, the various serotonergic systems involved in feeding and satiety and the roles of leptin, cortisol and insulin have shed much light on regulation of appetite and weight, however more studies are needed to further our understanding of the biological components regulating appetite and weight in anorexia nervosa (Connan & Stanley, 2003).

There have been a number of twin studies done to determine the relative contribution of genetic risk factors in the etiology of anorexia nervosa (Treasure & Holland, 1989; Bulik, Sullivan, Wade, & Kendler, 2000). In the study by Treasure and Holland (1989), they found that anorexia nervosa was greater in monozygotic (genetically identical) twins than in dizygotic (non-identical) twins, and the heritability was estimated at about 70%. However, the extent of the genetic contribution to anorexia nervosa remains unresolved. Larger scale twin studies are needed to determine the degree of the genetic and environmental contributions to the development of anorexia nervosa.



## *2.4 Treatment of Anorexia Nervosa*

Most practitioners and researchers agree that the treatment of this complex illness requires a co-ordinated, multidisciplinary approach focusing on the combined biological, social, behavioural, and psychological needs of the patient (Anderson, 1983; Beumont & Chambers, 1981; Beumont, Russell & Touyz, 1993; Rock & Yager, 1987). There is also general agreement that the treatment model should include the participation of health care professionals from many disciplines: psychiatrist, physician or internist, family therapist, dietitian, psychologist, nurse, occupational or recreational therapist, and art therapist (Hindmarch, 2000). The decision to treat in an in-patient unit or as an outpatient is made depending on the physical and mental status of the client. Some practitioners and researchers are of the view that a substantial number of patients do well as outpatients if their emaciation is not severe, they have no medical complications, they are motivated for change, and if they have the support of their friends and relatives (Beumont et al., 1993).

The treatment modalities, whether in-patient or outpatient based, may consist of one or more of the following approaches:

- **Psycho-educational:** The focus is on information sharing about the multifactorial causes of anorexia nervosa and its predisposing and perpetuating factors (Garner, 1988).
- **Cognitive-behavioural therapy (CBT):** Teaches the individual to identify and focus on thoughts, feelings, and behaviours that are associated with anorexia and helps examine and challenge these thoughts by replacing them with healthier thoughts and beliefs regarding weight, food, eating, and activity levels (Garner & Bemis, 1982; Fairburn, 1985).

- Interpersonal therapy (IPT): Focuses on the interpersonal context of restrictive behaviour, and how persons react to others, and teaches them to alter those interpersonal behaviours (Garfinkel & Garner, 1982).
- Pharmacotherapy: This is part of a treatment protocol that may include the use of antidepressants when there is evidence of a major depressive disorder. Sometimes sedatives are used during weight restoration or around mealtimes to decrease a patient's anxiety regarding food and weight. Nutritional supplements to correct deficiencies such as zinc, iron, magnesium, phosphate, potassium, and thiamine are frequently prescribed (Goldbloom & Kennedy, 1995; Walsh, 1995; Birmingham, Alothman, & Goldner, 1996; Birmingham & Beumont, 2004).
- Group and family or marital therapy: Family therapy is useful in helping the individual whose symptoms are seen as an indicator of family or parental marital distress. The family component is an integral part of treatment when dealing with adolescents. Groups can provide an atmosphere of mutual support that can help clients offset their sense of isolation, which may have resulted from many years of avoiding eating out with friends (Fairburn, 1985; Meades, 1993; Russell, Szumukler, Dare & Eisler, 1987).
- Motivation enhancement therapy (MET): This approach focuses on exploring the individual's ambivalent attitudes towards treatment and looks at readiness for change (Geller & Drab, 1999; Geller, Williams & Srikameswaren, 2001; Tantillo, Bitter & Adams, 2001; Vitousek, Watson & Wilson, 1998). It is based on Prochaska and Diclemente's (1992) trans-theoretical model of stages

of change. These stages include pre-contemplation (having no intention to change in the foreseeable future), contemplation (seriously thinking about change within the next six months), preparation (plan to make changes within the month), action (recent changes), maintenance (maintaining changes for at least six months and preventing relapse) and termination (no temptation of returning to their old way of coping). Understanding the individual's stage and readiness for change during their treatment is important, and so is the approach a therapist takes when exploring the individual's ambivalence about wanting to get better. The most effective approach in engaging and supporting individuals in their process of recovery is to "be curious," "assume nothing," "be active," "be on the same side," "be honest," "be patient," and show "empathy and validation" as described by Geller et al. (2001) and Vitousek et al. (1998).

- Nutrition therapy: This is an integral part of both inpatient and outpatient treatment programs. The goal of nutrition therapy will vary based on a client's degree of medical and nutritional complications, as well as a client's motivation for change. For clients who present with severe emaciation, medical and nutritional stabilization will be the primary goal. Achieving restoration of normal weight and working on normalization of eating patterns will depend on the client's readiness to make changes and recover. Individuals with anorexia nervosa tend to experience a multitude of cognitive, emotional, and physical changes while in treatment. Many will undergo significant physical changes that are associated with the discomfort of re-feeding

(abdominal distension and abdominal pain, edema, and/or constipation/diarrhea). In the process of normalization of their eating clients will also experience many cognitive and emotional changes as they are asked to re-introduce foods back into their diet and to challenge their thoughts, beliefs, and feelings regarding eating, weight, and body image. Finally, as clients carry on toward the process of normalizing their eating behaviour, it is common for them to continuously question their desire to recover (Rock & Yager, 1987; American Dietetic Association, 2001; Herrin, 2003; Birmingham & Beumont, 2004).

- Dialectical behaviour therapy (DBT): A comprehensive multi-modal cognitive-behavioural treatment developed by Marsha Linehan, PhD, for treating borderline personality disorders. The DBT therapists help clients identify dysfunctional patterns of behaviours and help them change those behaviours. DBT is a newer form of psychotherapy with recent use in treating individuals with eating disorders. The mindful eating and distress tolerance taught in DBT may help eating disorder clients assess their restrictive or dieting mindset which may help them in breaking the cycle of restriction and/or binge eating (Palmer & Birchall, 2003).

### *2.5 Recovery from Anorexia Nervosa*

Estimates of rates of recovery from anorexia nervosa vary widely, ranging from 15% to 70 % (Cockell, Zaitsoff & Geller, 2004; Fitcher & Quadflieg, 1999; Steinhausen, Rauss-Mason & Seidel, 1991; Strober, Freeman & Morrell, 1997; Ziepfel, Lowe, Reas,

Deter & Herzog, 2000). These varying rates reflect differences between populations studied, treatment used, length of follow-up and definition of recovery (meaning if patients have fully or partially recovered) (Steinhausen et al., 1991). For example, Cockell, Zaitsoff & Geller (2004) interviewed 32 patients who completed 15-week residential treatment program and found that at six months follow-up, 5 (15.6 %) fully recovered (meaning they were symptom free), 21 (65.6 %) patients achieved a partial recovery, (meaning that they met the diagnostic criteria for an eating disorder not otherwise specified (ED-NOS), and 6 (18.7%) met the diagnostic criteria for eating disorders. In contrast, Fitcher & Quadflieg (1999) studied 101 patients from the inpatient treatment program, at six year follow-up and found that 56 (55.4%) patients showed no symptoms, 27 (26.8%) had anorexia nervosa, 10 (9.9%) had bulimia nervosa, purging type, 2 (2.0%) were classified as having an eating disorder not otherwise specified, and 6 (5.9%) were deceased. Zipfel and colleagues (2000) followed up with 84 patients with anorexia nervosa 21 years after their first hospitalization and found that 42 (50.6%) patients had achieved a full recovery, 20 (23.4) % had an intermediate outcome (partial recovery), 9 (10.4%) still met full diagnostic criteria for anorexia nervosa, and 13 (15.6%) had died from causes related to anorexia nervosa (Zipfel, Lowe, Reas, Deter & Herzog, 2000). Steinhausen and colleagues (1991) reviewed 67 studies of four decades of outcome research, and reported the rates of recovery ranged from 50%–70% (Steinhausen et al., 1991).

Researchers have also used different definitions of “recovery”. For example, according to Morgan and Russell (1975), an individual who has achieved ‘good recovery’ (based on their Morgan–Russell scale), is one who has achieved normalization of weight

and menstrual function. Other researchers are very specific about their criteria for recovery. For example, according to Theander (1985), the criteria for recovery are “ a stable body weight within 15% of the average body weight for height, spontaneous and regular menstruation, normal eating habits without undue dieting or bulimic episodes, and a reasonably normal conception of the body without unrealistic overestimation of body size” (Theander, 1985, p. 496). Over all it is difficult to make specific claims about recovery rates in anorexia nervosa because of methodological differences between studies, and weaknesses in reported studies such as: not adhering to diagnostic criteria, deficiencies in sampling, and lack of agreement of outcome criteria with features that can define recovery from anorexia nervosa (Beresin et al., 1989; Pike, 1989; Steinhausen, 2000). Despite the differences, however most definitions of recovery are primarily based on the absence of eating disorder symptoms and are arbitrarily defined by researchers. The literature is also limited by lack of clients’ subjective interpretations on definitions of recovery (Pike, 1989; Steinhausen, 2000).

## *2.6 Clients’ Perception of Recovery from Anorexia Nervosa*

A number of studies have used a descriptive narrative process in order to understand recovery from clients’ perspectives (Bell, 2003; Beresin et al., 1989; D’Abundo & Chally, 2004; Eivors, Button, Warner & Turner, 2003; Garrett, 1997; Hsu, Crisp, & Callender, 1992; Jacobson, 2001; Maine, 1985). These studies reveal factors that individuals perceive to have influenced their recovery process, such as perception of treatment, motivation to recover, increased self-confidence, getting out of the harmful environment, intensive family therapy, satisfactory relationships, recognition of the

problem, and being fed up with the illness (Bell, 2003; Garrett, 1997; Hsu et al., 1992; Jacobson, 2001; Matoff & Matoff, 2001; Noordenbos, 1989; Rorty, Yager & Rossotto, 1993; Sharkey-Orgero, 1999; Pettersen & Rosenvinge, 2002).

In her study of patients' experience of treatment, Maine (1985) interviewed 24 participants, all of whom had received formal inpatient intervention. Patients rated their intervention as follows: 5 participants believed that their treatment was essential to their recovery, 16 participants believed that they would have recovered without treatment, and 3 saw their treatment as harmful to their recovery. According to this study, all participants reported insufficient help from clinicians with regard to their feelings about their food intake. Bell (2003), reviewed 23 studies of eating disorders, and reported that eight studies concluded that formal treatment was not only ineffective as perceived by clients, but in some cases even damaging, especially when the treatment goal was too narrowly focused on weight restoration and feeding. Beresin et al (1989) noted that clients' valued having some control over the type and pace of treatment. Clients also valued "honesty, consistency, reliability and flexibility," responded well to a therapy style that was open, respectful, non-judgemental, provided information about eating disorders, and was not overly focused on the treatment guidelines (Beresin et al., 1989, p.114). These investigators also reported that some clients valued hospitalization, since it "represented an assurance of safety, a refuge from home, school, and friends" and "they felt relieved that someone was taking over, structuring their world, and making decisions for them, particularly about food" (Beresin et al., 1989, p.119).

An intriguing feature of anorexia nervosa is the sense of control and power individuals derive from their disorder. These positive feelings can greatly contribute to a

client's ambivalence about wanting to engage in treatment and clients' readiness to recover (Geller & Drab, 1999; Vitousek et al., 1998). Despite anorexia's numerous medical, psychological, and social consequences, many individuals decide to continue their restrictive eating behaviour. The benefits of holding on to anorexia nervosa, as they see it, exceed their desire to recover. This is well described in a study by Serpell and colleagues (1999), which examines the attributes of 18 anorexic patients (still in treatment). Clients were asked to write two letters to their anorexia nervosa, one describing it as a friend and the other describing it as an enemy. "The perceived benefits of anorexia nervosa were gaining a sense of control, feeling looked-after, and feeling special. The perceived costs of anorexia were feeling taken over, constantly thinking about food, and losing or damaging personal relationships"(Serpell, Teasdale & Sullivan, 1999, p.177). The most unique element of this study is its focus on exploring the costs and benefits of change. The motivation to move on with recovery comes from patients' own decision as they continuously explore the cost and benefits of changing their restrictive symptoms and seeing anorexia more as a "foe" rather than a "friend" (Serpell et al., 1999). Similarly, getting fed up and feeling tired of the disorder as well as the recognition of how anorexia dominates all aspects of life marked a turning point for many patients in accepting their disorder and desiring a better life (D'Abundo et al., 2004; Pettersen et al., 2002).

Other features valued by clients during their recovery included "a focus on developing a positive attitude to one's body, forming a better relationship with others, and conflict resolution" (Noordenbos, 1989, p.17). Bloks & van Furth (2004) analyzed the relationship between coping strategies and recovery over a period of 2.5 years. They



identified the importance of social support in both coping with severe eating disorders as well as recovery from eating disorders. The study found that people who were fully recovered sought social support, were active in managing stress, and exhibited few avoidance or passive reactive attitudes (Blok & van Furth, 2004). In a case study done by Matoff et al. (2001), the turning point in the clients' recovery was acceptance of social support and the change in communication styles with others, which helped them move from feeling fat and powerless to feeling empowered in the decision making and self-acceptance (Matoff et al., 2001). In other qualitative studies, individuals with eating disorders viewed the following factors as instrumental to recovery: distance from the family, group therapy, positive job and school experiences, trusting others, risking to share their feelings and thoughts with others, eating out with friends and family, and developing good relationships (Bell, 2003; Beresin et al., 1989; D'Abundo et al., 2004; Eivors et al., 2003; Garrett, 1997; Hsu et al., 1992; Jacobson, 2001; Maine, 1985; Matoff & Matoff, 2001; Noordenbos, 1989; Pettersen et al., 2002; Rorty et al., 1993; Sharkey-Orgero, 1999; Surgenor, Plumridge & Horn, 2003; Tozzi, Sullivan, Fear, McKenzie & Bulik, 2003).

In summary, these findings suggest that patients stress the importance of personal strength, self-development, forming better relationships with others, being ready for change and being understood as important for recovery from anorexia nervosa. These factors are not explicitly related to treatment or theory but personalized descriptions of variables that each patient found essential for their recovery.

## 2.7 Normalization of Eating in Recovery from Anorexia Nervosa

Considerable literature has been devoted to the experiences of recovery from anorexia nervosa, but surprisingly little attention had been given to what happens to eating during recovery. Several studies reported that restrictive eating patterns and body image perception were the hardest features to change (Beresin et al., 1989; Maine, 1985; Pettersen & Rosenvinge, 2002), and according to Geller and colleagues (Geller, Drab-Hudson, Whisenhunt & Srikameswaran, 2004) the individual's readiness to change their restrictive eating pattern was predictive of the short-term outcome. When Pettersen & Rosenvinge (2002) asked patients what recovery meant for them, 76% of patients rated their ability to "accept myself and my body and not to use food to resolve problems and not to let food dominate life" as the most important (p. 68). A few studies addressing changes to eating behaviour refer to the absence of behavioural symptomatology, such as restricting, bingeing, and purging behaviours, and preoccupation with weight and shape (Beresin et al., 1989; Pike, 1989; Hsu et al., 1992; Steinhausen, 2000). Beyond these basic behaviours the literature is silent. We do not know if clients who have reached a normal weight, or stopped bingeing and purging, continue to avoid certain fattening foods in the fear of weight gain, continue to struggle with ritualistic eating behaviours or if they have been able to eat normally.

How does the literature define normal eating? A thorough search of numerous nutrition and eating disorder journals did not yield a suitable definition of *normal eating* for people who have recovered from anorexia nervosa. Some articles talk about a well-balanced meal plan that includes enough calories to promote weight restoration (Beaumont et al., 1981). Others specifically recommend 1,200 kcal in three meals, to be

gradually increased by 300 kcal to 500 kcal based on what a patient can tolerate (Mitchell, 1985; Rock, 1997). In his book on overcoming binge eating, Fairburn (1995) delineates specific steps used to regulate eating that emphasize the importance of having three meals. Finally, in Mosby's (1998) medical dictionary, the definition for a *normal diet* (also referred to as a *regular diet*) refers to a "well balanced diet containing all of the essential nutrients needed for optimal growth, repair of tissues, and the normal functions of the organ. Such a diet contains foods rich in proteins, carbohydrates, fats, minerals and vitamins, in proportions that meet the specific caloric requirements of the individual" (Anderson, 1998, p. 1398). This definition and set of recommendations centre on the medical model of patient care by focusing on assessing a patient's nutritional status and providing a well-balanced meal plan necessary to correct any nutritional deficiencies.

In summary, there are major gaps in the literature with regard to understanding how individuals change their eating behaviours during the process of recovery from anorexia nervosa, or what "normalization" of eating means for people who have recovered from this disorder. That is, does "normalization of eating" mean returning to one's own normal or "pre-anorexia" eating habits, or have individuals who have suffered from anorexia nervosa always had a difficult relationship with food so that the normalization process involves developing new eating patterns? This study, therefore, was designed to explore how individuals who have recovered from anorexia nervosa describe their own experiences and understandings of normalization of eating.

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## **Chapter 3: Normalization of Eating during Recovery from Anorexia Nervosa**

### **3.1 Introduction**

Anorexia nervosa has been described as both an “emotional disorder phobia” (Crisp, 1981) and as a “relentless pursuit of thinness” (Bruch, 1978). It predominantly affects females facing the developmental challenges of the transition from adolescence to young adulthood. However, anorexia is also known to affect males, children, and older adults (Palmer, 2000; Hoek & Hoeken, 2003). Just as anorexia nervosa is a complex disorder, so too is its etiology. The development of the disorder is influenced by a combination of physical, emotional, sociological, and familial factors (Hindmarch, 2000; Palmer, 2000). Clinicians and researchers have observed that the development of anorexia nervosa often manifests itself in adolescence as a result of stressful life situations for which the individual does not possess adequate coping skills. Feeling out of control and needing a form of escape from problems and negative emotions, these individuals turn to food as a way to distract themselves or numb the underlying feelings of distress. The decision of when and what to eat is the one thing these individuals perceive as being completely under their control. As a result, in the life of an individual suffering from anorexia nervosa, food transcends the nourishment role to become an object of rules: they are judged as good if they do not eat (or if they eat very little) or bad if they consume fattening foods or fear foods (Kolodny, 1987; Villapiano & Goodman, 2001; Herrin, 2003).

Recovery from anorexia nervosa is a long and difficult process. It involves addressing both psychological and food and weight issues. An individual who suffers from anorexia nervosa will not experience a full recovery if she makes significant

progress in only one aspect of the disorder (for example, resolving psychological issues without addressing food and weight problems) (Hindmarch, 2000).

Despite an increase in the amount of information on the outcome of eating disorders and increased awareness of different treatment modalities, the process of recovery remains poorly understood (Pike, 1998). A number of researchers have used qualitative methods to explore the recovery of individuals who suffer from anorexia nervosa from the perspective of the client (Hsu, Crisp, & Callender, 1992; Platt, 1992; Rorty, Yager, & Rossotto, 1993; Serpell, Treasure, Teasdale, & Sullivan, 1999; Bell, 2003; D'Abundo & Chally, 2004). Some of the themes identified by participants of these studies as significant to their recovery related to personal factors such as: self-acceptance, an active desire to change, knowing one's self, gaining self-respect, recognizing and accepting the problem (Maine, 1985; Beresin, Gordon, & Herzog, 1989; Pettersen & Rosenvinge, 2002; Surgenor, Plumridge, & Horn, 2003); supportive familial and non-familial relationships (Sharkey-Orgero, 1999; Jacobson, 2001; Tozzi, Sullivan, Fear, McKenzie, & Bulik 2003); treatment related themes (Noordenbos, 1989; O'Byrne, 1990; Matoff & Matoff, 2001; Tozzi et al., 2003) and social support and social functioning (Rorty et al., 1993).

In contrast to the growing literature on overall recovery process, I was unable to identify any studies that specifically addressed the process of eating normalization during the recovery from anorexia nervosa. Two empirical studies on the outcome of anorexia nervosa did talk briefly about the kinds of food choices participants were making at follow-up. More specifically, Hsu (1980) reported that in the 25 year period (1954-1978) "only one third of subjects were eating normally at follow-up, while half were still

consciously and purposefully avoiding high-calorie foods” (p. 1042). In the second study, Clinton & McKinlay (1986) showed that anorexia nervosa patients who had been judged as recovered by their psychiatrist and had been out of treatment for an average of 42.6 months continued to show distorted attitudes to food, eating, and weight, even though these attitudes were less extreme than those of a group of acutely ill anorexic patients. These empirical studies looked at different outcomes as measures of normal eating, but neither study defined normal eating or described the participants’ experiences of normal eating. Overall then, there is a large gap in the literature describing recovery from anorexia nervosa, in that little work appears to have specifically addressed clients’ experiences of eating as they incorporate fear foods back into their diet and work towards achieving a healthy eating pattern. The research presented in this thesis aims to begin filling that gap. This study was designed to increase an understanding of how women who had anorexia nervosa experienced changes in their eating behaviours and to identify major sources of support during their process of recovery.

### *3.2 Research Design and Methods*

A qualitative research approach is ideally suited for research that aims to explore people’s subjective experiences of a phenomenon (Pope and Mayes, 1995). As such, qualitative methods were deemed to be the best approach for this study, which aimed to gain an understanding of the normalization of the eating process from the perspective of those who have experienced it, as well as to examine the subjective meanings of those experiences. A grounded theory approach was used in this study to explain the process by which women with anorexia nervosa normalized their eating behaviours. According to Morse and Field (1995), a grounded theory is based on “symbolic interactionism that

stresses that human behaviour is developed through interaction with others...and that people construct realities from the symbols around them through interaction” (p. 27). This approach is well suited to capturing the social realities of human experiences, including how social interactions are involved in nutritional aspects of recovery from anorexia nervosa. The grounded theory approach is an inductive methodology, because the data lead to the theory, rather than the theory testing the data. For example, in this study the research began with interviews of the first four participants, and the questions that emerged from the analysis of these interviews were used to direct further data collection. By using this iterative process of data collection and analysis, major categories were developed and relationships between categories were identified and compared to the data of subsequent interviews. This constant comparative process continued until the point of ‘saturation’ was reached, or when new data collections did not yield further information about the phenomenon of interest (Strauss & Corbin, 1998).

### 3.2.1. *Sample selection and criteria*

A combination of convenience and theoretical sampling methods were used to select participants who were willing to discuss their experiences of eating normalization during the recovery process (Portney & Watkins, 2000). The target population for this study was women who at some point in their life met the diagnostic criteria for anorexia nervosa and who, at the time of the interview, considered themselves recovered from anorexia nervosa. Advertising posters (see Appendix A) were placed at the University of British Columbia (UBC) and Langara College campuses as well as in Vancouver community centers (two on Vancouver’s West Side and one on Vancouver’s East Side). The women who volunteered to participate in this study were 19 years old or older and

lived in the Lower Mainland. They were contacted to determine whether they met the following inclusion criteria: no hospitalization for anorexia nervosa in the last two years and maintenance of normal weight without any restricting, bingeing, or purging for at least one year. Interviews were arranged at locations most convenient for each qualified participant.

Each participant signed a letter of informed consent (see Appendix B), which detailed the purpose, procedures, and limits of confidentiality for the study. They were informed that their participation was entirely voluntary and that they could withdraw from the study at any time. Each participant was offered an honorarium of \$30 for her involvement in the study. Approval from Providence Health Care/University of British Columbia Research Ethics Board was received prior to conducting the study (see Appendix C).

### *3.2.2 Data collection*

The grounded theory method uses a range of approaches to data collection. For this study, interviews and the Eating Attitude Questionnaire-26 (EAT-26), were used to gather data. At the start of the interview, I obtained some demographic information and a history and a severity of their eating disorder symptoms (see Appendix D) and proceeded by asking an open-ended question such as “Tell me about your eating disorder, when did it start? Has it changed over time?” The interviews were semi-structured, with the participants determining the general content and pace of the interviews. Trigger questions were utilized to stimulate discussion throughout the initial interview in order to obtain in-depth information about each participant’s past and present eating behaviour practices. These included asking the participant to briefly describe her eating prior to the onset of

the disorder, at the onset of her disorder and more specifically her current typical daily intake, the type of foods she is avoiding and why, what normal eating means to her and what or who helped her during recovery (Appendix E). In the early stages of the interviewing process I let participants tell their stories in order to gather as many themes and ideas as possible. I frequently referred to the interview guide to ensure that all questions were discussed. In the later interviews in addition to asking the main questions I further explored the themes were identified in the previous interviews. As I became very familiar with the interview questions and the emerging themes I relied less on the interview guide. Each interview was tape-recorded and lasted one to two hours. The interviews were transcribed verbatim.

Immediately following each interview I recorded 1-2 pages of field notes to capture my impression and observations of the participant's non-verbal gestures and the essence of the interview process. Most of the comments pertained to the description and the information about the participant. For example: (Interview # 1) "I noticed every time she talked about her sister, who still lives in Europe, that her voice was quieter, almost hard to hear, and she became tearful... We had to stop the interview for few minutes." After reviewing each tape I continued writing the field notes about the conversation, including my own and the participants' comments. For example: (Interview # 3) "I am saying 'yes', 'of course', nodding, 'I know what you mean' too many times, I had to stop doing this, it could misdirect the conversation".

At the end of the interview, participants completed an EAT-26 questionnaire, (Appendix F), which is a 26-item, self-rating scale developed by Garner and Garfinkel

(1979) to assess anorexic attitudes regarding eating. The scores were compared to the respondents' beliefs regarding food, eating, and weight as stated in the interview.

### 3.2.3 *Data analysis*

Data analysis and data collection were systematic and interrelated processes that occurred simultaneously in this grounded theory study. The process flowed between data collection and analysis and as themes emerged from data it informed us about the possible future participants we needed to recruit in order to fully understand the process of normalization of eating (Strauss & Corbin, 1998). For example, after the coding and analysis of the fourth interview, I learned that participants who had only received outpatient treatment valued supportive relationships either with family members, friends, spouses, or support group members during their process of recovery. I then searched for other individuals who had inpatient treatment and explored whether their experience of support was similar to or different from that of the previous participants.

The principal analytical techniques of grounded theory are constant comparison of data from one interview to another, using three specific procedures of open coding, axial coding, and selective coding. I used the Atlas software program, (Scientific Software Development, Berlin, version 4.1), for data management by merging the data with the same codes into the same file. I began the analysis of the verbatim transcripts by open coding the data line by line, using exact words or phrases that described action in the setting (Strauss & Corbin, 1998). For example, for a statement such as "I always believed that one day I will be able to eat normally, without feeling guilty or out of control," open codes included "belief about eating normally," "feeling of guilt," and "control." These open codes were based on the data only, minimizing the influence of my preconceived



impressions of the phenomenon. Moving from basic concepts or open codes, I was looking for patterns, differences, and similarities in the identified code.

After the fourth interview, I began grouping codes into broader categories, which were generally more abstract in nature than open codes (Strauss & Corbin, 1998). Axial coding was used to define categories and make connections among categories and sub-categories. For example, altering recipes, always needing to feel hungry, eating less, and eating the same food were initially categorized under the heading of “control.” Some other categories identified through this process were acceptance, awareness, control over food, experimenting, flexible eating, transitioning, making choices, small changes, slow process, and time.

The next step in the data analysis was using selective coding to assist in consolidating the categories that emerged in the previous two coding methods (Hutchison, 1986; Strauss & Corbin, 1998). The focus of the selective process is to discover the core category—**freedom to enjoy food**—which was the central phenomenon of the study. This core category related systematically to all other major categories, which were: acknowledging the disorder, accepting support and deciding to get better, confronting old patterns and learning new ways, and food becoming a non-issue. The constant comparison method of data analysis was used throughout all phases of data analysis. Field notes were not coded, but were reviewed towards the end of analysis to cross-check my initial impressions with the later analysis.

#### *3.2.4 Issues of trustworthiness*

Trustworthiness is used in qualitative research as a broad concept that addresses the truth value of the findings (Erlandson et al., 1993). Trustworthiness is established in a

naturalistic inquiry through credibility (which is analogous to the concept of internal validity in empirical research) and dependability and transferability (external validity). Credibility for the grounded theory is earned by the extent to which the theory is grounded in the data and is comprehensive in relation to the data (Strauss & Corbin, 1994). To ensure credibility of the study I used a method called member checks, which involved contacting participants either by phone or interviewing them in person in order to allow them to judge the study for accuracy (Lincoln & Guba, 1985). Five people responded to this request for evaluation, and they found the findings consistent with their experiences. I have also employed peer debriefing by requesting feedback from other graduate students and professionals about the methods, meanings, and interpretations of the study (Lincoln & Guba, 1985). The rigor of the study was further enhanced by the use of triangulation method, or use of multiple data collection (interviews, field notes, and the EAT-26) (Lincoln & Guba, 1985).

Transferability of the data is best accomplished by providing 'thick description', meaning that the description needs to include sufficient information for readers to understand the findings and determine the degree to which findings might apply in other contexts (Lincon & Guba, 1985). In order to provide the 'thickest' possible range of information, researchers must ensure that adequate sampling is provided and that all categories are 'saturated'. According to Morse (1985), in grounded theory, evaluating the adequacy of the sample to determine when sampling is complete is more dependent on the quality and adequacy of data than the number of participants. "Adequacy refers to the amount of data obtained and whether or not saturation occurred" (Morse, 1985, p. 189). In this study, by the time I interviewed the eleventh participant, the themes began

repeating and no new information was forthcoming. The last two participants were interviewed to ensure that the saturation was reached, as well as to apply a 'member's check' technique to indicate whether the categories already identified in the analysis were recognizable in the new participants' process of recovery from anorexia nervosa.

It must be acknowledged that my background in nutrition and fifteen years of experience working in the area of eating disorders will influence data analysis. When conducting qualitative research, it is important to recognize that the researcher is the primary instrument for data collection and analysis, and that this presents the potential for possible data misinterpretation (Creswell, 1998). As an eating disorder dietitian, I have naturally chosen to explore the normalization of eating during recovery from anorexia nervosa. However, my professional experience brings with it many preconceived notions about this research topic. This experience may have advantages in helping me identify an important research question and sensitizing me to the field of study, but it also creates the potential for biases (Strauss & Corbin, 1998). It is therefore important that I disclose my biases and provide my interpretation of the normalization of eating process and appropriate treatment. I believe that restoring nutritional health and being able to eat all foods are essential to recovery and nutrition counseling should occur concurrently with psychotherapy. Dietitians working in this area need to gain knowledge and skills in counseling. I also believe that the multidisciplinary approach to treatment is the most effective and that individuals will change their eating behaviours only when they are ready (Hindmarch, 2000).

In addition to being aware of and disclosing my perceived biases in relation to the research topic, I also took specific steps in data collection and analysis to

reduce the influence of my prior assumptions. During the interview process, I made sure that participants provided detailed explanations of their experiences and answered questions fully. In doing this, I refrained from commenting, other than to prompt or clarify. Throughout analysis I constantly compared one piece of data with another thus being able to better monitor the contaminating effects of personal bias on the interpretation of data. In a naturalistic study, the researcher cannot ensure that observations are free from all biases, but she/he can ensure that the “thick description” or sufficient details are collected (Erlandson, Harris, Skipper & Allen, 1993).

Table 3.1: Description of Participants <sup>1</sup>

Code Name <sup>2</sup>	Age	Age at onset of AN	Duration of symptoms	Years since recovery	Occupation	Marital Status	No. of children	Current BMI
Anna	28	16	5	6	student	single	0	24.1
Mary	23	14	5	3	student	single	0	20.5
Carol	24	18	3	2	research assistant	single	0	20
Judy	34	14	14	6	education coordinator	single	0	19.5
Emma	32	13	10	9	student	divorced	0	20.4
Doris	29	19	5	5	clerk	married	1	20.5
Sally	23	16	3	4	manager	married	0	22
June	20	13	4	3	student	single	0	20.2
Gloria	20	13	4	3	student	single	0	23.1
Debbie	19	12.5	3 to 4	3	student	single	0	21.2
Helen	23	13	8	2	student	single	0	21.5
Tina	30	14	7	7 to 9	student	single	0	21
Susan	59	14	21	24	nurse	divorced	3	24.5

<sup>1</sup> All information was self reported

<sup>2</sup> Pseudonyms substituted for participants' names

### 3.3 Participant Description

As detailed in Table 3.1, thirteen women, aged 19 to 59, were interviewed for this study. One participant was 59 years old, three participants were in their early thirties, two were in their late twenties, six were between 20 and 25, and one was 19 years old. All participants lived in the Lower Mainland, either with roommates, or by themselves in a

student residence, or with their partners. All but one participant were Canadian and of a predominately European heritage. Their level of education was generally advanced, as most participants were recruited from UBC. The onset and the duration of the illness varied for the study's participants. For most women, onset occurred during their early teens (13 years to 16 years of age). For most the duration of their symptoms ranged from three to seven years, with one lasting 10 years, another 14 years and one lasting 21 years. The length of recovery time for most women ranged from two to nine years with one participant recovered for 24 years. Eleven women struggled with the restrictive sub-type of anorexia, while two had the binge-purge subtype.

### 3.4 Findings

For the thirteen women in this study, normalization of eating was a slow and a gradual process during recovery from anorexia nervosa. It required incremental changes in eating habits as they transitioned from control over food and their body to freedom to enjoy food and life. Ten women in this study considered themselves to be fully recovered from anorexia nervosa. Three women felt that they were recovered 'clinically speaking', but still had some level of guilt about eating fear foods and felt the need to exercise in order to maintain their body weight.

The overall categories and themes that emerged from the data led to the construction of a core variable and four phases of recovery. The core variable, **freedom to enjoy food**, permeated and integrated all four phases, which were labelled as:

- Acknowledging the disorder;
- Accepting support and deciding to change;
- Confronting old patterns and learning new ways;

- Food becoming a non-issue.

Each phase included common experiences that stemmed from changes that the women made as they worked towards normalizing their eating. To understand those four phases of recovery, however, it is first necessary to have an appreciation of the participants' experiences of developing and having anorexia.

Prior to the onset of their disorder, all women in this study experienced some difficulty during their adolescent years that left them powerless, confused, and distressed. For some, distress was due to conflict within their family: "I never felt like I was worth anything at home...anorexia gave me some purpose" (Anna), "anorexia was my saviour" (Judy), "I was told if I could lose some weight I could jump higher...I wanted to go to national competitions" (Gloria), "I was overweight and teased about it" (Sally), and "in high school I did not like when guys made comments about my body" (Doris). These were challenging times for these women, and they needed a sense of control. They felt that they could not voice their feelings or change others, so they changed themselves by controlling their food intake and their body.

Control over food was a common theme among all the women in the study, as is generally the case for all individuals who suffer from anorexia nervosa. These individuals came to learn that the best way of dealing with their stress, insecurity, and general feelings of discomfort was to control their food intake. Every comment, encounter, observation, and experience for these women was translated into food statements and control over food: "The one thing in my life I could control was my food intake" (Mary).

Restricting food intake provided more than just control. Participants described the central role that food played in their lives: It was "calming, and comforting" (Anna), it

provided “immediate gratification” (Emma) and “empowerment” (Doris). By focusing on food and devoting all their free time to making decisions of what food to eat or not to eat, participants temporarily distracted themselves from having to deal with real issues. However, over time, regardless of what they chose to eat, the feelings surrounding unresolved issues generally intensified. The women then began questioning how important their control over food really was. For example, June asked: “What is the importance of food? It is important for survival, [and restricting] is a loss of control... You have no control over yourself, but food is controlling you... It is that awareness.” The awareness and acceptance of their disorder forced the women to look at their illness and to judge whether they wanted to recover.

#### 3.4.1 *Phase one: Acknowledging the disorder*

The initial phase of recovery began when individuals acknowledged the disorder by being aware of the losses they incurred in their life as a consequence of their disorder. The categories that emerged from data analysis depicting the awareness of the disorder were:

- Awareness of physical complications;
- Decline in social activity;
- Disliking the type of person they had become;
- Being tired of the game.

The cost of holding on to anorexia was too high for all of the participants. It affected their emotional, social, and physical well-being. They came to realize that the final outcome of anorexia was generally death, and that death was not an option they were willing to consider, despite the severity of their illness:



I really felt like I was going to die. Like, there were days I could not move...I could not hold myself up. And then I thought—the inner voice was telling me—“You could die”! Like, you might end your life, and you are only in your 20s. I did not want to die, but something, some survival mechanism, I think that must have told me: “Continue this, and you might die”. So, the fear of death made me recover...I want to get married and have a child. So, those things allowed me to bring down my controls (Gloria).

The degree of physical illness became obvious to Gloria when her physician told her and her parents that she may die. He said:

“She is severely emaciated...I am not sure how long, but like, one more month.

And, I do not think she is going to survive.”

Gloria was not clear why her physician had given her one month, but to her that sounded very definite and imminent. She knew that death was not an option she would consider. She wanted to go to school and to accomplish many things in sports, career, and life. She came to understand that there were too many opportunities and too much unrealized potential that could easily be lost to anorexia.

In addition to having various physical ailments, all participants in this study admitted to being lonely. Their friends and family members could not understand their preoccupation with food and avoidance of social activities that involved food. In the initial stages of their disorder, friends tried to be accommodating, but as the disorder progressed, participants experienced a major decline in their social life. Debbie describes the loss of her friends with a great deal of sadness:

I was really looking at my life, and self, and realized I had no friends, and I was really lonely, and had nothing to do. And people were talking about hanging out on weekends and stuff, and I had nothing.

Participants were disappointed at the type of people they became: people who would lie and deceive the people who cared about them.

My mom, let me tell you, she was so, so sad. It was so painful for her to see how each day I was becoming puffier and puffier, my body was full of water, and my hair was falling out in huge chunks...She was so sad, and tried so hard to get me to eat. No, I did not like who I became, and worse of all, I was so miserable (Doris).

As each participant's physical and emotional well-being deteriorated, she also became tired of the game: "I got tired. I got tired of lying. I got tired of being tired...It was too much. I exhausted myself, to the point I could not even do it anymore" (Mary). Judy called anorexia a "waste of time" and living it a "waste of life." Anna talked about her realization: "Like, I knew it is not going to change anything, anything at all. I really needed to change the way I live." However, the process of making changes presented a dilemma that all participants struggled with, during their initial phases of recovery. Judy talked about feeling stuck and unsure about how to proceed:

[I was] just stuck in this big black hole. And I knew that either I had to recover or it would kill me. It was one of the two. There is no maintaining this life for the next five or ten years.

Awareness of having lost opportunities to anorexia and needing to acknowledge the disorder was important in deciding to make changes. Realizing that anorexia took

away things they once enjoyed, “the innocence of teenage years” (Judy) helped the women to reach out and accept support in their struggle to recover. During their recovery, all participants experienced feelings of confusion and ambivalence. They knew they did not want to live with anorexia, but they feared that if they let go of their way of eating they would lose all control and that their weight gain would become unstoppable. However, in order to get better, the women had to relinquish that false sense of control that anorexia imposed on their lives. Judy describes having to ask her mother for help and explain the extent of the problem:

I think I was at my lowest weight at that point. I think my body could not handle me eating anything any more....I felt like my body was shutting down....That is when I got really scared. I started to cry and I said [to my mother], “Something is wrong with me,” and that is when I acknowledged....I said the words: “I think I am anorexic.”

#### *3.4.2 Phase two: Accepting support and deciding to change*

The second phase of the recovery process began once the participants made the decision to accept support and share their feelings and worries about the changes they had to go through in order to recover. The categories that emerged from that data analysis influencing the women’s decision were:

- Being ready;
- Deciding to change their eating pattern and accepting weight gain;
- Engaging support.

Women in this study talked about being ready or, as one participant referred to it, finding their “inner drive” (Susan). Carol felt that the same determination that kept her anorexic

for so many years was also the force that prepared her for the challenge of changing anorexic eating behaviour: "I had this drive to get better." She, like the other women, had reached a certain point in her disorder when she had to make a decision to let go of anorexia because she wanted to move on and get better. June talked about not only being ready to make changes, but making changes for her own sake, being motivated from within: "There is like this big door that won't open, unless you want to open and share... Yeah, decide to open up that door, look outside and let them in.... So, it is up to the person."

The acceptance of their body's needs and acknowledging the hunger was an important step in the women's decision to change their eating patterns. This was a difficult and stressful process for all participants, always requiring a conscious effort. The women were aware of the dangers of anorexia and wanted to get better, but they also knew that their desire alone was not going to change their eating behaviour. They had to challenge their thoughts of not needing to eat and to add food to their daily intake in a gradual manner:

I guess when I was tired of this and decided to recover, it was that conscious thought to eat...when I started to eat more, that sort of in itself triggered more recovery...because I just decided...But at first it was hard, because it was more food than I was used to eating, and it was such a big adjustment. (Emma)

The decision to get better was not only about needing to eat more food, but also about coming to terms with weight gain. For some participants, this process was very difficult. How much they gained depended on their level of comfort and support, but also on how significantly body image related to their self-evaluation:

And so I decided I was going to put on some weight, and my doctor said that ten pounds would be fine, and anyway...I thought that would be okay...but it was hard....It took more than a year. However, when I gained weight, I realized that I looked better, and that was also something that I probably would not have thought...I could see it, like, almost from a different perspective, like, almost from looking through somebody else's eyes...And I decided to stay, keep that weight. (Emma)

What helped other participants to tolerate this initial weight gain was support from others and the continual reassurance and that in time they would get used to their new body image.

Engaging support was a recurring theme and a significant factor that women valued as they worked towards normalizing their eating behaviour. In this study, the source of primary support for participants differed somewhat, but invariably included spouses or other family members, friends, therapists, teachers, spiritual leaders, mentors (through the AA association), and, for one participant, a community leader/minister whom she referred to as an uncle despite lack of a biological relation.

For some participants, family was the main source of support. Doris referred to the support her family gave her as the foundation for her recovery. Eating support for Gloria included her mother making meals she could eat but not watching how much she ate or discussing and focusing on food at all:

When I was going through a phase of eating, they would not say anything...they gave me a lot of space, but at the same time they were emotionally supportive.

Other participants had to move away from family conflict in order to change their eating habits. Anna realized that staying at home meant having much less control over eating. It was only when she moved to another country that she felt free, no longer obliged to the family, and much more in control of everything.

Participants also described the importance of connecting with friends who understood their struggle and did not dwell on their disorder or what they ate. For some, this made it easier to be honest and willing to try new foods. There was no pressure, no expectations. It was all up to them:

They did not have any judgment on me. I was exploring and learning about myself, and that was, I think, the best thing that I could ever have done timing-wise (Gloria).

Having support was significant in assisting women in working towards eating normalization by trying new foods and challenging their old beliefs around food and eating.

#### *3.4.3 Phase three: Confronting old patterns and learning new ways*

This phase was the longest and the most difficult part of the women's recovery. It included the following categories:

- Mentoring healthy eating;
- Experimenting with new foods;
- Making incremental changes.

Needing to take risks continually by adding foods that they had come to fear and deprive themselves of made many participants question whether the process was worth the emotional and physical struggle:

It was so traumatic, and some days it was so awful, so awful physically eating it, and letting yourself go. You just feel like you are walking naked, you know, and everyone is looking at you, and it is such an awful feeling. But I had to do it. I *had* to do it (Doris).

The anxiety associated with eating foods they feared was all-encompassing for the women, so much so that they needed someone in their life to say: "It is okay to eat this," or "Your body needs protein, so you can have this egg" (Sally). Trusting others and relying on support and reassurance was vital as the women began experimenting and adding new foods to their diet.

Five participants talked about the benefits of having mentors who practised healthy eating patterns without focusing on food and weight. For one participant it was a dietitian whom she trusted and for others it was their therapist, family member or a close friend. What helped Judy to take steps towards adding more food to her diet was having a mentor, her boyfriend who did not initially know about her eating disorder and did not make any comments about her food choices or her eating patterns.

It was not someone pushing me to do it...He role-modeled really healthy eating patterns to me. He was a mentor to me. I watched someone do it that I respected, and wanted to do it too...He lived a really healthy life, you know, like, just a healthy life, and I wanted it bad (Judy).

For the women in this study, anorexic thoughts and beliefs around food and eating were full of rules and daily rituals. For example, women were not allowing themselves any snacks, were not eating past 7:00pm, needed to clean their house before allowing themselves to eat, or needed to run two miles in order to justify having lunch. Initially,

rules provided Carol, Judy, and Emma with a feeling of security, a feeling that if they followed these rules they could maintain control. Carol would not eat lunch at all, instead opting for a run in order to justify having a cinnamon bun every time she went out for lunch with her sister. Behind these rules was the underlying fear that if they ate anything more than their pre-planned intake, they would not be able to stop eating and would “become huge” (Judy).

Judy began testing her self-imposed rules by making incremental changes and adding small amounts of select food to her meals over several weeks. This gave Judy an opportunity to prove that “I could eat that and not be huge” (Judy). For these women, the experience of starting to eat forbidden foods again was too distressing. Tolerating physical fullness and abdominal distension was a difficult process for all participants. Choosing small portions, “like a couple bites” (Anna), was a way to deal with the physical and emotional changes. Mary, Emma, Carol, and Judy described how they began their process of eating normalization by focusing on one meal at the time, for example breakfast: “It would have been a very small bowl of cereal which would have been mostly fruit and a little bit of cereal, very minimal” (Carol).

Having a small breakfast, such as bran flakes cereal with milk, and then snacking throughout the day on fruits and vegetables was a compromising alternative for Helen as she began re-nourishing herself. For her, the nibbling on food throughout the day was easier to deal with than struggling with anxiousness about being full and distended after regularly portioned meal. Yet, as participants made small changes in their eating behaviour, they gradually changed their anorexic thoughts about the amount of food they can eat and still not gain any weight. Women became pleased when they realized that by



having some starch or protein foods they did not 'balloon' and some initially lost weight before they gradually began regaining weight. This new experience gave participants the confidence to experiment with food and eating further and gradually reclaiming a new sense of self. But for some participants the experience was more traumatic, Mary and Gloria remember days when they 'relapsed' into bingeing as their bodies were deprived of food for too long. Following their binge episodes they would restrict for two days as a way of dealing with their guilt and anxiety. The support Gloria received from her mother was critical in decreasing and eventually stopping her bingeing episodes.

For some participants, being involved in making meals and having set meal times was helpful as they continued experimenting with new foods and expanding their repertoire of food. This provided women with a sense of predictability in their daily routine, thus reducing the time they spent thinking about food. Planning a meal with a supportive family member or a partner gave the participants a sense of control over their eating behaviour as well as reconnecting with the people that were important in their life. As participants became more flexible with their food choices and more comfortable in planning and making meals, they gradually entered a phase of their life where anorexia was losing influence over their eating behaviour and where food became a part of their physical nurturance and social enjoyment.

#### *3.4.4 Phase four: Food became a non-issue*

Through each phase of normalization of eating participants began to gain a broader perspective on the enjoyment of eating and being with others. Through all this, a new healthy self emerged that appreciated life and what it had to offer. The following

categories best describe the final transitioning from the life of restricting to the life of the freedom to enjoy:

- Eating whatever/whenever I want;
- Reaching a balance;
- Creating an identity without an eating disorder;
- Gaining freedom to enjoy food and life.

Participants spoke of not wanting food to have priority in their lives. When I asked them to describe their typical daily intake, most women said that it varied from day to day and depended on who they were with, how tired they were, and how much time they had to prepare a meal. The word “whatever” was used repeatedly as the women tried to express that food was not an issue for them any more:

So breakfast is bagel and Cheese Whiz, or cereal and milk. I also love nuts, fruit, or muffins, *whatever* is available. Lunch depends on the day. It might be pizza, or a sandwich; it might be a salad; *whatever* I happen to be craving and depends where I am....Dinners are *whatever* is easy and convenient: wrap or tofu and rice casserole, *whatever* my boyfriend makes. I love his cooking, especially his curry dishes. (Judy)

When I asked participants what normal eating meant to them, ten women reported being completely free from any preoccupation with food, seeing food as part of enjoyment and sharing with others, being free from exercise and body obsession and considering food and activity part of balanced living. Women talked about normal eating as not being self-conscious of eating in front of others, but learning that eating together implied a family connection and social acceptance.

Food is enjoyable again. You know, I can go and have turkey dinner with family.

I can go out to a restaurant and just order things that I like off the menu. Now I can socialize with food (Doris).

However, Sally, Anna, and Helen still experienced issues interfering with their decision to choose what and where they would eat, or to be able to take a day off from their daily exercise routine. All three had made tremendous strides in their recovery, but still felt that they had some remnants of anorexia in their thoughts and behaviour. Sally and Anna still had difficulty adding fat containing foods to their meals. When Sally made meals at home, she was still afraid to add salad dressing or mayonnaise: "But if I am out, and if food is already made with it, I will eat it, but at home I can not add it myself."

Helen's biggest barrier to eating normalization was exercise and eating out. She worked very hard to decrease her activity from three hours every day to just one hour, though she still felt unable to take a day off from exercise despite how tired or weak she felt. In the past two years of recovery, she has been exercising every day, but hoped that one day she would be able to have a day where she did not feel compelled to exercise. Eating out for Helen was more of a challenge: "I'd rather not deal with the guilt of eating that food." Yet, in order to maintain friendships and to spend time with her boyfriend, she would go out to vegetarian restaurants, because it was safer. Their menu choices would be "lower in fat" and "healthier" (Helen).

All participants were focused on being healthy and wanted to correct any damage their body sustained from years of restricting. This concern made them even more committed to recovery. Being healthy meant "eating healthy". Previous to recovery, being healthy meant, "not eating any fat, avoiding most proteins, eating a lot of fruits and

vegetables, and drinking copious amounts of coffee. “Now fruits and vegetables help to make up a part of a well balanced diet” (Judy).

Table 3:2 Participants’ diet type

Code Name 2	Age	Diet type at the onset of anorexia nervosa	Current diet type
Anna	28	Vegan	Fish/Poultry (no red meat, limited wheat and dairy)
Mary	23	Lacto-vegetarian	Regular diet-no red meat only
Carol	24	Lacto-ovo vegetarian	Regular diet-no red meat only
Judy	34	Lacto-ovo vegetarian	Regular diet-no pork only
Emma	32	Regular-LF/LC*	Regular diet
Doris	29	Lacto-ovo vegetarian Skim milk and egg whites	Regular diet
Sally	23	Lacto-ovo vegetarian	Regular diet
June	20	Regular-LF/LC	Regular diet
Gloria	20	Regular-LF/LC	Regular diet
Debbie	19	Regular-LF/LC	Regular diet
Helen	23	Lacto-vegetarian (skim milk only)	Lacto-ovo vegetarian
Tina	30	Lacto-ovo vegetarian	Lacto-ovo vegetarian
Susan	59	Lacto-ovo vegetarian	Regular diet-no red meat only

\*LF/LC indicates low fat/low calorie

As detailed in Table 3.2, eight participants who were lacto-ovo vegetarian and one who was vegan, struggled during recovery between their moral and ethical obligation for animal welfare and their need to have a healthy balance of all foods in their diet. For some it meant giving up vegetarian eating habits, because becoming vegetarian was a way of avoiding fattening foods and thus too closely linked with anorexia nervosa. At the time of interview, out of nine participants who had been vegetarian (eight lacto-ovo and one vegan) two participants reported that they were lacto-ovo vegetarians, one excluded

red meat and ate small amounts of dairy and wheat foods, four avoided red meat only, and two included all foods. For the other four participants, normal eating included a healthy balance all food groups and foods they once classified as forbidden.

In addition to eating healthfully, participants saw moderate activity as a part of a healthy lifestyle. Some women were active on a regular basis. For example, Tina liked to do physical activity "3 to 4 times a week for an hour or so." For others, physical activity was more sporadic. Susan talked about trying to incorporate physical activity back into her life. Debbie referred to healthy eating and moderate physical activity that included her friends as part "of an integrated approach to health." Doris also valued the balance she achieved in life. Five years prior to her interview, anorexia was the only thing that mattered to her. During the interview she expressed enjoying being a daughter, loving her job, having a good circle of friends, loving being a mother and a wife, and sharing food with all of the people important to her:

I look forward to so many things in my life now. I look forward to having a nice dinner. I also look forward to playing with my baby. I look forward to my walk, and I also look forward to reading my book with some tea.

New identities begin to emerge as the women stepped out of the shell of anorexia and learned that all feelings, pleasant and unpleasant, all challenges and risks they took during recovery made them a stronger person. Achieving freedom to enjoy food and life was the final step in the normalization of eating during the women's recovery from anorexia nervosa. For most women, food finally resumed its fitting place of function: "Food is fuel...for me now. It totally has a different chain of reference" (Judy).

The type of treatment participants received during their recovery is important to note. Five participants attended various inpatient programs, while eight participants changed their eating as outpatients and some with limited therapy. All three participants who considered themselves "still recovering" had been part of the inpatient treatment program. The three "still recovering" participants also had the highest scores on the EAT-26 scale, with scores of 31, 13, and 10. Of the ten "recovered" participants, seven had scores of 0 to 5, and three had scores of 6 to 9. The EAT test is most often used for measuring the severity of anorexic symptoms and the changes of the symptoms with treatment over time. A score of over 20 indicates significant eating and weight concerns (Garner & Bernis, 1982; Garner & Garfinkel 1979).

In this study, ten participants reached the final phase of recovery, where food and eating were no longer associated with issues of control, but were about enjoying the taste and smell of food and about sharing food with others. Three participants still continue to work on normalizing their eating and looking forward to a future without anorexia:

I want my grandchildren to come over to my house and eat baked goods...I want to enjoy my old age...be the nurturer verses being a strong grandma who is out running and eating really healthy. (Sally)

### 3.5 Discussion

In this section I will discuss these findings in relation to other literature, describing the overall process of recovery from anorexia nervosa and the normalization of eating during this process. I will then review the limitations of the study and finally, I will discuss the findings' implications for the practice and make recommendations for possible future research.

The findings of this study describe the process of changing eating behaviour in the recovery from anorexia nervosa. This process centres on moving towards freedom to enjoy food, through four phases: acknowledging the disorder, accepting support and deciding to change, confronting old patterns and learning new ways, and food becoming a non-issue. Although some qualitative studies have identified the themes of acknowledging the disorder (Sharkey-Orgero, 1999), accepting support (Pettersen et al., 2002) and deciding to change when they are ready (Geller & Drab, 1999; Tantillo et al., 2001) as significant components of recovery process, no study has identified these phases and themes as part of normalizing eating behaviour during recovery.

Although presented here as four sequential phases, recovery for these participants was not a linear step-by-step progression. They moved back and forth in their recovery, they would eat more food but would compensate by increasing the level of exercise and some moved from anorexia to bulimia nervosa but for all it was a gradual transformation from controlling and being preoccupied with everything they eat to reaching a **freedom to enjoy food** once again. The four phases of eating behaviour changes described in this study parallel some of the stages of change, which are the core constructs of the Transtheoretical Model (TTM) (Prochaska, DiClemente & Norcross, 1992). The TTM-

stages of change are pre-contemplation (not being ready for change), contemplation (thinking about change, usually within next six months), preparation (intending to take action within the next month), action (commitment to change) maintenance (maintaining changes) and termination (total self-efficacy and new coping skills are internalized). In the contemplation stage people are working on identifying the pros and cons of change (Decisional Balance) and the awareness of this balance can keep people either stuck for a longer period of time in contemplation or motivate them to change (Prochaska et al., 1992; Prochaska, Redding, Evers, 1997; Cockell, Geller, and Linden, 2003). The transition from pre-contemplation stage to contemplation stage involves increasing awareness of "Cons" while decreasing awareness of the "Pros" was needed to move from contemplation to action stage (Cockell et al., 2003). Women in this study talked about acknowledging anorexia nervosa and being aware of the cons of having anorexia nervosa in their lives, as the first phase of their recovery process, which parallels movement to the contemplation stage of change. They talked about being tired of the game, being tired of feeling sick and lonely, and recognizing that anorexia dominated all aspects of their life. They realized that anorexia provided them with the false sense of control and that they still had to face their fears of eating and needing to gain weight, thus they became aware of the diminishing benefits or pros of anorexia. Other studies present similar themes of getting fed up and feeling tired of the disorder (Beresin et al., 1989; Pettersen et al., 2002; D'Abundo et al., 2004), "recognizing the problem" (Jacobson, 2001, p. 248), "awakening to the dangers of anorexia" (Sharkey-Orghero, 1999, p.130) and accepting the disorder and working towards decreasing the severity of the symptoms of anorexia nervosa (D'Abundo et al., 2004). In this study few participants described the 'letting go of



anorexia' and being ready to change eating behaviour was essential to their recovery. Other studies have also examined the importance of assessing an individual's readiness and motivation for change as well as the extent to which individual makes changes for herself versus for others (Vitousek et al., 1998 Geller & Drab 1999; Geller et al., 2001; Geller et al., 2004).

The second phase of recovery greatly depended on engaging support and trusting others as women began adding small amounts of food to their diet. This phase of recovery is similar to the preparation-action stage of change, where individuals develop a plan of action that helps them in changing their behaviour (Prochaska et al., 1992; Prochaska, et al., 1997). The plan of action for the participants in this study involved engaging support by reaching to others and trusting them. The source of support varied for the participants. For some it was their family or family member, while for others the support came from friends or partners, therapists, or support groups, AA sponsors, and religious organizations. Participants talked about surrounding themselves with people who were positive and who did not make any judgments or comments about the type of food they consumed. They liked being treated normally, as if anorexia did not play a part in their interaction with others.

This is in agreement with other studies, which also recognized the importance of support (Noordenbos, 1989; Sharkey-Orgero, 1999; Jacobson 2001), good social function (Pettersen et al., 2002; Rorty et al., 1999), supportive non-familial relationships (Tozzi et al., 2003), and acceptance of relationships with others (D'Adundo et al., 2004) as being helpful in the recovery from anorexia nervosa. It should be noted that the sources of support varies for different individuals: of the 13 participants in this study,

family support was critical to the recovery for four women, but three other women needed to distance themselves from family members in order to cope with their intense feelings of anger. Instead those women talked about the importance of supportive friends, therapists and partners.

The third phase of recovery is comparable to the action-maintenance stage of the model (Prochaska et al., 1992; Prochaska, et al., 1997). During this phase participants struggled with challenging their beliefs about healthy and fattening foods, and gradually adding forbidden foods back into their diet. They also talked about their “fear of relapse” during this time of recovery. They felt that “if I go through a really bad stress I might turn to it again” (Sally). But it was a success over small challenges and the support of others that made the backward and forward struggle worthwhile to move on with their recovery. Their concept of healthy eating had to shift from including predominately fruits and vegetable, no fat and low calorie food choices to adding starches, meats, fish, dairy and fats. For the women in this study, this was reportedly the hardest and longest part of the recovery process. They realized that the old pattern of eating safe foods and restricting was a maladaptive way of dealing with their feelings, while being hungry had once been equated to “feeling powerful and in control”, it now was seen as “undesirable and out of control”. The only way to recover was to let go of their restriction and dieting and to start adding food back into their diet. Other findings also suggest that readiness to change restrictive eating behaviour is the most consistent predictor of short-term outcome (Geller et al., 2004), or to stop restricting/bingeing/purging behaviours was the most meaningful measure in assessing recovery from anorexia nervosa (Jordan, Redding, Troop, Treasure, & Serpell, 2003). The need for a gradual increase in food intake and weight gain, as well

as a very slow transition from one food to another, was a common theme for all women in this study. Adding small amounts of food to their diet was helpful in learning to tolerate the physical discomfort associated with digestion, such as feeling bloated, abdominal distension, and cramps. In addition to being able to tolerate small increases in food amounts during their recovery, the women found it easier to adjust to their new body and accept the new weight as part of their healthy selves if an increase was very gradual.

For nine participants in this study becoming vegetarian was a way to lose weight and because vegetarianism is a socially acceptable lifestyle it was also a way of excluding a greater range of foods or food groups from their diet. During recovery participants challenged their beliefs and explored if the choice to be vegetarian was related to meat avoidance due to fear of fat or as a result of their moral concerns for animal welfare. Two participants maintained their lacto-ovo-vegetarians practice and all others introduced fish and poultry to their diets, but some continued to avoid red meat. Although, some studies found that, young females who are struggling with food and weight issues, choose a vegetarian diet as an attempt to mask dieting behaviours (Neumark-Sztainer, Story, Resnick, & Blum, 1997; Klopp, Heiss, & Smith, 2003), Janelle and Barr (1995) found that vegetarians presented less dietary restraint than non-vegetarians. It should be noted, however, that enrolment criteria for the latter study included being of normal weight, not exercising excessively, and experiencing regular menstrual cycles with no use of oral contraceptives. These enrolment criteria likely excluded women who become vegetarian as a prelude to developing anorexia nervosa.

In this study, thirteen women talked about their experiences of moving away from a restrictive and controlled eating pattern to eating and enjoying a wide variety of foods. Ten women considered themselves recovered and free to enjoy all foods, while three women felt that they were “clinically recovered”, which they described as being at a normal body weight, having no physical symptoms, a normal menstrual cycle, and did not restrict food, but they still had some level of guilt about food and body image. These three participants are still in the third phase of the recovery, continually working on normalizing their eating behaviours. When we compare duration of illness between two groups, we find that in our ‘recovered group’ the duration of illness ranged from 3-21 years, whereas, in ‘recovering group’ it ranged from 3-8 years, (see Table 3.1). Also, when we look at the years post recovery we find that the ‘recovered group’ has been recovered from 3-24 years whereas, in the ‘recovering group’ the recovery ranged from 2-5 years. In his long-term study Theander (1985) shows that recovery may not be seen until 10 years or more following initial assessment in other long-term studies the time to recovery ranges from 4-21 years after follow-up (Steinhausen, Rauss-Mason & Seidel, 1991; Strober, Freeman & Morrell, 1997; Fitcher & Quadflieg, 1999 Ziepfel et al., 2000).

Interestingly, these three women were three of the five participants who attended a formal inpatient treatment program as part of their recovery. The other women who are fully recovered made the changes in their eating as outpatients with limited therapy. They used the support of their families, friends, spouses, physicians, churches, and support groups. This is not to say that an informal treatment is more effective than a formal one. Possibly, these three participants presented with medical symptoms that were more acute,

and perhaps they were not ready to let go of anorexia as early as other participants and may have overly relied on the treatment program to initiate change.

In contrast to the three participants who considered themselves only “clinically recovered” ten participants had moved to the fourth and the final phase of recovery where food and eating were no longer associated with eating disorders. This phase of the recovery is similar to the termination stage of the Transtheoretical model, in which individuals have internalized healthy coping mechanisms to deal with stresses and had no need to ever use the old ways of restricting (Prochaska et al., 1992). Women in this study talked about being free to eat any food they desired and not having any thoughts or preoccupations with when and what they have eaten. Food was no longer equated to calories, fat, or safe/unsafe categories, it was not a threat to them and they were free to enjoy food and to share their enjoyment with others.

Interestingly, these ten women may have less preoccupation with food than many North American women who have never experienced eating disorder. Their EAT scores were all well below the eating disorder cut off of 20. The results of these ten participants were similar to the results of the unrestrained non-dieting controls in Sunday and Halmi’s study (2000) where they had no preoccupation or any rituals around food and weight. Whereas, in the same study restrained eating dieters were slightly more preoccupied with thoughts about eating and their bodies and had slightly higher ritual scores (using Yale-Brown-Cornell Eating Disorders Scale), than were subjects who were recovered from eating disorders, however, there were no statistically significant differences between the restrained dieters and recovered eating disorder group (Sunday & Halmi, 2000). Although eating restraint scales were not used in this study, the attitudes expressed by

these ten women indicate that they had very low levels of restraint and resembled that of unrestrained non-dieter group in Sunday & Halmi (2000) study. In contrast, according to Paa and Larson (1998) approximately 32 % of American women are restrained eaters, meaning that “they rely on cognitive dieting rules rather than on physiological signs of hunger” and comparing to unrestrained eaters their [restrained eaters] weight is more likely to fluctuate p. 91.

Women in this study have learned through personal struggles that physical appearance is not central to evaluation of one’s self worth, and our current beauty norms devalue women’s qualities and achievements.

### *3.6 Strengths and Limitations of the Study*

To ensure methodological rigor, I have followed the procedures of grounded theory including data collection, coding, analysis and other qualitative research procedures such as member’s check and peer debriefing (Strauss & Corbin, 1989). Triangulation of participants’ EAT-26 scores with their self-described level of recovery supports the credibility of the findings. Nevertheless, there were some limitations that need to be recognized.

The study was somewhat limited by the sample size of only 13 participants. However, in qualitative research the adequacy of the recruitment is not judged by the sample size but by the saturation of major categories. Though data saturation was achieved, as no new information was obtained after the recruitment of the last participant, the study did not include participants from various cultural or socio-economic backgrounds and could have further explored experiences of individuals who undergo inpatient versus out patient treatment of their eating disorder. Most participants were

Caucasian, predominately of European heritage (German, English, Czechoslovakian); one participant was Asian (Korean), and another one was Hispanic (Mexican).

Applicability refers to how well the findings of this study fit with other groups. The findings of this study were specific to women of European heritage and women who have received or were in the process of receiving post-secondary education. In addition, the ages of the participants were similar, ranging from 19 to 34 years, although one participant was 59 years old.

### *3.7 Implications of the Findings*

The findings of this study have some implications in understanding and supporting women in normalization of eating during the process of recovery from anorexia nervosa. First, the findings revealed that the experiences outside of treatment are as important to normalization of eating during recovery from anorexia nervosa as experiences in treatment. When we look specifically at the process of normalization of eating, most women (eight) in this study had changed their restrictive eating behaviour without needing to be hospitalized. The most difficult aspect of their recovery was adding food to their diet and accepting gradual weight gain. As indicated by the participants, changes in eating habits had to be very gradual. Having a choice and control over how much food they incorporated into their diet was a necessary part of changing their eating behaviour. If a gradual increase in their dietary intake was critical in initiating change, then an important question for clinicians to explore is whether hospitals or formal treatment facilities are the best place to work with clients on normalizing their eating behaviour. As experienced by three participants in this study, when the focus is on weight gain of an average of 0.5–1.0 kg per week, women are not allowed enough time to accept

their new body image. Similar findings are reported by Maine (1985), with 16 out of 24 participants believing that they would have recovered without an inpatient treatment and three participants finding hospitalization harmful to their recovery. Perhaps the process of eating normalization can be enhanced in absence of hospitalization (providing that individuals are medically stable) with support from family, friends, and professional caregivers. This way, weight becomes less of a focus, and individuals have enough time to incorporate various foods back into their diet at their own pace.

Second, women in this study relied on their family members, friends, partners, professional care-providers, and support groups to make changes in the eating behaviour. This study clearly shows that for individuals who are ready to challenge their anorexic way of eating, having a supportive relationship with a person who is open, knowledgeable, responsive to their needs, and encouraging them to be responsible for their own change was as fundamental to recovery as any treatment program.

Since relapse and re-hospitalization are common for eating disorder patients (Field et al., 1997; Herzog et al., 1999), clinicians can help clients identify and integrate different external sources of support early in the treatment. This would be beneficial in building a strong social network that clients can use during their recovery, thus relying less on the treatment program as the main source of support. Also for some of the women in the study recognizing the danger of having anorexia nervosa came as the result of education they had received either from physicians, therapists, dietitians, or books was important throughout the process of recovery.

Lastly, mentoring and supporting individuals at meal times could be beneficial if the relationship between the client and the mentor is built on trust and honesty. If the



client feels safe and willing to explore her feelings around food, she will take risks and try different foods.

Considering that this is the first study exploring the experiences of eating normalization in individuals who have recovered from anorexia nervosa, replication qualitative studies are required to assess the extent to which these findings generalize to other samples and can be applied to professional practice. Other studies that include participants with other eating disorders (such as bulimia nervosa) are required to compare findings and to further our understanding of the process of eating normalization in eating disorders. Further research could also explore the process of nutritional recovery with participants of different ethnic backgrounds, diverse educational backgrounds and diverse age groups. This is because the experiences of eating normalization may be different during the mid-life stage, when relationships, career development, and child rearing present great uncertainty and may impact the process of normalization of eating during recovery in ways yet to be identified.

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## **Chapter 4: Role of the Dietitian in the Process of Recovery from Anorexia Nervosa**

### **4.1 Introduction**

The role of the dietitian in the treatment of eating disorders has gradually shifted in recent decades. Instead of the traditional medical model of treatment, many dietitians have adopted a counseling approach where they explore a client's beliefs and feelings around food and eating and discuss with him or her the underlying issues that trigger eating disorder symptoms (Eckstein-Harmon, 1993; Krey, Palmer & Porcelli, 1989; Licavoli, 1995; Reiff & Reiff, 1992; Saloff-Coste, Hamburg & Herzog, 1994; Woolsey, 2002).

The traditional model of nutrition intervention was education-based, where the main focus was on re-nourishment by ensuring adequate caloric intake and educating clients on physical complications associated with eating disorders. Little emphasis was placed on understanding the meaning clients placed on food as a way of coping with life issues and daily demands (Licavoli, 1995). It was understood that dietitians may be aware of these connections, but all psychological issues that arose when individuals used "food as symbols" were "left to psychiatrists" to explore, with dietitians restricted to counselling clients who specifically required modifications in their therapeutic diets (Williams, 1973, p. 262). A dietitian's primary role was to develop a nutritional meal plan to assist clients in restoring normal nutritional status, educate clients about food and nutrition, monitor anthropometric and biochemical measures, and communicate with the treatment team about the dietary changes (Krey et al., 1989; Rock & Yager, 1987).

In the 1970's and 1980's, advances in social psychology made an important contribution to medical, nutrition, nursing, and other allied health care by exploring and

thus offering a better understanding of how different interactions between a client and a health care provider influenced the client's perceptions, motivations, and actions (Huse & Lucas, 1983; Krey et al., 1989). Dietitians came to understand that clients who have eating disorders may be averse to consulting with a dietitian. They may be resistant to changing their eating behaviour because of their association of restricting with control. The interaction between a dietitian and a client can be very challenging for both parties. Therefore, a dietitian must have a thorough understanding of the psychopathology of eating disorders and the function of eating disorder symptoms (restricting, bingeing and purging) in their clients' lives.

More recently, some practitioners have advocated a nutrition therapist role for the dietitian (Licavoli, 1995; Rieff & Rieff, 1992; Saloff-Coste et al., 1994; Woolsey, 2002). According to Rieff and Rieff (1992), a nutrition therapist is more client-focused and views the client's eating behaviour as driven by emotional needs. The nutrition therapist thus takes more time to explore personal issues, whereas an approach traditionally used by dietitians is didactic in nature, with limited time dedicated to developing a therapeutic alliance and addressing the client's emotional needs (Rieff & Rieff, 1992). It is important to note that the terms *nutrition therapists* and *counsellor* not only pertain to a nutritionist with specialized training, but also to "any professional who is delivering nutrition information, or who at least plays a temporary role as a nutrition counsellor," while *dietitian* refers to a professional who has a degree from an accredited university and is a registered dietitian with a provincial and/or a national association (Herrin, 2003, p. xv).

As dietitians move into the role of nutrition therapists and "begin to walk on the edge of the therapy," they may encounter complex therapeutic relationship issues (Saloff-

Coste et al., 1994, p. 50). The most common issues that dietitians need to be aware of are transference, counter-transference, and boundary issues (Herrin, 2003; Saloff-Coste et al., 1994; Woosley, 2002). Transference involves clients transferring their feelings of anger, sadness, or hurt experienced in the past from parents, friends, or other individuals onto the dynamics of the session (Saloff-Coste et al., 1994; Woosley, 2002). Counter-transference, on the other hand, is the emotion that a therapist may experience during the session in response to a client's statement or behaviour. The therapist may experience "emotional reaction to the patient, including feelings unconsciously induced in the analyst by the interpersonal pressure of the patient in the clinical setting" (Sadock & Sadock, 2000, p. 2189). When working with individuals suffering from eating disorders, the dietitian is bound to experience many feelings of counter-transference; however, the dietitian should have a clear understanding of personal and professional boundaries (Herrin, 2003; Reiff & Reiff, 1992; Saloff-Coste et al., 1994; Woosley, 2002). Saloff-Coste et al. (1994) describe some common boundaries and counter-transference generated mistakes made by dietitians, such as problem solving for clients and coming up with all of the recommendations, socializing with the clients and becoming friends, or getting discouraged with the clients if nutrition goals are not met.

In today's literature and practice, the need for nutrition counselling has been identified as a useful therapeutic intervention in changing eating behaviour of clients with eating disorders (Brambilla, Draisci, Peirone & Brunetta, 1995; Cairns & Levy-Milne, 2006; Hsu, Crisp & Callender, 1992; Waisberg & Woods, 2002). However, a survey by Cairns & Levy-Milne, (2006) indicates that 61% of dietitians who practice in Canada tend to use an educational model content oriented strategies, while only 34% use

thinking/feeling or process oriented strategies. Participants in this and other studies report that the education dietitians receive during their schooling does not adequately prepare them to deal with the psychopathology of eating disorders (Reiff & Reiff, 1992; Dopart et al., 2000; Cairns & Levy-Milne, 2006). In order to be more effective at nutrition counselling, dietitians should learn more about different therapies such as: cognitive behavioural therapy, the trans-theoretical model of change, and motivational interviewing (Cairns & Levy-Milne, 2006).

The literature on effective treatment for anorexia nervosa refers to the importance of the multidisciplinary model of treatment involving practitioners from medicine, nursing, psychology, nutrition, social work, art therapy, occupational therapy, and music therapy (Anderson, 1983; Beumont, Russell & Touyz, 1981; Beumont, Chamers, Rouse & Abraham, 1993; Dopart, King, Lyon & van Rooyen, 2000; Dwyer, 1985; Hindmarch, 2000; Martin, 1998). A client benefits from the diverse knowledge base provided by members of different disciplines on the team. Most importantly, team members can collaborate to meet the needs of the client better. Knowing that all of the team members, including the client and her family, are working towards a common goal together may increase a client's sense of security and confidence (Dopart et al., 2000; Reiff & Reiff, 1992). In addition, working with a multidisciplinary team offers a great opportunity for dietitians to learn from their colleagues about different counselling strategies (Cairns & Levy-Milne, 2006).

Overall then, current academic and professional literature recognizes an important role for dietitians in the treatment of patients with eating disorders, particularly as nutritional counselors and as members of multidisciplinary teams (Herrin, 2003; Larson,

1989; Reiff & Reiff 1992; Rock & Curran-Celentano, 1994, 1996; Rock & Yager, 1987; Saloff-Coste et al., 1994; Woolsey, 2002). Very little information is available about clients' perspectives of the role of the dietitian in the process of recovery from eating disorders. While I was conducting a study on normalization of eating during the process of recovery from anorexia nervosa, I found out that some study participants discussed the role of the dietitian in their recovery process and that their comments would make a valuable contribution to the literature in this area. The purpose of this report, therefore, is to describe clients' perspectives on the significance of the dietitian's role in assisting them towards normalization of eating during recovery from anorexia nervosa.

#### *4.2 Research Design and Methods*

This study used an inductive qualitative research design. Qualitative research is an inquiry process of understanding, exploring, and describing a particular phenomenon or event about which there is little information, as in the case of this study (Creswell, 1989). Data collection and analysis procedures used were consistent with grounded theory method.

##### *4.2.1 Selection and recruitment of participants*

A convenience sampling method was used to recruit individuals who had recovered from anorexia nervosa, meaning that participants were selected based on the inclusion criteria and their willingness to discuss their experiences of the process of normalization of eating (Strauss & Corbin, 1998). Women who were 19 years or older and volunteered to participate in the study had to meet the inclusion criteria of no hospitalization for anorexia nervosa in the last two years, maintenance of normal weight, and lack of restricting, bingeing, and purging for at least one year. Finally, participants

whom I had seen for nutrition counselling were excluded from the study in order to minimize the interviewee's bias about the effectiveness of the dietitian's role and encourage the participants to be very honest during the interview process.

Recruitment posters (Appendix A), were placed on the campuses of the University of British Columbia and Langara College and in Vancouver community centers (two on Vancouver's West Side and one on Vancouver's East Side). Women who met the inclusion criteria and agreed to participate in the study were asked to sign a letter of informed consent (Appendix B), which detailed the purpose, procedures, and confidentiality of the study. At the end of the interview, each participant received \$30 as a gesture of appreciation for her involvement in the study. Approval from Providence Health Care/University of British Columbia Research Ethics Board was received prior to conducting the study (Appendix C).

#### *4.2.2 Data collection*

Data were collected through individual interviews conducted at a location convenient for the participants. Pseudonyms were substituted for participants' names. Data for this study emerged while interviewing participants on a broader topic of normalization of eating during their recovery from anorexia nervosa. These interviews were semi-structured, one to two hours in length, tape recorded and transcribed verbatim. At the start of the interview, I obtained demographic information about each participant (Appendix D), and then proceeded by asking open-ended questions that pertained to their eating patterns during the process of recovery. As participants described their struggles they that had experienced at the onset of their disorder and during the recovery phase, I noticed that some talked about the significance of dietitian's role in their recovery.



However, if the mention of dietitian did not come up during the interview, then I asked: “Have you ever seen a dietitian for nutrition counselling? If yes, what was your experience? If not, do you think that seeing a dietitian would have made any difference in your recovery?” Trigger questions were utilized to stimulate discussion throughout the initial interviews, so as to obtain in-depth information about the participants’ past and present eating behaviours (Appendix E).

Participants in this study included some women who had received nutrition counselling from dietitians as well as others who received treatment from other health care providers (physicians or therapists), but had not seen a dietitian. Data from participants who had not seen a dietitian for education and nutrition counselling were included in the analysis for this paper because they provide information on the different types of support participants found beneficial in their normalization of eating and participants’ perceptions on recovery without the help of a dietitian.

#### *4.2.3 Data analysis*

Data analysis occurred simultaneously with sampling and data collection. The use of the constant comparative technique was central to the data analysis, because it allowed me to cross-check emerging concepts and to verify the concepts with former and new participants, thus authenticating the trustworthiness of the emerging themes (Erlandson, Harris, Skipper & Allen, 1993).

Initially, analysis consisted of using exact words and phrases to identify the basic concepts or open codes in the data. Moving from basic concepts or open codes, I looked for patterns, differences, and similarities in the identified codes and then grouped them into broader categories. Summary memos were written to identify the relationships and

connections among categories, further refining categories to ensure that emerging themes reflected the data (Lincoln & Guba, 1985).

The concept of trustworthiness is commonly used to assess the quality of qualitative research, since it is a broad concept that addresses the truth value of the findings, the basis for obtaining the findings, and the external criteria for evaluating the approach (Erlandson et al., 1993). A technique called member checks, which involved taking the final data to three participants so that they could judge it for accuracy, was utilized during the data collection and analysis to enhance the credibility of this qualitative study (Lincoln & Guba, 1985).

A peer debriefing technique was also used in this study. It parallels the “positivist paradigm of inter-rater reliability” in that feedback from other graduate students and researchers was requested to pose critical questions about methods, meanings, and interpretations of the study to ensure that the findings were comprehensive in relation to the data (Lincoln & Guba, 1985).

#### *4.3 Findings*

Thirteen women participated in this study, but only six women worked with a dietitian as part of their inpatient or outpatient treatment. Of those who did not work with a dietitian, one participant received nutrition education through her Overeaters Anonymous support group, another worked with her therapist by setting some goals around eating, two received limited information on nutrition from their physician, and three received no nutrition education and relied mainly on family and friends as their support and mentors for normal eating.

The six participants who had the opportunity to work with a dietitian reported a wide range of experiences. Sally, Judy and Debbie valued the education they received during the weight gain stage. A dietitian was somebody they trusted to provide them with constant guidance in developing a meal plan and to give them reassurance regarding their physical changes and the damage to their body sustained due to years of restriction. The support and mentoring about what constituted a normal meal was also reported as useful during the women's recovery. One of these participants described the dietitian as her therapist, and said she was "pivotal to her recovery" (Sally). She trusted the dietitian implicitly and relied on her counselling skills to help her deal with food and other psychological issues. For Helen, June and Doris however, the interaction with the dietitian was frequently disappointing. They felt that there was too much focus on food, weight, and meal plans. They were dissatisfied with the dietitian's approach, which made them feel misunderstood and not interesting to the dietitian as individuals.

Seven participants who did not have a chance to work with a dietitian acknowledged that a dietitian would have been the most qualified person to help them in restructuring of their anorexic thoughts about food and dieting. These seven participants attribute their recovery to their desire to get better and to taking responsibility for making changes to their food intake, having family members and partners not focus on food or eating disorders, as well as support and education provided by physicians and therapists. Four participants wondered whether they would have recovered sooner if they had received adequate education about the complications and physiological damage they sustained due to years of restricting.

In this study, three important themes emerged from the data describing the role of the dietitian in the process of recovery from anorexia: education, support, and mentoring.

#### 4.3.1 *Education*

Four women in this study perceived the theme of education about nutrition as necessary to their process of recovery. They reported that nutrition information and education during the phase of weight gain acceptance was important in providing them with a better understanding of their body's functioning:

To learn kind of what you need, what the different vitamins do for the different parts of the body is crucial...and I think that information has to be given....It just needs to be repeated again and again, but every time it is repeated it is done in a different way so it is a gradual thing (Judy).

For some, education about the complications associated with anorexia was very useful in helping them work on their denial. For Debbie, having information made her realize the damage she suffered by clinging onto anorexic behaviour and experiencing complications such as "fainting and heart problems". She thought that seeing a dietitian was helpful, because she was able to get a "reality check" about her own emaciated appearance and education about the severity of impending complications if she continued to ignore the symptoms she was experiencing. Sally worried that the years of food restriction had "messed up [her] metabolic rate" and found that weekly meetings with a dietitian helped her understand how her body functioned. She learned that her metabolism would normalize once she resumed a regular eating pattern. Sally stated: "I am not sure if I could have recovered...or maybe I could have but with many more hospitalizations" without a dietitian's guidance and constant reassurance.

Ongoing education and a realization that the body requires a lot more nutrients than normally consumed by them made it easier for the women in the study to shift their cognitions around food and eating. These included a huge repertoire of forbidden foods, which the women considered to be fattening and unhealthy, as well as rules about when and what they were allowed to eat. The reason for avoiding forbidden foods was the fear that once they began eating these foods they would not be able to stop: "My body wants to make up for the years that I have deprived it of those foods" (Gloria). Carol talked about going for an occasional coffee and a cinnamon bun with her sister. The only way she could justify having this food was "purposely not having breakfast on those days so that I would in my mind rationalize having these extra calories."

Misconceptions were not only centered on food, but also on the body and how much nutrition the body needs to function. Some women felt that their body would deceive them if they let go of their controlled eating pattern. Sally's rules around eating included not being allowed to eat after seven in the evening, or before her run. If she were to let go of her rules, she felt that her eating would "get out of control". For Sally, Judy, and Anna misconceptions included not only the food and the body, but also their self-value. They had to "deserve to eat" (Judy), and they would only permit themselves to sit down and have a meal after they had cleaned the house or had a productive day.

For Doris, Helen, and June any focus on food, including the education about the function of nutrients was not useful during the initial phase of recovery. Doris needed somebody that she could trust; somebody she knew and felt would understand her, her family, and her culture. She felt that the dietitian she saw "put too much emphasis on food, and [she] did not know me," so she preferred to work with her "spiritual therapist,

or minister” from her church. For Helen and June, the interaction with the dietitian was very disappointing as well:

I do not really think she was interested in me. She had given me this diet, so all she did was I came in, she had this sheet and said, you are going to have one portion of this, one portion of carbohydrates...and after one year it had not worked (June).

Helen took nutrition courses as part of her education and felt that “I know everything, I do not need someone to tell me what I should be eating, I already know.” For her, working with her psychotherapist was helpful, but only in the latter part of her recovery.

Of the seven participants who did not have the opportunity to work with a dietitian, some thought that having a qualified person teach them about nutrition may have alleviated some of their fears about gaining too much weight. Mary felt that if she had had somebody she could work with to help her with food and portion selection, her fears around food would not have been as intense “I remember not eating because I did not know what to eat...I was at a loss...so I ate only small, like a bite size... two bites of apple.... It is something small size. Some felt that their family “would have benefited from some education...and I think we would have had less arguments around eating” (Tina). Emma wanted to see a dietitian, but could not afford to pay for nutrition counselling: “I wish I could have hired a nutritionist...but I did not have money...That is why I worked in a health food store, because I did not know how to make decisions about my food.” The health food store was a safe place, where Emma could try different foods and feel less guilty about her eating.

Ten participants in this study who had received nutrition education either from a dietitian or a health care provider expressed that this education was important in increasing their awareness of the complications associated with restricting, and their body's nutritional needs in order to function. Through this education, they also learned that if they continued to avoid foods they feared and did not challenge their fears and their cognitions around forbidden foods that they may never fully recover.

#### 4.3.2 *Support*

The theme of support was important for the women throughout their recovery, but particularly critical during the time they were incorporating food into their diet and beginning to gain weight. They needed constant reassurance and validation of their feelings as well as reality checks about their physical changes, food choices, and food portions. For some, it was a dietitian who provided support and reassurance, while for others it came from a trusted family member, a therapist, a spiritual belief, or a group support. Gloria did not have an opportunity to work with a dietitian, but she felt emotionally supported by her mother, "not because we had open communication," but because she "gave me space and never questioned what I ate or if I ate too much or too little. It was all up to me."

For Sally, having therapy with a dietitian was pivotal in her recovery: "She was there for me every day, she came to rounds, she saw me outside her working hours...I got the feeling she really cared for me as a person." Sally saw the dietitian daily when she was in the hospital, and then had weekly outpatient visits with her for over two years. Sally needed constant reassurance about how much she ate and how much weight she would gain. They worked closely on setting realistic goals for weight gain and adding

different foods to Sally's diet. She felt that her dietitian understood her struggles and tolerated her emotional outbursts when she did or did not gain weight. Sally felt unconditionally valued and accepted as a whole person. Having this trusting relationship made it easier for Sally to accept the dietitian challenging her about her obsessive thinking about food or her beliefs about unhealthy foods.

Three participants found the interaction with the dietitian as a negative experience. When Helen recalled her first session with her dietitian, her voice reflected her disappointment mixed with anger: "It was a joke...I do not know what dietitians do, but she did not know anything about eating disorders.... I never went back." When asked to imagine what sharing her feelings about the session with the dietitian would cause, Helen resolutely replied: "She would not have understood." Helen indicated that at the time she saw the dietitian, she was very ambivalent about letting go of her control over food and needed to have a dietitian understand how intricately food, exercise, and feelings were entwined in her life.

These women felt supported by people who showed genuine interest in their individual experiences and struggles and recognized their vulnerability and fear of weight gain, their need to let go of control over food, and their distress about not having that control in their life. The women were more receptive to information about food and more open to changing their thought patterns when they felt that the dietitian cared for them as a person and passed no judgment about their food choices and eating behaviours.

#### 4.3.3 *Mentoring*

The benefit of having mentors with healthy eating habits was described by five participants as helpful in their process of eating normalization. Mentors for two



participants were health care providers (dietitian and therapist). The other women tried to model their eating patterns after a family member, boyfriend, or a trusted friend. For Sally, eating with her dietitian “was like being granted a permission to eat different foods.” Sally admired how comfortable the dietitian was with eating different foods and enjoyed socializing during their meals:

I think the things I learned the most from her [dietitian] were from her own healthy attitudes towards eating, you know? It was not the way she sat down and told me, “You have to follow the food guide,” but I liked what she did eat in front of me...it was healthy choices in a real sense versus what I would consider healthy choices. She was a very healthy eater...like all foods can fit into a healthy diet.

For other participants, modeling eating on a family member or a friend was a way of having emotional support and feeling safe during meals. The women valued the times when food (or their disorder) was not the centre of the conversation and when the focus was on the social aspect of eating. Five participants stated that mentoring was a way of legalizing foods they avoided for a long time. Observing people they trusted eat a variety of foods was a way of validating the fact that all foods are part of normal eating and of learning that food can once again be part of the social aspect of life.

#### *4.4 Discussion*

The findings of this study reveal three themes that describe the role of the dietitian in the treatment of eating disorders: education, support, and mentoring. There is some literature that discusses the role of the dietitian in the treatment of individuals with eating disorders, however most of this literature has been written by dietitians and therapists in

the field thus, representing their perspective of the treatment (Herrin, 2003; Larson, 1989; Reiff & Reiff 1992; Rock & Curran-Celentano, 1994, 1996; Rock & Yager, 1987; Saloff-Coste et al., 1994; Woolsey, 2002). These findings are based on the participants' experiences and are unique as no one else has discussed these themes in relation to academic and professional literature that contrasts nutrition education versus nutrition therapist roles for dietitian.

Thirteen women who participated in the study, when asked about the role of a dietitian in the treatment of eating disorders stated that the role of a dietitian was to provide education on nutrition and "what is healthy eating". However, six participants who had an opportunity to work with a dietitian reported mixed feelings about their interactions, as some felt that the dietitian had limited knowledge about anorexia nervosa and limited counselling skills. This indicates that patients' expectation of the dietitian's function goes beyond the role of an educator and is approaching that of a 'nutrition therapist'. Several papers define a *nutrition therapist* as a dietitian or nutritionist who works in the area of eating disorders, because the focus is on the thoughts, feelings, beliefs, and behaviours around eating and food (Licavoli, 1995; Reiff & Reiff, 1992; Rock et al., 1994; Saloff-Coste et al., 1994; Woolsey, 2002). In literature as well as in practice, clinicians vary in their opinion on whether a dietitian should explore psychological issues. Rock and Curran-Celentano (1994) and Herrin (2003) recommend that a dietitian focus on food-related issues, whereas Licavoli (1995) and Reiff and Reiff (1992) believe that dietitians working in the area of eating disorders are nutrition therapists and should engage in the counselling process. The experiences and responses of women participating in this study support the notion that dietitians who practice in the

area of eating disorders go beyond the role of an educator, and that they need to understand how psychological issues impact on individuals' ability to make nutritional changes. For example, having a trusting relationship was important for few participants and they talked about 'feeling understood' as very significant to their relationship with their dietitian, therapist and other care providers. However, the findings also support the recommendations of Rock and Curran-Celentano (1994) and Herrin (2003) that a dietitian should practice within the guidelines of her expertise. For example one participant valued having dietitian's permission to phone her any time she needed to talk to someone and referred to her as her therapist as well as her dietitian. However, she was aware that at times she was making dietary changes to please her dietitian. A bond that is too strong could lead to a dependent relationship between the client and the dietitian thus preventing the client from learning to develop alternative support networks.

Alternatively, it may lead to a situation where individuals cannot work with another dietitian if the preferred dietitian becomes unavailable. Therefore, Rock and Curran-Celentano (1994) and Herrin (2003) recommend for dietitians to be clear about their role and to set limits on the therapeutic relationship from the very beginning.

More often, dietitians experience resistance to the nutrition advice they offer to clients who struggle with eating disorders. As described by three participants of this study who were dissatisfied with the treatment provided by their dietitian, being emotionally vulnerable contributed to their ambivalence about their recovery for the fear of losing all control. The trans-theoretical model (the stages of change model) developed by Prochaska & DiClemente (1984) is especially effective in addressing the ambivalence and resistance to treatment. The model is used in the field of nutrition to study a wide

range of dietary change interventions such as decreasing the intake of dietary fat and increasing the intake of fibre, fruits, and vegetables (Greene et al., 1999; Finckenor et al., 2000; Kristal et al., 1999; Sigman-Grant, 1996). The stages of change model is commonly used in treating clients with eating disorders in determining the clients' ambivalence towards treatment and their readiness for change. Thus, if the dietitian who counseled these three participants (June, Helen, Doris), had understood that women were in the pre-contemplative stage, and focused only on discussing the dangers associated with eating disorders rather than changes to their dietary behaviour, maybe these participants would have been less resistant to the intervention. Being able to match the nutrition intervention to an individual's stage of change tends to contribute to a positive shift in dietary behaviour (Greene, Rossi, Rossi, Velicer, Fava & Prochaska, 1999; Finckenor & Byrd-Bredbenner, 2000; Kristal, Glanz, Curry & Patterson, 1999; Sigman-Grant, 1996).

Women in this study talked about the support and validation by their friends, family, and therapists, which created a safe environment in which to challenge and change their eating behaviour. Similarly, Tozzi and colleagues (2003), reported that one of the most commonly mentioned factor in the recovery of 69 participants was having a supportive relationship. Also, both Hsu et al (1992) and Garrett (1997) found that participants were more open to changes when they felt understood and supported by staff during their treatment. Equally, for the participants in this study, encountering support was needed to begin the process of normalization of eating and regaining the sense of control over food.

Mentoring was the third theme described as an important part in the role of a dietitian. Even though, only one participant received mentoring from a dietitian, the mentoring process for all five participants of this study was a way of obtaining permission to eat foods that they had deprived themselves for many years. Two participants benefited from having meal support with either a dietitian or a therapist, while others relied on trusted family members or friends, trying to emulate their way of eating. There is no literature on the role of modelling healthy eating behaviour at different stages of recovery from an eating disorder. It may be premature to generalize the experience of one participant to the importance of dietitians' roles nevertheless, there are many benefits to a dietitian having a meal with a client. This would allow the dietitian to observe the foods that the client eats, her habits, and the rituals associated with eating while providing the client with an emotional support and a feeling of safety during the meal. Mentoring for five participants of this study was a way of learning that all foods are part of normal eating, and that food can again be a part of their social life.

#### *4.5 Implications for Dietetic Practice*

This study has highlighted several important recommendations that participants valued or found were lacking in their sessions with their dietitian. A small sample size and the characteristics of the study impose some limitations when trying to create a generalized application. Nevertheless, some suggestions can be made about how a dietitian can help in her client's process of normalization of eating.

Participants viewed a dietitian's role not only as that of an educator who provided information on nutrition and the physiological effects of restricting, but also as that of a therapist who understood and validated their fears of letting go of control over food while

supporting gradual changes in their eating behaviour. Participants were more receptive to nutritional information and more open to changing their thoughts about food and eating when they felt that the dietitian was open to and empathic with their struggle, emotional outbursts, and distorted thinking around food and eating. If a dietitian chooses to work in the area of eating disorders, she must be comfortable with moving out of the nutrition educator role and into the nutrition therapist role. The nutrition therapist role is more client-focused than content-focused and requires time to understand the client's emotional needs (Reiff & Reiff, 1992; Woolsey, 2002).

#### *4.6 Future Research*

The findings reported in this paper were secondary findings within a study exploring the process of normalization of eating behaviour during recovery from anorexia nervosa. As such, they represent the experiences of a sample that was limited in size and diversity of participants, and saturation of the themes presented in this paper was not reached. While these themes do represent the experiences of the women in this study, it is possible that the themes could be described in more detail and that additional themes might be identified in larger studies. Therefore, in order to more fully understand clients' perspectives of the role of the dietitian in the process of recovery from eating disorders additional research with a larger and more diverse sample is needed. Such a sample should include participants with a range of education level, occupation, ethnicity, geographic location and treatment experiences.

In this study, only five participants benefited from the mentoring process (and only one from a dietitian) but other participants commented that working with a therapist or dietitian would have helped them during their recovery process. There is no literature

on the benefits of mentoring. The small sample does not allow us to accurately assess the universality of the mentoring theme as described by five participants, and more specifically with regard to the role of a dietitian. Therefore, more research using in-depth interviews, focus groups or self-report questionnaires are needed on the role of a dietitian on mentoring healthy eating behaviour at different stages of normalization of eating during recovery from an eating disorder.

Individuals who participated in this study were diagnosed with anorexia nervosa at the onset of their illness. Future studies should explore the experiences of individuals with bulimia nervosa or binge eating disorder, examining the role of the dietitian in their process of normalization of eating during recovery from eating disorders.

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## **Chapter 5: Conclusion**

The purpose of this study was to understand the process of eating normalization as experienced and described by women who had suffered from anorexia nervosa and who now perceived themselves as recovered. This study aimed to explore four main research questions:

1. How did individuals who have had anorexia nervosa experience making nutrition changes in their process of recovery?
2. What concepts or themes were most important to them in normalizing of their eating behaviour?
3. Who or what were the major sources of support for them in normalizing of their eating behaviour?
4. If they had an opportunity to work with a dietitian, how significant was the dietitian in assisting them toward normalization of their eating?

Thirteen women participated in this study, but only six participants had the opportunity to work with a dietitian during their recovery process.

Thus far in this thesis, the findings have been presented in relation to two areas: understanding the process of normalization of eating during the recovery from anorexia nervosa and the significance of the dietitian's role during the process of recovery. The limitations of this study and implications for practice and research in relation to the objectives were presented in each chapter. In this chapter I will provide the summary of findings in relation to the original questions, thus integrating the findings of the two previous chapters, followed by the discussion of the overall significance of the thesis

research to the eating disorders and dietetics fields and recommendation for future research.

### 5.1 *Summary of Findings*

The experience of making nutrition changes was a long and difficult course during participants' recovery from anorexia nervosa. They reported that the process of normalizing their eating was a gradual progression of adding one food or a 'few bites' at a time. For some, having nutrition education was helpful in accepting their bodies' nutritional needs and weight gain. Finding support (both professional and non-professional) was valuable in making and maintaining changes to their eating behaviours and important in preventing relapse. Other factors that participants identified as helpful in normalizing of their eating behaviour were: gradual weight gain, having support and reassurance of others as they were experimenting with 'fear foods', eating meals with people they trusted, shifting the focus away from food and the disorder, and having mentors who practiced 'normal' eating patterns.

The participants identified the following themes as important in the normalization of their eating behaviour during the recovery from anorexia nervosa. The process of normalizing eating led to the freedom to enjoy all foods, which was the central category and comprised of four phases:

- 1) Acknowledging the disorder (decline in social activity, awareness of physical complications, disliking the type of person one became, and finally becoming tired of the anorexic game);
- 2) Accepting support and deciding to change (deciding to change eating patterns, accepting weight gain, being ready, and engaging support);

- 3) Confronting old patterns and learning new ways (experimenting with new foods, making incremental changes, and mentoring healthy eating);
- 4) Food becoming a non-issue (eating whatever/whenever one wants, reaching a balance, creating an identity without an eating disorder, and gaining freedom to enjoy food and life).

Participants' major sources of support came from their therapist, physician, friends, family members, dietitian, groups such as Alcoholics Anonymous or Overeaters Anonymous, and their belief in spirituality. Having these supports made it easier for the women to tolerate the changes in their eating disorder behaviour.

Participants in this study had varied views and feelings on the significance of the dietitian's role during their recovery process. Three themes emerged from the data: education, support, and mentoring. Six participants had the opportunity to work with a dietitian during their recovery process. Three participants who found nutritional intervention beneficial, felt validated and understood by their dietitian. They felt valued as a person when the dietitian took time to understand the struggle of having anorexia nervosa in their lives and to explore the 'function and purpose' of their symptoms (restricting, bingeing, purging and over-exercising). These three participants were open to the information about the dangerous effects of restrictive behaviours on their health and respected the dietitians' knowledge about nutrition as well as insight into the psychological nature of the disorder. In contrast, the three participants who were dissatisfied with nutrition intervention felt that dietitian was more focused on food,

weight and developing meal plans and less interested in understanding participants' struggles with food and fear of weight gain.

Two of the five participants had the opportunity to have meals with their dietitian or therapist and found this part of the mentoring process beneficial when challenging fear foods and increasing the food repertoire.

## 5.2 Discussion

The data collected from this study can begin to address the question of what "normal eating" means in the context of recovery from anorexia nervosa. This is the topic that the academic literature has been largely silent on as nutritional aspects of recovery are usually defined in terms of achieving and maintaining a normal body weight as well as demonstrating an absence of symptoms such as restricting, bingeing, and purging (Hsu, Crisp & Harding, 1979; Morgan & Russell, 1975). Therefore, the criteria for determining the nutritional outcome are very limited in its relevance and application. As relapse and repeated admissions to treatment programs are common occurrences, some studies question if an individual with an eating disorder can ever be free from food and weight preoccupation (Strober, Freeman & Morrell, 1997; Herzog, Dorer, Keel, Selwyn & Ekebald, 1999). Some studies further indicate that excessive dietary restraint continues to be a problem for a significant percentage of individuals, even though their body weight is within the normal range at the time of follow-up (Pike, 1998; Windauer, Lennerts, Talbot, Touyz & Beumont, 1993).

In the literature, the term *normalized eating* refers to the intake of calories needed to "maintain one's weight at a minimum BMI of 20 or 90% of recommended weight"(Pike, 1998, p459). However, being at a normal weight and being symptom-free



can mask many dysfunctional eating habits and does not necessarily imply having freedom to enjoy all foods, as described by most participants of our study. The concept of "normal eating" for these women was described as: "freedom to eat whatever I want"(Anna), being "able to eat what other people eat" (Mary), "eating all different foods and not feeling guilty anymore" (Judy), "eating when I am hungry and stopping when I am full whereas before I would eat what I have decided that I would allow myself to eat"(Gloria), having a "healthy relationship with food" (June), "flexible eating" (Tina), and "enjoying all foods and sharing with friends" (Susan). Ten participants in this study had moved on to a place in their life where food was a non-issue. Three participants perceived themselves as still recovering as they still experienced some level of guilt if they did not make the "right (food) choice". Food, for most participants was not looked at as a source of control or power or associated with any conflicts between pleasure and guilt. For these women, food lost the meaning of self-control and became nourishment for their body and a way of socially interacting with their family, friends, and partners. A theme of eating whatever they want and whenever they want was frequently evoked by participants as a way of expressing their newly acquired freedom to enjoy food and life without anorexia nervosa. These findings indicate that individuals who have recovered from anorexia nervosa can experience nutritional recovery that is not defined only in terms of achieving and maintaining a normal body weight and absence of symptoms, as described in the literature, but achieving a healthy relationship with food and freedom to eat "whatever, whenever" they want while enjoying the social aspect of eating and food.

The study findings have some implications for practitioners who work in the field of eating disorders, treatment approaches of anorexia nervosa and dietetic practice. The

normalization of eating for the women in this study involved a gradual progression of adding small amounts of food, encouragement to experiment with “fear foods”, support around meals, and mentoring of healthy eating behaviour. Based on the literature and this study’s findings, there are specific roles and skills that dietitians must master when working with individuals with eating disorders. Dietitians must have a good understanding of cognitive, behavioural, and motivational therapy. They can act as educators, nutrition therapists, and mentors, who would support their clients in challenging their maladaptive food patterns and working towards normalization of eating behaviour.

Women in this study talked about the experiences of social support and validation by their friends, family and therapists, which provided safety to challenge and change their eating behaviour. Therefore, clinicians should encourage clients who had a strong friendship network prior to the onset of their anorexia nervosa, to gradually reconnect with their friends. In the initial stages of their recovery participants talked about feeling lonely and that they needed time to learn to trust others and that they would not judge them but accept them as they are. For some participants finding support and people they could count on occurred over a long period of time.

Most of the women in this study made the changes in their eating as an outpatient, without needing to be hospitalized. For them there was a helpful balance between physician’s clinical monitoring of their health, individual or group therapy and supportive relationships. Four participants who were hospitalized found the treatment too focused on weight and food and had difficulty tolerating weight gains. Similarly, other studies reported that clients found treatment to be not as effective and in some cases perceived to

be harmful when the focus was primarily on reduction of symptoms and weight restoration (Maine, 1985; Bell, 2003). Therefore, the treatment approach should be less focused on weight and the increase in a client's nutrient intake should be gradual. However, in view of the present economic realities, and the increased cost of health care, hospitals cannot afford to keep clients for a long time. Consequently, inpatient treatments should be used only for a brief medical and nutritional stabilization but a gradual increase in a client daily intake can be better accomplished on an outpatient basis with support network and in combination of a group therapy for development of different skills as: meal planning and preparation and grocery shopping and other psychotherapies such as: assertiveness or body image.

### *5.3 Future research*

Research that concentrates at the different phases of normalization of eating may yield new insight to further our understanding of how nutritional changes are made during the process of recovery from anorexia nervosa. Future research using larger and more heterogeneous samples with varied socio-cultural backgrounds, education, age, gender, treatment, and eating disorder diagnoses are needed to obtain more in-depth knowledge of individuals' experiences as they change their eating patterns while recovering from eating disorders.

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## Appendix: B

### Participant Consent Form

**Title:** Understanding individuals' experiences of normalization of eating in recovery from anorexia nervosa.

**Investigator:** Kosa Matic-Smyrnis, RD

**Faculty Advisors:** Dr. Gwen Chapman, PhD, RD  
Dr. Josie Geller, PhD,  
Dr. Susan Barr, PhD, RD

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time.

#### **Purpose**

The purpose of this study is to gain an understanding of how women normalized their eating behaviour during their recovery from anorexia nervosa.

#### **Procedure**

If you decide to take part in this study, you will be asked to complete a brief one page questionnaire and participate in an interview. The questionnaire explores your thoughts and feelings about food, eating, and exercise. The interview will be conducted at a time and place that is convenient for you and will not take more than one hour of your time. You will be asked for permission to have the interviews tape-recorded. You will be asked to reflect upon your eating and food related experiences and share any thoughts and feelings that assisted you in normalizing your eating in the process of recovery.

#### **Risk and Potential Benefits**

Although there is no direct potential benefit for you in participating in this study, the information that you provide will help dietitians and other health care professionals understand how women made changes in their food and weight related behaviour as they recovered from anorexia nervosa.

## Appendix: D

### Demographic Data Form

Age:

Current Living Situation:

Current Employment:

Current weight:

Height:

Marital Status:

Number of children:

Your estimate of age at onset of anorexia nervosa:

The type of treatments you received:

Last time you restricted or used other eating disorder behavior such as: vomiting, laxatives, diuretics, enemas, or over-exercising with the primary intention to lose weight.

## Appendix: E

### Interview Guide

Tell me about your first experience at the onset of your illness.

What kind of impact did anorexia have on your eating?

Did you decide to get better?

*Probe: Did you make any changes? What or who did you find most helpful in your recovery? What was not helpful?*

Did you make changes in your eating?

Can you describe your typical daily intake?

*Probes: Do you still have any fear foods? Do you use a lot of diet foods? Do you avoid any food groups and why? Do you eat out?*

Did anything need to change before you could give up your old eating habits?

Have you ever seen a dietitian for nutrition counselling?

*Probe: What was helpful? What could she/he have done differently?*

What does normal eating or nutritional recovery mean to you?

How would you describe a recovered individual of anorexia?

Is there anything else that you would like to share about your recovery?

## Appendix F: Eating Attitude Test (EAT)-26

### EATING ATTITUDES TEST-26 (EAT-26)

*Please check a response for each of the following questions*		Always	Usually	Often	Sometimes	Rarely	Never
1	Am terrified about being overweight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Avoid eating when I am hungry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Find myself preoccupied with food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Have gone on eating binges where I feel that I may not be able to stop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Cut my food into small pieces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Aware of the calorie content of foods I eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Feel that others would prefer if I ate more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Vomit after I have eaten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Feel extremely guilty after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Am preoccupied with a desire to be thinner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Thinking about burning up calories when I exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Other people think that I am too thin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Am preoccupied with the thought of having fat on my body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Take longer than others to eat my meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Avoid foods with sugar in them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Eat diet foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Feel that food controls my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Display self-control around food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Feel that others pressure me to eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Give too much time and thought to food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Feel uncomfortable after eating sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Engage in dieting behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	Like my stomach to be empty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	Enjoy trying new rich foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	Have the impulse to vomit after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cutoff score= 20 (Each extreme response in the anorexic' direction was given 3 points, while adjacent alternative were weighed as 2 points and 1 point respectively. Adapted from Garner, Olmsted, Bohr, and Garfinkel (1982, p. 875). Adapted by permission.



## Appendix G: List of Open Codes

|HU: Nutritional recovery: **Example of open codes**

File: [c\coding\nutritional recovery 3]

Edited by: Super

Date/Time: 2004/06/30 - 12:00:07

-----  
Code-Filter: All

-----!  
  
able to step outside it (anorexia)  
accept and love yourself  
accept my weight  
acceptance  
acceptance of body's needs and function  
acceptance of self and how she looks  
acceptance unconditional by others  
accepted me for who I was  
accepting my failures  
accepting of myself  
accepting physical change  
accepting that I am not perfect  
accountability for my decisions.  
acknowledge any issues that bother you  
acknowledgment  
another wave of rebellion  
any sort of help  
ate a lot of fruit  
ate by myself  
ate for others  
ate healthy foods  
ate in silence  
ate less  
ate more of the same food  
ate only raw fruits and vegetables  
ate small amounts of fear food with boyfriend  
ate so I can get out of hospital  
ate three small meals  
ate what they gave me  
attention for doing the right things  
attention when she lost weight  
avoiding certain foods  
avoiding fats and desserts  
avoiding food  
avoiding junk food  
avoiding meals  
avoiding stressors by working  
aware of feelings and triggers  
aware of her feelings as they come up  
aware of her hunger and satiety  
aware of my blossoming figure.  
aware of my social surroundings  
aware of physical damage caused by restricting  
aware of physical signs  
aware of underlining issues

awareness of what I want in my life  
balance of emotional and physical health  
balanced meals  
balanced perspective on life  
balancing food and activity  
balancing meals  
beauty  
became active again  
became bulimic for four months  
became more reflective and insightful  
became more relaxed around walking and eating  
became vegetarian  
becomes their identity  
becoming a statistic  
becoming aware of anorexia and its cost  
becoming aware of anorexia made me want to change  
becoming increasingly more open  
being a good student  
being available  
being aware of triggers  
being away helped with permission to eat  
being different  
being happy  
being honest  
belief around fear foods and exercise I have not challenged  
belief that God gave me this incredible experience  
belief that most women and girls are preoccupied with their weight and fat  
belief that thin is attractive  
beliefs that she should eat only if active  
body image dissatisfaction  
body image was never a concern  
body was developing and changing  
bonding with friends and people skills are just as important as grades  
boyfriend wishes we can eat same foods  
breakfast if I have time  
breakfast is usually the same  
breakfast meal  
bulimic four months during recovery stage  
burning calories  
can't force someone to recover,  
can never measure up  
can not exercise if I do not eat  
changing  
channelling energy towards positive things  
chaos after the announcement  
choose different  
choosing food she likes  
choosing lower fat foods  
close-knit group of friends  
coach told me to have only a pop a day  
coach weight focused  
cognitive impairment  
comfortable talking about it  
comments about body changing  
comments now are concern driven  
comparing to others

comparing with others  
comparison to alcoholism  
concern the impact it would have on her sister  
concerned with my weight.  
conflict during meals  
conflicting expectations  
connected with people through group support  
connecting with friends again  
conscious effort to change  
conscious effort to eat  
conscious thought pattern to get better  
consequences of anorexia  
control in family  
control of the type of food I ate  
control over everything I did  
control over food  
controlling food and exercise  
core group of people who were part of this journey  
cost of anorexia  
cost of anorexia-drop out of university  
cost of food is a factor  
could not afford ongoing therapy  
could not be with my friends  
could not drink milk  
could not see herself as thin  
could not walk up the stairs  
couldn't even do it anymore  
cultural differences  
cultural shock  
cutting back on portions  
dad had unrealistic view of what is healthy  
dad was just devastated  
daily routine  
dealing with daily stressors without thinking about eating disorder  
deceive family about eating  
decided to keep weight  
decided to recover  
decided to sort of keep at it  
deciding to get better  
decision was to improve life not focus on eating disorder  
decisions-not able to make or follow through  
definitely very gradual  
depends on my schedule  
depression  
describing somebody who is recovered  
deserve it(food)  
dessert was part of my prize so I did not feel guilty having it  
determination can take you other way  
determined to do it on her own  
Dichotomous thinking  
dichotomous thinking about recovery  
did not want to be in and out of the hospital  
didn't have a social life  
diet foods were eliminated out of my diet  
dieting  
dieting and healthy eating was part of growing up  
dieting to cope

different coping skills  
difficulty adding fat to cooking  
dinner is whatever  
dinner meal  
dinner really varies  
disbelief about the degree of sickness  
discomfort with weight  
distorted thinking about body image  
do not enjoy cooking  
do not want if for the rest of my life  
does not weigh herself  
drawing and school activities helped  
earlier intervention could have been helpful  
eat fruits and vegetables throughout the day  
eat as much as I want  
eat at least three times a day  
eat less due to less activity  
eat one type of protein during the day  
eat so I could run  
eat what I like  
eat whatever I want  
eat whatever I want to eat  
eat whatever you want  
eat whenever I am hungry  
eating according to a preconceived plan  
eating alone  
eating appropriate quantities  
eating as little as I can  
eating depended on how much I exercised and ate a previous day  
eating desserts and fats is not worth the guilt  
eating during special occasions  
eating more variety  
education around nutrition would have been helpful  
education around the consequences of restricting  
education on what is healthy eating and why  
embarrassing needing to examine every dish when I go out  
embarrassed about hair loss  
emphasis off food  
enjoy activity  
enjoy being the smart one  
enjoy food  
enjoyed being with friends  
enjoyed eating out with friends  
enjoyed trying new foods  
enjoying everything  
enjoying everything around me  
euphoria at the beginning of anorexia  
every girls wants to be a model  
everybody gave up  
everyone was watching me  
everything in moderation  
examine every entree I order

## Appendix H: List of Axial Codes

|HU: Nutritional recovery: **Example of axial codes**

File: [c\coding\nutritional recovery 5]

Edited by: Super

Date/Time: 2004/11/10 - 2:08:34

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Code-Filter: All  
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acceptance of self, body's needs  
anorexia made me stronger but it was also draining  
awareness of hunger, satiety, food  
balance in eating/food/activity/perspective on life  
conscious effort to eat  
cost of anorexia  
decision to recover and let go, freedom, recover my way  
easier to eat when food is not the focus  
eat whatever I want, whenever I am hungry  
eating issues when growing up  
eating out and special occasions  
eating pattern and type of meals, snacks  
enjoyed trying new foods and exploring new flavours  
experimenting, taking risks, trying to eat more food,  
fear of change/fear of relapse  
flexible eating  
food and activity relationship and its relationship to recovery  
food and its function and reasons for eating  
food became a non issue  
food choices, eating/avoiding certain foods/fear foods  
food portions/small amounts/quantities at meals  
food rules/rituals  
guilt when eating  
health conscious/healthy eating  
meal planning, food preparation  
moving away, leaving home, transitioning  
non eating disorder identity  
nutritional information, education during recovery  
nutritionists as perceived by participants  
physical complications, concerned about health  
recovery is a gradual and continuous process  
turning points  
support around eating  
supportive family, friends, groups, environment  
time