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Voices of Anorexia Uncovered: The Healing Journey Unveiled

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VOICES OF ANOREXIA UNCOVERED: THE HEALING JOURNEY UNVEILED

by

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Abstract

Eating disorders have the highest mortality rate of any psychiatric illness. The current rate of anorexia nervosa is 1% in North America, representing approximately three million cases. Consequently, this illness has attracted a growing body of research and treatment. Current research in the field has focused primarily on the etiology of the illness. Furthermore, outcome studies are primarily quantitative in nature and have indicated that there is no treatment modality that consistently results in longitudinal recovery. What appears to be absent from the literature is the exploration of the recovery process from the perspective of those who have recovered. The purpose of this study was to gain a better understanding of women's recovery process from anorexia nervosa and to delineate a theoretical framework through which healing occurs. The informants of the present study participated in in-depth interviews, which were analyzed using the grounded theory methodology. Informants had opportunities to confirm and refine the theoretical construction. Healing from an eating disorder was described as an interwoven journey through seven conceptual phases: denial, window of hope, quiet time, opening awareness, finding self, taking responsibility and ongoing construction. A wellness model of living was also identified and described by informants that developed out of their healing journey. This theory can be utilized to inform future research on women's recovery of anorexia nervosa, as well as guide treatment approaches for women suffering with anorexia nervosa.

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To my mom, who I am certain watched my journey unfold from above. I have finally achieved a dream we both held for me, and I hope you are smiling as broadly as I am. I miss you and love you always.

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Chapter 1. INTRODUCTION

An eating disorder is broadly characterized as a persistent disturbance of eating behaviour or behaviour intended to control weight that significantly impairs health or psychosocial functioning (Gilbert, 2005). Eating disorders have become the third leading chronic illness among female adolescents (Kalisvaart & Hergenroeder, 2007), and have the highest mortality rate of any psychiatric illness (Birmingham, Su, Hlynsky, Goldner, & Gao, 2005). Rates of recovery reported in the literature range from 24 – 75% (Katzman, Golden, Neumark-Szainer, Yager, & Strober, 2000), clearly suggesting that a comprehensive theoretical framework to guide successful treatment has yet to be identified.

Research Problem

Despite increased attention and awareness of both the severity and chronicity of eating disorders, significant gaps in our knowledge limit our ability to effectively treat these disorders. Research on eating disorders has been dominated by an almost exclusive focus on pathological outcomes and determinants. The psychological literature has focused primarily on empirical, quantitatively-based studies of the phenomena (Garrett, 1997). There is a plethora of articles and examinations of the disorder with little progress towards a comprehensive understanding of its cause or its cure. Outcome measures and treatment responses have largely been defined by quantifiable physical determinants (e.g. body weight), associated physical sequelae (e.g. menses), attitudes and beliefs about weight and shape, and measures of comorbidity (e.g. anxiety) (Federici & Kaplan, 2004).

These approaches fail to take into account the subjective experience of the individual suffering from an eating disorder, and their response to treatment and recovery. The voices of those who suffer from eating disorders are notably absent from the literature.

Purpose of the Study

The present research will address the omissions noted above by presenting the experience of recovery as described by those who have recovered from an eating disorder. Due to the consensus amongst experts that bulimia nervosa, anorexia nervosa, and binge eating differ significantly in potential predictive risk and protective factors, and effective treatment modalities, only anorexia will be considered (Striegel-Moore & Cachelin, 2001). Bulimia nervosa, binge eating, and EDNOS (eating disorders not otherwise stated) warrant their own independent study effort. Additionally, research indicates a significantly higher rate of recovery with bulimia and binge eating disorders; anorexia appears to be more resistant to change.

Through a qualitative study utilizing grounded theory methodology, exploring in-depth subjective perceptions of recovery can result in a theory developed that captures the process of recovery. A proposed theoretical framework of recovery can guide future research in its application to etiology and treatment development. This study also facilitates the gaining of insight into the language, terminology, and meanings of recovery amongst those who experience the illness. This can lend itself to kindling new ideas and avenues for future research, which may result in significant contributions and implications for treatment programs beyond the current literature on eating disorders.

Theoretical Sensitivity: Assumptions

Within grounded theory methodology, researcher objectivity and sensitivity are required for making discoveries. Objectivity is necessary to 'arrive at an impartial and accurate interpretation of events" (Strauss & Corbin, 1998), while sensitivity allows for the perception of subtle nuances and meanings in data and "to recognize the connections between concepts" (ibid.). The researcher, as the primary data collection instrument typically brings a considerable background in professional experience, and academic knowledge to the inquiry, which composes the "sensitivity" aspect of the experience. It is important for researchers therefore to identify any assumptions, biases, or preferences that may influence data collection, data analysis, and the development of the grounded theory (Orland-Barak, 2002).

My Personal Journey

I, myself, have had many years of personal experience with anorexia nervosa, including both subtypes of restricting and purging. Even before adolescence I was engaging in restricting eating, often pretending to eat breakfast while flushing it down the toilet when my mother wasn't looking, and throwing out my lunches. In adolescence I was very athletically oriented, involved in track and field, volley-ball, and ballet. During this time I was exposed to, and friends with, many girls struggling with body image and self-esteem issues, including myself. During my adolescence I was hospitalized for eating disorder related health concerns on three separate occasions. I was a client in three in-patient treatment programs in the southern Ontario region resulting in almost two years of my life institutionalized. I worked with many individuals from professions including

social work, psychology, psychiatry, and other mental-health related fields. I was exposed to a variety of treatment philosophies and programming based on those philosophies over a span of ten years. Throughout this time I became exposed, acquainted and even friends with many other youth struggling with eating disorders, and was privy to many intimate details of their lives, and their story of battling with an eating disorder.

After five years of attempts at recovery, and "failing" each time, I was introduced to The Wellness Centre and a treatment program that was intrinsically different than anything else I had participated in. It is through this treatment process that I learned how to heal from my eating disorder, beyond recovering my weight and my cognitive functioning. I have considered myself healed from my eating disorder for ten years now. My experience of recovery and healing provides me, I believe, with greater insight into the dynamics that occur in recovery, and the various experiences that one can be party to. It also has given me exposure to many other individuals who have also healed from anorexia and/or bulimia over the years, and their stories of recovery that have been shared with me. These stories, coupled with my own are a guiding force in the development of the current research, including data collection and analysis procedures, which will be discussed later.

I have remained an active advocate in the eating disorder field since my healing; co-facilitating support groups for individuals struggling with eating disorders; co-chairing the Eating Disorder Coalition of Guelph and Wellington awareness campaigns; several ongoing public speaking and education initiatives with various professionals and

community members of the etiology and the recovery experience of eating disorders; and specific training in working holistically with those suffering with an eating disorder.

Coupled with my own personal experience of recovery from anorexia and the many heroic stories of others who have recovered, I struggled to understand the lack of empirical evidence for longitudinal recovery of anorexia. It made me consider why it is that I healed from an eating disorder, how I healed from it, and why I hadn't in the numerous attempts made prior to coming to The Wellness Centre. The lack of research focusing on the recovery experience itself, from the perspective of the "recovered", and the positive outcomes of healing has led my interest in emancipating the voices of those recovered from anorexia nervosa, and uncovering the insight and knowledge they possess.

Presentation of the Study

The purpose of this study is to learn more about the experience of recovery from those who have recovered from an eating disorder. An additional goal is to develop a theoretical framework that encompasses and explains the process of recovery. Chapter 2 provides an overview and analysis of the literature regarding eating disorders, etiology, treatment and prognosis. Chapter 3 outlines the research design and methodology used in the investigation, and includes a discussion of how my lens coloured the data collection and analysis process. Chapter 4 reports the findings that emerged from an analysis of the informant interviews. It also provides a description and discussion of the emergent theory of healing that was developed. In Chapter 5, I compare the findings in relation to the theoretical framework. Subsequently, I discuss the implications of the findings for

both practice and research, and put forth recommendations of future research opportunities. Lastly, I present my reflections on the research process for me, and the significance of the study from my lens.

Chapter 2. LITERATURE REVIEW

Eating disorder research has spanned over 100 years, gaining prevalence in the past 40 years. It has attracted research attention from several disciplines including medicine, nursing, nutrition, psychology, sociology, and other health professions. The following review will describe the clinical presentation of anorexia nervosa followed by the historical development of the etiological considerations most reported in the literature. Lastly, a review of the treatment approaches and a summary of the outcome literature will be presented.

Clinical Presentation of Anorexia Nervosa

The American Psychiatric Association (APA, 1994) has set forth a set of criteria for diagnosing anorexia nervosa (published in the DSM IV). The diagnostic criteria are as follows:

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during a period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, that is, the absence of at least three consecutive menstrual cycles.

In addition, the DSM IV identifies two types of anorexia. In the first or restricting type, there is a restriction of food intake to a very low level without regular binge-eating

or purging behaviours. In the second type, the binge-eating/purging type, although restriction of food intake is present, there is regular engagement in binge-eating or purging behaviour, by self-induced vomiting, misuse of laxatives, diuretics or enemas (APA, 1994).

Estimates of the prevalence of anorexia nervosa in North America range from .5% to 1% of the female population, accounting for approximately three million women. This statistic is likely to be an underestimate given the increasing specificity in the DSM criteria for diagnosing anorexia nervosa, combined with the ever increasing rate of diagnosis in the eating disorder not otherwise specified category in the DSM IV (Fairburn Cooper, Bohn, O'Connor, Doll, & Palmer, 2007).

Comorbidity with other psychiatric conditions is consistently reported with this disorder. Some of the most prevalent comorbid conditions include depression, obsessive-compulsive disorder, substance abuse, and sexual abuse (DeGroot, Kennedy, Rodin, & McVey, 1992; Gold & Slaby, 1991; Lucy, Livingstone, Neiderman, & Lask, 2002; O'Brien & Vincent, 2003; Pollice, Kaye, Greena, & Weltzin, 1998). Research exploring the etiology of these disorders has focused on biological, psychological, and sociocultural factors. These will be discussed next.

Etiology

Biological Factors

Biological factors pertain to the genetic heritability of anorexia nervosa and biochemical and neurological functioning of individuals diagnosed with anorexia. Despite varying methodologies, studies have consistently demonstrated the presence of elevated rates of anorexia nervosa in families with individuals with this disorder in

comparison to a control population. This supports a substantial role for genetic risk factors in the development of anorexia nervosa (Bulik, 2005).

The neuroendocrine hypothesis of eating disorders has received the most research attention among biological theories. Malnourished patients with anorexia display changes in every endocrine system studied. Attention has focused on how these changes affect hypothalamus functions and whether this is secondary to eating disorders or an etiological consideration (Paulson, 1999). It remains unclear as to whether neuroendocrine abnormalities cause anorexia or are the result of weight disturbances. Disturbances in the levels of the neurotransmitters serotonin and norepinephrine are found in individuals diagnosed with anorexia. Serotonin plays an important role in satiety, and decreased levels may be associated with decreased satiety, resulting in an additive vulnerability factor to the development of anorexia (Brewerton, 1995). Further evidence supporting a relationship between serotonin and anorexia is found in studies reporting that increase levels of serotonergic activity is potentially associated with compulsive and perfectionistic tendencies, which are traits common amongst individuals with anorexia (Barbarich, Kaye, & Jimerson, 2003; Jarry & Vaccarino, 1996). However, serotonin alterations have also been found in many other disorders such as depression, obsessive-compulsive disorder, and substance abuse, all which are noted as comorbid disorders to anorexia (Ericsson, Poston, & Foreyt, 1996).

What remains unclear in the literature is the causal nature of such biological findings. Studies clearly point to a biological role in the etiology and maintenance of anorexia, but do not point to a causal role. Neurochemical abnormalities may be as a result of the anorexic eating behaviour as opposed to the cause of it (O'Brien & Vincent,

2003). This has clear implications for the treatment of anorexia nervosa, as pharmacological treatment, which will be discussed further, is often applied as part of the treatment planning for those suffering with anorexia. Neurobiology also plays a role in the expression of psychological disturbances with anorexic patients.

Psychological Factors

Psychological factors reflect personality traits that have been implicated in the onset, symptomatic expression and maintenance of anorexia (Cassin & von Ranson, 2005). The anorexia personality is consistently characterized by perfectionism, obsessive-compulsiveness, neuroticism, and negative emotionality (Cassin & von Ranson, 2005; Jaffa & McDermott, 2007; Vitousek & Manke, 1994). Personality disorders are less frequent in recovered patients compared to chronically ill patients, indicating that the state of the illness influences the assessment of personality disorders. However, the role of personality disorders in the development and maintenance of anorexia remains unclear. Personality disorder symptoms may be correlates or consequences of anorexia rather than causal factors (Bornstein, 2001).

Cognitive behavioural models posit that anorexic symptoms are maintained by a characteristic set of key cognitive dysfunctions. These appear to be centered on beliefs and attitudes about weight, shape, and food. Core cognitive disturbances are understood in terms of schemas (organized cognitive structures) that unite the views of the self and the culturally derived beliefs about the virtue of thinness for female appearance. Approval and self-worth are based on body weight, and such schemas give rise to the belief that the solution to a view of the self as unworthy, imperfect, and overwhelmed is thinness and weight loss (Shafran & de Silva, 2005). However, this approach does not

take into consideration the fact that the majority of women who hold similar beliefs do not necessarily develop anorexia or other eating disorders.

As stated earlier, affective disorders, such as depression, frequently exist concurrently with anorexia. Historically, comorbidity rates are reported as varying from 24% to 79% (Abraham & Llewellyn-Jones, 2001; Costin, 1996). Though it is generally accepted that there is a relationship between affective disorders and anorexia, it has not been proven whether anorexia is a variant of depression or not. Some suggest that affective disorders could predispose an individual to anorexia, directly precipitate anorexia, or arise throughout the course of the illness, exacerbating the eating symptomology (Laessle, Kittl, Fichter, & Wittchen, 1987; Wade, Bulik, Neale, & Kendler, 2000). Some would suggest that the social temperament of western society is strongly implicated in the prevalence of psychological disturbances in individuals with anorexia nervosa. The focus on valuing externally oriented outcomes such as performance, production, fortune, fame and body ideals and the fast-paced environment may lend itself more to illness than to wellness.

Sociocultural Factors

The sociocultural perspective is perhaps the well-documented framework used to explain why eating disorders occur; identifying pressure to be thin as a major source of body image disturbance and eating disordered behaviour. In today's North American culture, thinness represents attractiveness and asceticism, virtue, success, and control (Costin, 1996). Culturally dictated definitions such as these are portrayed in various ways through various media domains. The extent to which media images impact normal

individuals, or are only selectively misinterpreted by those susceptible to or suffering from anorexia, is a matter of continued debate.

The effect of media portrayal on body image is clearly documented in the study by Becker, Burwell, Gilman, Herzog, and Hamburg (2002). Following the introduction of television on the island of Fiji, increases in overall scores on the Eating Attitudes Test and a higher incidence of self-induced vomiting were found. More importantly, subjects explicitly linked these thoughts and behaviours with aesthetic ideals drawn from western television influence.

Models, actresses, Playboy centerfolds, and Miss America contestants have become thinner in the twentieth century, stabilizing the ideal of extreme thinness (Garner & Garfinkel, 1980; Wiseman, Gray, Mosimann, & Ahrens, 1992). More recently, a study conducted by Keel & Klump (2003) found little evidence that anorexia is culturally bound, but did find that weight phobia criteria is culture bound, substantiating the "thin ideal" as a mediating factor in the rise of anorexia in western societies.

How a woman views her body is associated with a drive for thinness, and such weight concerns have been significantly associated with the onset of eating disorder symptoms (Cooper, Deepak, Grocutt, & Bailey, 2007; Killen, 1994). Femininity has been associated with being thin, and attractiveness has been linked to body dimensions that change with trends in Western culture (Stice, 1994).

Prospective studies have linked dieting to eating disorders (Fairburn, Cooper, Doll, & Welch, 1999), however whether it leads to anorexia remains controversial. The continuity theory proposed by Nasser & Katzman (2003) suggests that the risk of developing anorexia is proportional to the intensity of dieting. Conversely, it has been

suggested that dieting alone does not lead to an eating disorder, but it is the act of dieting coupled with other risk factors that may (Jaffa & McDermott, 2007).

In summary, the research indicates that there are biological, psychological, and sociocultural factors that relate to anorexia nervosa. The main factors within these domains are neurotransmitter disturbances, affective mood disorders, and the 'thin ideal' concept. However, research today has not supported a causal relationship between these variables and the onset or maintenance of anorexia nervosa. Based on these relationships a number of treatment modalities have been developed. These will be discussed next.

Treatment

For some individuals, treatment for anorexia varies on a continuum from rapid recovery, to chronic debilitation, with resistance to treatment. The most effective treatment remains debated in the literature and amongst field practitioners. There is a general consensus in today's perspective that anorexia nervosa is a result of multifactorial causality incorporating causal factors at the biological, psychological and sociocultural levels. As a result, it is argued that treatment needs to be multidimensional, incorporating a team approach to treatment involving professions from varied fields of expertise, and incorporating various therapeutic strategies. Types of treatment range from intensive inpatient hospitalization or institutionalization, residential programs, to varying levels of outpatient care.

According to the APA guidelines, the goals of treatment for anorexia nervosa are:

1. restore patients to healthy weight (at which menses and normal ovulation in females, normal sexual drive and hormone levels in males, and normal physical and sexual growth and development in children and adolescents are restored);
2. treat physical complications

3. enhance patients' motivation to cooperate in the restoration of healthy eating patterns and to participate in treatment
4. provide education regarding healthy nutrition and eating patterns
5. correct core dysfunctional thoughts, attitudes, and feelings related to the eating disorder
6. treat associated psychiatric conditions, including defects in mood regulation, self-esteem, and behavior
7. enlist family support and provide family counseling and therapy where appropriate and
8. prevent relapse. (2000, p.3)

Cognitive behavioural therapy and psychodynamic therapy were considered to be the strongest psychosocial interventions used in the treatment of anorexia nervosa. However, family therapy is the most extensively researched treatment for anorexia nervosa in controlled comparative studies (Wilson, Grilo, & Vitousek, 2007).

Cognitive Behavioural Therapy

The core basis of existing cognitive behavioural models of anorexia nervosa is that symptoms are precipitated and maintained through a set of maladaptive thinking patterns. It is an individual's beliefs, interpretations and perceptions of events that determine their feelings, moods and actions. Consequently, the primary goal of this therapy is to identify and modify these maladaptive cognitions, beliefs and perceptions. Individuals will make progress once these maladaptive cognitions are identified and challenged. Thus the focus of cognitive behavioural therapy (CBT) with anorexic clients is on changing eating habits, and thoughts about food, weight, and body image through cognitive restructuring, and psychoeducation (Fairburn, Cooper, & Shafran, 2003; Garner, Vitousek, & Pike, 1997). Explanations for the partial involuntary nature of weight control, how extreme dieting can increase uncontrolled eating, and the ineffectiveness of purging as weight control is also provided (Hersen & Ammerman, 2000). In anorexia, considerable

attention is paid to enhancing motivation for change and engaging patients as active collaborators. The recommended approach specifies 1-2 years of individual therapy for clients who begin treatment at a low body weight, and 1 year for those who are weight-restored (Wilson, et al., 2007; Vitousek, Watson & Wilson, 1998).

Cognitive behavioural therapy does not address specific interpersonal relationships, unconscious motivation for the disorder or any genetic or cultural component. Recent reviews have concluded that there is no empirical evidence to support the validity of CBT in anorexia (in contrast to bulimia nervosa) (Cooper, 1997; Leung, Waller & Thomas, 1999). Additionally, no significant reductions in either eating behaviours or anorexic cognitions after CBT treatment are found (Leung, et al., 1999; Wilson, et al., 2007). It is suggested that CBT combined with alternate forms of therapy might produce more successful results.

Psychodynamic Therapy

Psychodynamic therapies have the longest history in the treatment of eating disorders. A psychodynamic view of behaviour traditionally emphasizes internal conflicts, motives, and unconscious forces. Underlying all psychodynamic theories lays the premise that without addressing and resolving underlying causes for disordered behaviour such as anorexic symptoms, they may subside, but will inevitably return. Bruch (1978), a pioneer thinker on treating eating disorders, described the core therapeutic elements to change as being through developing an understanding of the meaning of food for the individual and assisting in finding alternatives to self-experience and self-expression.

Contemporary psychodynamic theories typically share five postulates: that much of mental life is unconscious; mental processes operate in parallel resulting in individuals can experience conflicting feelings that motivate them in opposing ways; stable personality patterns begin to form in childhood; mental representations of the self, others, and relationships guide people's interactions with others; and lastly, that personality development involves not only learning to regulate sexual and aggressive feelings, but also moving from an immature, socially dependent state to a mature, independent one (Westen, 1998).

With the emergence of contemporary relational psychodynamic theories and therapies such as object relations, eating disorders are seen as an expression of traumatic self-object internalizations from childhood acted out in the current state. The self-structure is internalized in early childhood through relationships, and functions as a blueprint for establishing and maintaining future relationships. The means to resolution is through the relationship formed with the therapist, whereby internalized states can be explored and modified. Symptoms are viewed as functional for the individual, and attempts at removal are fruitless (Costin, 1996). In therapy the premise is that when the underlying issues are expressed, worked through and resolved, the eating disorder behaviours will no longer serve a purpose and cease to exist.

The main criticisms of psychodynamic therapies are that some anorexics are in such a state of starvation or depression that psychotherapy and 'intrinsic' work cannot be effectively undertaken; and that awareness and insight into the understanding of the anorexic illness is not sufficient to initiate behavioural changes (Garner & Garfinkel, 1997). There is a consensus that at some point the individual will need to deal directly

with the disordered behaviours and develop new coping strategies (Bruch, 1978; Costin, 1996). Additionally it has been charged with failing to take into account the social system that creates pathology.

Family Therapy

Family therapy has been gradually accumulating empirical evidence indicating the circumstances surrounding its most effective use. Family therapy however, is far from being a unified conceptual system. A number of different models exist with distinctive views of the nature of family therapy and the mechanisms that bring about change (Dare & Eisler, 1997). The best studied approach is a specific form of family therapy known as the Maudsley model (Dare & Eisler, 1997; Lock & Le Grange, 2005). The highest success of this approach has been found among adolescents with relatively short term duration of anorexia nervosa. A study conducted by Russell, Szmukler, Dare and Eisler (1987) produced a striking recovery rate of 90% symptom-free at 5 years follow up. These results have been replicated in case series (Le Grange, Binford, & Loeb, 2005) and in randomized controlled trials (Lock, Agras, Bryson, & Kraemer, 2005).

The Maudsley model in many ways resembles the structural approach coined by Minuchin, Rossman, and Baker (1978) although with important modifications. In the therapy the parents are encouraged to take control of their child's eating, but in engaging the family in this process there is no assumption that the observed pattern of family functioning is dysfunctional. There are no presumptions made that the therapist knows

what kind of organization will be most effective for the family unit (Dare & Eisler, 1997).

Studies examining the outcome of family treatments compared with other psychological interventions on adult populations are significantly less positive. This may partially reflect the increased chronicity of anorexia amongst adult population. As well, the expectation of parents of adult children to engage in the therapy in the same fashion as those of adolescents is not feasible. However, it is noted that family dynamics do play a role in the development of anorexia (Dare & Eisler, 1997; Fairburn & Brownell, 2002; Garner & Garfinkel, 1997) and so necessitates engagement with the family to change dysfunctional patterns. The most effective means of doing this has yet to be established in the literature.

Prognosis

Though the prognosis of individuals with anorexia nervosa is variable, it is also consistently poor. Steinhausen (2002) is the only author to conduct a meta-analysis of outcome studies in the twentieth century. Full recovery was found in less than half of the patients, while the remaining either improved (30%) or developed a chronic course of the disorder (20%) (Steinhausen, 2007). The mean crude mortality rate cited from this study was 5%. At follow-up a large proportion of anorectic individuals suffered from additional psychiatric disorders, mainly anxiety disorders, affective disorders, obsessive-compulsive disorder, and substance abuse.

Long-term outcome studies support the findings above, showing that a significant number of individuals do not fully recover from anorexia, despite treatment (Geller,

Zaitsoff, & Srikameswaran, 2005; Steinhausen, 2007). The outcome studies for anorexia have not changed significantly over time. Early studies have shown that prognosis is poor and the disease is sometimes deadly (Bruch, 1973; Halmi, Brodland, & Loney, 1973; Hsu, Crisp, & Harding, 1979).

Conclusion

Over the past two decades, the focus of research on anorexia nervosa and related eating disorders has grown exponentially. Despite this, there remains a limited understanding of the eating disorder recovery process. With fewer than half of those diagnosed with an eating disorder achieving recovery, and eating disorders achieving the highest mortality rate of any psychiatric illness (Birmingham et al., 2005), the need to develop a comprehensive understanding remains essential.

Most of the research on anorexia nervosa has focused on delineating the etiology of the disorder. It is not clear why some respond to treatment, while others do not, nor why some recovery fully, while others retain behavioural and affective disturbances even in the absence of anorexic behaviour. Though research has recently acknowledged a multidisciplinary approach to treatment, very few studies have been conducted to test the effectiveness of this approach. It can also be argued that most treatments occurring and being studied today do not incorporate a multidisciplinary approach, but rather remain entrenched in single modal therapies.

The voice of the individual anorexic and their personal experiences with the disorder, treatment, and recovery appear to be absent in the literature. In order for a

thorough understanding of the etiology and recovery of anorexia to be achieved, it is critical to include the insights and knowledge of individuals recovering from this disease. This study will attempt to explore the in-depth subjective experiences of people recovering from anorexia nervosa, and develop a grounded theory on the recovery process that could impact development of future treatment and future avenues for research.

Chapter 3. METHODOLOGY

This chapter presents the grounded theory methodology used in this study to gain insight into the research questions. An overview of the epistemological paradigm, grounded theory methodology and the data collection procedures will be discussed first. Then the sources of theoretical sensitivity that the present researcher brings to the analysis and interpretation of the data is outlined. Lastly an overview of the data analysis procedures for this study will be outlined.

Qualitative Research and Grounded Theory

Qualitative research is designed to facilitate researchers in developing a fuller understanding of a phenomenon (Creswell, 2007). Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry (Denzin & Lincoln, 2000). Creswell (2007) summarizes the characteristics of qualitative research as follows: qualitative research is naturalistic; utilizes multiple interactive methods of data collection within an emergent design versus one that is preconceived; analysis is inductive, with a focus on participants' meanings; and is fundamentally interpretive. The researchers themselves are required to look at social phenomenon holistically and systematically reflect upon their own role and bias in the research process. Many paradigms operate within the qualitative research framework such as post-positivism, constructivism and critical theory.

A constructivist paradigm assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and the viewed and aims toward interpretive understanding of subjects' meanings (Lincoln & Guba, 2000). Research is carried out with a focus on developing an understanding of how people construct meaning in their natural settings. Constructivism, also referred to as interpretivism by some, is based on the premise that humans attach unique meanings to life experience; that they are active participants in meaning making. These constructions are formulated individually or co-constructed interpersonally. Reality is subjective and dynamic; meanings are socially embedded and socially constructed out of life experiences. Some meanings are inexorable over time; other meanings are highly subject to reconstruction (Coady & Lehmann, 2008). Though multiple realities therefore can exist, knowledge can be gained through reconstructions that reach consensus across participants.

Context is important in constructivism as neither the researcher, individual, nor methodology are objective, rather they are reflective of the values, and external and internal influences present at the time (i.e. social, political climate). Theory in this paradigm is inductively derived and is idiographic. Due to the subjective nature of constructivism, the researcher's values are considered imminent and should be recognized and embraced in the discovery process. The researcher needs to be reflexive, and operate as co-facilitator in the construction of knowledge. The focus of the subjective experience of participants and the meanings they attribute to phenomena lends itself to qualitative methodology, such as grounded theory.

Grounded theory methodology is a type of qualitative design often used to address phenomenon in which all relevant concepts have not yet been identified or the relationships between the concepts are inadequately understood or conceptualized (Strauss & Corbin, 1990). Grounded theory is a qualitative research method that seeks to develop theory that is derived from the patterns in the data. Rather than beginning with a theory with the intent of proving it, in grounded theory, one begins with an area or subject of study, and focuses on that area with minimal structure (Strauss & Corbin, 1998).

A constructivist grounded theory recognizes that the view creates the data and ensuing analysis through interaction with the viewed. Data do not provide a window on reality Glaser (1978, 1992). Instead a "discovered" reality "arises from the interactive process and its temporal, cultural, and structural contexts; researchers and subjects frame that interaction and confer meaning upon it" (Charmaz, 2000). Glaser (1992) establishes four relevant characteristics of grounded theory: fit, work, relevance, and modifiability. The grounded theory approach will be discussed further in the data collection and analysis section.

Grounded theory methods were used to guide data collection and analysis to understand the psychological and social processes of recovery from anorexia nervosa. As a qualitative research approach, grounded theory methods are used to inductively capture the social realities of human experience. In other words, grounded theory will help to identify what is missing in the current literature on anorexia nervosa by starting with a fresh perspective that is unencumbered by current issues and foci. Grounded theory methods have been particularly useful in understanding individuals' experiences of

illness and recovery from their perspective (Lamoureux & Bottorff, 2005). As such this approach will help to identify previously undiscovered factors related to recovery from anorexia nervosa. It will also facilitate the development of client centered research and interventions by focusing on the voices of those recovered from anorexia nervosa.

Theoretical Sensitivity

Theoretical sensitivity refers to the attribute of having "insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't" (Strauss & Corbin, 1990). Theoretical sensitivity comes from and can be developed by the researcher through various sources including professional and personal experience, and various mediums of literature on the subject.

Personal & Professional Experience

Drawing upon personal and professional experience may give the researcher a basis for making comparisons that help stimulate the generation of potentially relevant concepts, and the relationships between the concepts. Sensitivity is enhanced however only if the researcher has the capacity to stand back from their own lens of interpretation to be open to hear about others that may be different and unique.

As I mentioned in the beginning I have had my own experience with an eating disorder and the process of healing. Despite the assumptions and understanding that I have developed regarding the process of healing, I believe that I have remained open to what the data presents. I also believe that my own personal insight into this experience sensitized me to listening to the participants' story and influenced the types of research

questions asked during the interview. I also believe that having a shared experience of healing from an eating disorder influenced the kind of responses participants shared and the way in which they shared them. I perceive this influence to be of significant benefit in enriching the data used for this study.

Technical Literature

Technical literature refers to readings on past and current theory, research, and reports or manuals that have been published regarding the phenomenon being studied. Used analytically, technical literature provides a source of information that stimulates thinking about issues and developing conceptual questions (Strauss & Corbin, 1990). Three theoretical lenses through which I viewed eating disorders and the recovery experience were considered relevant to this study. These three lenses are: psychodynamic theory; ecological systems theory; and post-traumatic resiliency theory. Each theory will be discussed below.

Psychodynamic Theory

Psychodynamic theory refers to the study of the interrelationships of the various parts of the mind, personality, and psyche as they relate to mental, emotional, or motivational forces (especially at the unconscious levels). The mental forces involved in psychodynamics are often divided into two parts: (a) interaction of emotional forces and: (b) inner forces affecting behavior: the study of the emotional and motivational forces that affect behavior and states of mind (Godsit, 1996).

In psychodynamic theories, "dynamic" refers to the continually shifting and changing internal energies that motivate and influence behaviour (Grossman Dean 2002).

These forces are shaped by past as well as current experiences. They emphasize internal representations of interpersonal interactions, including the relationships that are developed between client and clinician. Early relationships with primary caregivers are seen as most important, as childhood experiences lead to the development of unconscious beliefs that guide the conscious actions (Grossman Dean, 2002). As postulated by Jung, the development of the self is the ultimate goal of psychological development. The self is an archetype that represents the transcendence of all opposites so that every aspect of your self is expressed equally. The "troubles" or problems that individuals experience are seen as failures on the road to self-realization, troubles that need to be resolved in order for self-actualization to occur. The goal of therapy therefore is to bring forward the neglected aspects of the individual into the light and promote their unfolding (Bienenfeld, 2006), awareness and subsequent resolution, leading to self-realization.

Eating disorder research, particularly anorexia nervosa, has identified the family dynamics and relationships, cultural messages, and early childhood experiences, as either a protective or risk factor associated with the onset of anorexia nervosa. One could thereby argue, that in order for recovery to become a reality, the internalized and unconscious internalizations will need to be surfaced, and explored.

Ecological Systems Theory

Ecological systems theory, a precursor to bioecological systems theory views individuals' as growing entities that reshape the environment they live in while simultaneously being altered by that same environment. There is reciprocity of influence between the two. It looks at an individual's development within the context of the system

of relationships that form his or her environment. Bronfenbrenner's theory defines complex "layers" of environment, each having an effect on an individual's development. This theory has recently been renamed "*bioecological* systems theory" which accords equal importance to the role in development of the biopsychological characteristics of the individual person. The interaction between factors in the individual's maturing biology, her immediate family/community environment, and the societal landscape fuels and steers her development. Changes or conflict in any one layer will ripple throughout other layers. To study an individual's development then, we must look not only at the person and their immediate environment (family and friends), but also at the interaction of the larger environment (society) as well.

Ecological systems theory identifies five levels of interaction, which all uniquely contribute to the development of an individual: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Berk, 2000). The mircrosystem incorporates the relationships and interactions a person has with their immediate surroundings (e.g. family, friends, and neighbourhood). The mesosystem provides the connection between the structures of the child's microsystem (e.g. the connection between the child's teacher and his parents) (ibid.). The exosystem defines the larger social system in which the individual does not function directly in, but the microsystem (e.g. a parent's workplace schedule or a community's resources). The macrosystem is considered to be the outermost layer of the individual's environment (e.g. society), comprising of cultural values, customs and laws. Lastly, the chronosystem, encompasses the dimension of time as it related to an individual's environment (e.g. a parent's death or physiological changes).

Although ecological systems theory has traditionally focused on the impact of the five systems on the individual, recent conceptualizations have recognized their interrelationship and the individuals' ability to impact the ecological systems. This is known as the bioecological systems theory. This theory treats development as a process that continues both through the life course and across successive generations, thus according importance to historical continuity and change as forces indirectly affecting human development through their impact on the systems the individual develops within (Bronfenbrenner, 2000). Subsequently, it would confer that in order to resolve the identified issues for an individual, such as anorexia, one would need to look to the systematic development of anorexia for the individual and deal effectively with all systems that are potentially increasing or decreasing the risk and protective factors associated with the illness, and address their interrelationships.

The bioecological systems approach is consistent with the multidimensional etiology of eating disorders. In other words, the etiology of eating disorders is imbedded in the multiple contexts or systems identified in ecological systems paradigm (i.e. individual, family, cultural influences).

Resiliency & Post-Traumatic Growth

Psychological research on stress reactions has been dominated by an almost exclusive focus on pathological outcomes. While the negative impact of stress and trauma can indeed be profound, this largely one-sided focus has resulted in the relative neglect of other potentially positive stress-related outcomes. Understanding the competencies, personal or spiritual growth, and other positive changes that can result

from individual's confrontation with significant adversity is an important aspect to be aware of when discussing experiences of recovery. Coupled with the lack of research in this area, there is no clear consensus on the definition of psychological growth, some referring to post-traumatic growth, resiliency, stress-related growth; they all share the idea that post-traumatic growth is the process of getting and maintaining perceived positive outcomes from a traumatic experience (Siegel & Schrimshaw, 2000).

In contrast resilience research derives from the field of childhood psychopathology, and is centered on trying to understand why many children who grew up in unhealthy environments, and possess personal vulnerabilities, develop into well-functioning, healthy adults. Risk and protective factors have been discovered to be orthogonal, hence much of resilience research conducted today focuses on these factors, although the models are becoming more complex as the interrelationships between risk and protective factors are viewed as dynamic and sometimes reciprocally related (Calhoun & Tedeschi, 2006).

As it is applied to young adults and adults, some scholars conceptualize resilience as the ability to transform traumatic experiences into positive personal growth experiences (Bonanno, 2004; Janoff-Bulman, 2004). However, not all scholars subscribe to the notion that reconfiguration or transformation is part of resilience (Calhoun & Tedeschi, 2006), believing instead that resilience is associated more with the resistance to stress, or the individuals capacity to recover to the prior status quo. For the purposes of this study, resilience is described as the "capacity to rebound from adversity, to be strengthened and more resourceful" (Walsh, 1998). Individuals are able to reconfigure their cognitions, beliefs, and behaviours in a manner that allows them to adapt to

traumatic experiences and withstand future traumas. This lens through which the present researcher conducts data collection and analysis is seen in the wording and research questions that ask to identify the "best moments" in the recovery experience, as well as inquiring as to how the recovery experience has changed the way they see themselves or live their lives. This relates to the transformative nature of resilience and/or how the individual experiences the recovery.

Participants

The purpose of the study was to explore the healing process through the narratives of women with an eating disorder. Men and women with eating disorders have been found to significantly differ in regards to the eating disorder etiology (Crosscope-Happel, Hutchins, Getz, & Hayes, 2000) and as such, only women were recruited for this study. The original participants of the study were eleven women between the ages of 19 and 50 who identified as having suffered from an eating disorder. Since the purpose at the oustet of the study was not to centre on one typology of an eating disorder, no selection criteria was used in relation to participants' diagnosis. Of the eleven, ten identified as meeting the DSM-IV criteria for anorexia, with one meeting the DSM-IV criteria for binge-eating disorder. Significant differences are consistently found between the etiology and treatment success between anorexia nervosa, bulimia nervosa, binge-eating and EDNOS (eating disorder not otherwise specified). Consequently, in order to limit complications in identifying relevant themes among participants, the binge-eating disorder interview was excluded from analysis.

In total, ten women ranging in age from 19 to 31, were included for the purpose of this study. All participants identified as considering themselves healed for a minimum of five years. Participants also had engaged in the program within the last five years. Nine were Caucasian and one was of Southeastern descent. All of the women spoke English as their native language. The women of this study completed higher levels of education than the general population. All but one participant had completed or was in the process of completing post-secondary education. Only one had not received their high school diploma. Seven women identified as single with no children, two were married with children and one was divorced with no children. Over eighty percent of the sample had received professional psychotherapy in Southern Ontario specifically for their anorexia. All ten participants had completed The Wellness Centre program at least once in the last five years, and all were self-identified as having healed from their eating disorder for at least five years. Healed from anorexia was defined based on how the women subjectively defined it rather than by a professional diagnosis. A researcher using grounded theory method does not assume any face value relevancy for a conventional variable such as "professional diagnosis" unless is emerged as relevant in the data itself (Glaser, 1998).

Participant Recruitment

Participants were recruited from an organization named The Wellness Centre. The Wellness Centre, located within the southern Ontario region is an organization that has been providing healing focused therapy to individuals with eating disorders for the past twenty years. The Wellness Centre has two primary offices with primary therapists located in each. Both individual and group counseling is offered to potential clients,

however the material of the program remains the same regardless of model of delivery. The Wellness Centre serves individuals from all gender and ethnic backgrounds between the ages of 14 to 65 with exceptions being made on a case-by-case basis. The program accepts individuals who are suffering from other mental health issues as well, such as depression, anxiety and substance abuse as it is recognized that many of these disorders occur co-comittently. The program has also provided individual and group support to family members and friends of clients as it is recognized that eating disorders affect more than just the client themselves. It also reflects the centre's belief that the program is helpful in improving the quality of life for individuals regardless of whether they are suffering with a diagnosed mental health illness or not.

Recruitment letters were provided to the primary therapist at The Wellness Centre, which gave a brief overview of the study goals and an invitation to contact the researcher directly via phone or email for more information about the study. The primary therapist sent out the recruitment letters to all individuals who had completed the program and had engaged in the program within the last five years. Once participants connected with the researcher, the researcher confirmed that the participant had completed the program once within the last five years and self-declared themselves recovered. All participants were provided an email copy of the consent form, and a convenient time and location for the interview to take place was decided. All participants selected in collaboration with the researcher the location in which they would feel most comfortable discussing their healing process. This resulted in interviews taking place in participants' homes, coffee shops, and a research office. Only one interview was conducted via phone as one individual was out of province during the interview time

period. Prior to commencing with the interview, the researcher again discussed the purpose of the study, went over the consent form with participants, provided a hard copy of the consent form and addressed any questions the participant had.

Data Collection Procedures

Participants were recruited from an organization named The Wellness Centre. The Wellness Centre, located within the southern Ontario region is an organization that has been providing healing focused therapy to individuals with eating disorders for the past twenty years. Recruitment letters (Appendix A) were provided to the primary therapist at The Wellness Centre, which gave a brief overview of the study goals and an invitation to contact the researcher directly via phone or email for more information about the study. Once participants connected with the researcher all participants were provided a soft copy of the consent form (Appendix B), and a convenient time and location for the interview to take place was decided. All participants selected in collaboration with the researcher the location in which they would feel most comfortable discussing their healing process. This resulted in interviews taking place in participants' homes, coffee shops, and a research office. Only one interview was conducted via phone as one individual was out of province during the interview time period. Prior to commencing with the interview, the researcher again discussed the purpose of the study, went over the consent form with participants and addressed any questions the participant had.

Data was obtained through semi-structured participant interviews. Women were asked to talk about their experience of recovering from anorexia. The interviews were guided by broad, open-ended sensitizing questions beginning with "tell me as much as

you can about your recovery experience" (see Appendix C for Interview Guiding Questions). I did not rigidly adhere to the interview guide in order to follow participants' story. Follow up and probing questions were used to help participants elaborate their responses, and clarify information and meaning.

Interviews ranged in duration from one and a half to two and half hours each, depending on the amount of information the participant shared. Although Glaser (1998) recommends documenting interviews with field notes and observations to expedite coding and analysis, I used audio-recording to obtain verbatim data. All women consented to having their interviews audio-recorded and transcribed. I augmented the research data base through the use of field notes containing my initial reactions and reflections and by memoing my ideas about the relationships within the data after each interview.

During the first interview, each participant was asked and agreed to participate in a follow-up focus group. Individual participant's availability and preferred method of contact was noted and maintained for follow-up communication. Participants were provided with Debrief Forms (Appendix D) at the end of the interview. Each participant received a copy of the initial findings of the study as well as receiving a discussion of the emerging theory of healing. I asked each woman to evaluate the comprehensiveness of the emerging theory, thus allowing participants to confirm or refine my explication of the emerging theory. Responses that were provided in relation to the findings were incorporated into the data analysis yielding a rich and comprehensive theory that reflects the experiences of the women interviewed.

Researcher Influence

At the onset of the interview, participants were informed that I had been a client at The Wellness Centre program, but I did not elaborate on my experiences or my viewpoints. It appeared however that this disclosure created a feeling of shared experience that influenced the data collection process. The interviews often had a conversational texture and tempo to them. This fostered a relaxed atmosphere and supported a discussion of difficult topics. Participants were extremely open to sharing very personal anecdotes about their experience in a very honest and detailed way. They commented that they felt comfortable that I would honour their experiences from a position of non-judgment. When probed as to why, their responses indicated that a base of trust and confidence was created as a result of our perceived shared experience. This contributed significantly to the rich, descriptive nature of the data obtained. It also appeared that participants felt I possessed insight and understanding into the experiences we were discussing as they frequently would say "you know what I mean", looking for consensus. It seemed that participants viewed me as an insider throughout the interview process, which further facilitated self-disclosure of their healing experiences. . This directly influenced the quantity and rich quality of data that shaped the analysis and emergent theory of healing.

Data Analysis

Data analysis during the grounded theory research process occurs in a non-linear fashion. Several research processes are in operation simultaneously (Stern, 1980). From the beginning of the study, data are examined as they arrived. The data is coded, categorized, conceptualized, and thoughts concerning the research were written down in

the form of memos (Strauss & Corbin, 1990). The data collection and analysis continue to proceed simultaneously and the theory emerges from the data itself (Charmaz, 1983). In grounded theory, there are six phases of data analysis. These phases are "(a) organizing the data; (b) generating categories, themes, and patterns; (c) coding the data; (d) testing the emergent understandings; (e) searching for alternative explanations; (f) writing the report" (Marshall & Rossman, 1999, p. 152).

The grounded theory methodology outlined by Strauss and Corbin (1990) was used to analyze the data collected in this study. Coding is the process of placing a conceptual label on discreet occurrences, events, or other instances of phenomenon found within the data. Verbatim transcripts and researcher memos were both analyzed. The following section elaborates on the coding procedures as well as memo writing and theoretical sampling used in the development of the grounded theory of healing from anorexia.

Open Coding

Open coding is based on the concept of "opening the inquiry widely" (Berg, 2007), and is the process by which the naming and categorizing of the phenomena through close examination of the data occurs. The data was broken down and examined line-by-line to identify discreet words or phrases that reflect important ideas, actions or events (Lamoureux & Bottorff, 2005). All identified concepts were then grouped into substantive codes which were grounded in the substance of what participants had said (Glaser & Strauss, 1967). This prevented any preconceived impressions to be imposed

on the data. For example any comment that participants made in regards to arguments with their family over their eating disorder was given the code name "family conflict".

Next differences and similarities were discovered amongst the codes through the constant comparison method, which will lead to the development of initial conceptual names for categorizing the data. The conceptual names were more abstract than the names given to concepts and were grounded in the substance of what participants had said (Strauss & Corbin, 1990). For instance, "family conflict" was grouped with other substantive codes that were related to negative interpersonal experiences participants had as a result of their eating disorder prior to entering treatment.

Axial Coding

The second type of coding is axial coding which is aimed at making connections between a category and its subcategories (ibid.). The method in which the categories were developed further was by using the paradigm model. This model was used by focusing on specifying a category (phenomenon) in terms of the conditions that give rise to it, its context, the social interactions through which it is handled, and its consequences. Throughout this process I remained conscious of how the categories grouped together into phases of recovery (the major categories). As the phases emerged each was given an abstract label to capture the process that was occurring in that phase. For example the categories of "disempowerment by authority", "disillusionment of recovery" and "dismissed insight" were included in the major category of "eating disorder intervention experiences". I continued to question the relationship between the categories and to the major categories. Changes were made on a continual basis such as re-labeling a category

or moving a category to another phase. For example "eating disorder intervention experiences" was re-labeled and divided into "the road most taken"' and "the road less traveled".

Selective coding

The last form of coding, selective coding, involves "integrating concepts around a core category, and filling in categories that need further refinement and development" (Strauss & Corbin, 1990). This is the stage in which the categories are integrated to formulate the theory. The integration process of the categories at the selective coding stage was similar to that of axial coding, however it was accomplished at a higher, more abstract level of analysis. This was the process that helped to identify the salience of sense of self as the core category in healing through an eating disorder and quiet time as the vehicle through which this occurs. These will both be discussed further in the following chapter.

Theoretical Sampling

Theoretical sampling is a strategy by which one seeks out and collects pertinent data to elaborate and refine categories in the emerging theory. Theoretical sampling is an emergent process; as codes are discovered and compared with each other that the investigator can know emergent codes, their properties, and where to collect data further (Charmaz, 2006). Theoretical sampling was used in this research as a means to support initial coding, to elaborate the interview guide, and to selectively sample the literature. During initial coding I used codes elicited from the raw data to direct further data

collection from which codes could be theoretically refined. For example, the first participant rejected the use of the word "recovery" to define her experience, she preferred the use of the word "healing". The second participant also commented on my use of the word "recovery" to capture her experience. By asking other participants during their interviews to comment upon "recovery" and "healing" I was able to confirm that for this group of participants healing and recovery are defined differently, and healing is preferential to describing their journeys.

Further data collection and analysis resulted in additional categories. At each phase of the grounded theory, hypotheses were generated about the relationships between the categories and tested with the data. Both confirmatory and contradictory data were examined to increase the richness of the theory as it progressed (Hutchinson, 1986). Saturation of categories occurs when there is no new data to add to existing codes and no new codes under which data fit (Glaser, 1978). Relationships between the categories continued to be developed until a pattern emerged among the relationships. This pattern and the interrelationships between the major categories were focused on as a means to developing the theory. A meta-analysis using the constant comparison method was also utilized at this stage to identify the flow with which the healing process occurred amongst all participants. These were refined through repeated analysis and memoing until the researcher achieved saturation and satisfaction with the final proposed theoretical framework of healing.

Memoing

Memos refer to written records of analysis by the researcher, which are then incorporated in the development and formulation of a grounded theory. At every step of the analysis I wrote memos to keep track of the thoughts, questions, and associations about how the data, codes, categories and relationships would integrate into a core explanatory process. Memo writing helped me preserve "emerging hypotheses, analytical schemes, hunches, and abstractions" (Stern, 1980 p.21). The sorting of memos was also an important step in the development of the theory as it provided an opportunity to cluster the concepts (ibid.) Memos that discussed the same category were put together to clarify its dimensions and its distinction from other categories. Memos were also sorted by the phases of the healing process. This facilitated the generation of a theoretical outline that integrated the main ideas of the theory (Charmaz, 1983).

Member Checking

A qualitative research study is defined as having credibility and validity when it presents descriptions of interpretations that are recognizable by those who have shared their experiences in the research process. This is often achieved through "member checking". Though member checking has been challenged in that it implies that a single reality can be captured, shifting the authority towards participants "affirms their dignity as research partners" (Padgett, 2008 p.191). Upon completion of the data analysis, a summary of the findings was provided via email to all participants inquiring as to how well the findings fit with their experiences. Initially, a focus group was offered as a

format to elicit feedback, however with the complexity of everyone's schedule, it was agreed upon by all participants that feedback via phone or email would be preferable. Feedback was received from 7 of the original ten participants. All feedback was supportive of the findings.

A second member check was conducted at the end of the data analysis. This consisted of emailing out to the participants the emerging theory of healing that was developed out of the data with a description of each category identified. Again, seven participants responded with a resounding support of the theory formulated. The women's responses to the research process and product illustrated the accuracy and efficacy of the study's theory. Several commented that the theory was "right on the mark" and a good "reflection of the real experience". The women found the theory useful in providing a language that reflected their experiences, which they can use to share their experience with others.

Summary

This chapter provided an overview of the grounded theory method and how it was applied to this study. The approaches to theoretical sensitivity, sampling, data analysis specific to grounded theory were outlined. My own influence on the process and the evaluation of the efficacy of the findings by participants were also discussed.

Chapter 4. FINDINGS

In this chapter I outline the theory of healing from an eating disorder. First, a brief discourse of the qualitative differences between recovery and healing as defined by the research participants is submitted. They felt it imperative that readers distinguish between the two, and couch the research within the discourse of healing. The grounded theory of healing and wellness is then presented. The theory of healing is divided into three conceptual phases with seven categories presented within. Each phase and corresponding categories are presented in turn. Once the theory of healing and wellness is explained the healing process is discussed. This includes participant's perspectives on their eating disorder, experiences of treatment, and healing outcomes. Lastly, a discussion of participants evolving journey of learning and healing, and the ideological shift participants experienced as a result of this healing process.

Definition: Recovery vs. Healing

Healing and recovery are terms laden with subjective meaning and can present as complete opposites, or variances along the same continuum. Rather than provide a definition to the participants, I asked participants to share their own personal definitions of what recovery and healing meant to them in relation to their eating disorder. What follows is my consolidation of their responses, validated by the participants.

Recovery and healing were seen as two concepts on opposite ends of a continuum, with recovery being a step towards healing. For the purpose of this research recovery is defined as a return to one's baseline or "normal functioning", including

weight restoration, and an absence of eating disorder behaviour. For the purposes of this paper healing on the other hand is defined as a personal transformation and transcendence of suffering from the eating disorder that result in sustainable change at the physical, emotional, intellectual and spiritual level. Healing is what the informants of the present study identified that they experienced.

The Theory of Healing

The theory of healing from an eating disorder was derived from interviews with ten women. In most cases the words of participants were used to name the phases and categories; in others they were chosen based upon my experience with the data. Although the process of recovery as presented here in a linear fashion, this is only to facilitate communication; it is important to note that the phases are not meant to be taken as such. The process of healing from an eating disorder is a complex interplay of smaller processes that are unfolding sometimes interactively and sometimes in a more sequential fashion. This is not surprising given the complex nature of the etiology of an eating disorder that has been demonstrated repeatedly through research.

Participants identified three conceptual phases that capture their healing process. With them are seven categories that were central to their healing: Opening to Change (denial, a window of hope); Finding the pathways to healing (quiet time, opening awareness); and Awakening and adhering to the voice within (seeing through the haze: sensing self, responsibility to and for oneself, and ongoing construction). Once individuals have begun to develop the ability to quiet their mind in the quiet time phase, the remaining phases are experienced as an iterative process, an ongoing construction of

learning. Participants moved between the phases with fluidity, growing along each dimension in an intuitively self-directed manner. Participants also identified Quiet Time as a phase during which they identified a "no going back" point in healing. All participants clearly shared a deep belief that they never fear going back into their eating disorder or "regressing" in the manner most commonly found in the treatment of eating disorders. Although they have setbacks, what is distinct about them is that participants conceptualized these "setbacks" as times in which more awareness and learning was needed; viewing experiences through a positive rather than a negative framework.

Figure 1 presents the theory of healing. The upward spiral is used to represent the evolving process of healing participants identified; a process of continual growth and transformational change. There is no final destination, no "end point" in which to mark the end of their journey. Rather they felt that you continue to grow and evolve in ways long after you have healed from the eating disorder. The line represents the "point of no return" identified above through the quiet time phase.

The Theory of Wellness

Though a model of wellness was not an objective of the present study, its presence was very clear through the review of the findings. Participants spoke about the evolving sense of learning that occurred not only within the framework of healing from the eating disorder, but for many years thereafter. They recognized that from the process

Figure 1: The Theory of Healing

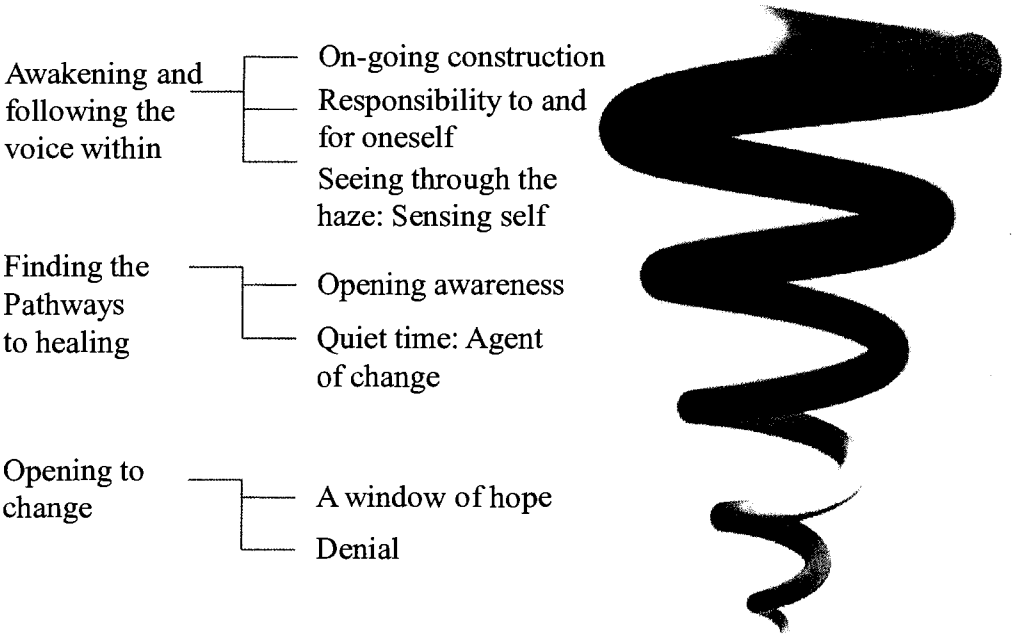
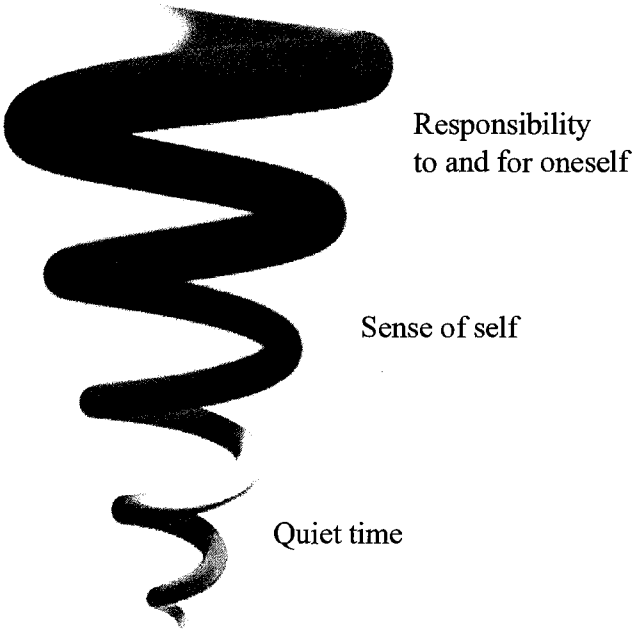


Figure 2: The Theory of Wellness



of healing they took core concepts and have activated them in their every day life; this is how they have constructed wellness and the methods through which they achieve this. The theory of wellness as identified by participants is a continuation of the theory of healing, just with fewer phases or dimensions identified. The theory of wellness is presented in Figure 2.

It consists of individuals engaging in quiet time on a daily basis, as they did in the theory of healing. Through the quiet time they maintain a constant connection to their sense of self, which fosters their ability to be responsible to and for themselves. The quiet time is a pinnacle strategy in the maintenance of participants' wellness. It is through quiet time that they are able to maintain an open awareness and presence in their life; they are able to maintain a strong connection to their core self. This connection empowers them to clearly navigate their life path in ways that are supportive, positive, and originate from a position of inner knowledge and strength. This is what participant's believe have led them to maintain a balance of health and wellness in their lives.

Participants openly acknowledge that life is not "perfect"; it is fraught with challenges. The difference that participants identified is that they meet these challenges with inner resources and tools to navigate through them. The inner resources draw upon their inner connection to self, their inner strength and a trust of knowing who they are and what they need. They meet challenges head on with a belief that they will overcome them and will do so through inner strength and support. They no longer delve into negative unsupportive, self-destructive behaviours that only contribute to the complexity of life's every day problems. It is through adhering to the above three principles that they continue to benefit, grow and transform their lives. The other distinct difference is that in

the theory of wellness these core phases occur and are in operation simultaneously, there is no concrete or subjective differentiation made by participant's about the process of wellness. The distinction is arbitrary in nature. Similar to the theory of healing though, the process is again not linear in fashion, individuals do still experience challenges and obstacles that result in movement along a continuum of each dimension. Again, movement is constructed as an indication of learning that the present life situation

The Healing Process

The data revealed consistencies regarding the process of healing from an eating disorder amongst the research informants. They indicated not only the phases that they went through to heal, but also the non-linear and iterative fashion of the healing process itself. Research participants identified three conceptual phases they processed through: Opening to Change, Finding the Pathways to Healing and Awakening and Following the Voice Within. What follows is a summary of their experiences through each phase.

Opening to Change

Denial

As with most mental, and some would argue, physical health issues, informants initially identified varying degrees of denial of their eating disorder. The denial came in many forms: repressing or suppressing their awareness of the extremity of their thoughts, feelings and behaviours; refusal to accept loved one's concerns; and even reconstructing their disease to medical professionals. For instance one research participant recounted

how she underwent several different forms of testing to identify her sudden weight loss instead of acknowledging that she was suffering from anorexia:

> For a long time I was saying no, I eat normally, I don't have a problem. So she [doctor] would say, ok, if you really are eating normally, then something's wrong with you and we need to figure out what it is…she was seeing me like 3 times a week…taking lots of blood tests trying to find out why I was losing so much weight. (I4P2).

Even while friends and family are desperately trying to intervene participants shared how they held steadfast to the belief that nothing was wrong with them:

> …of course you know, at first I was fine, and I was like there's nothing wrong with me, and Deb came over a couple of times to try to talk to me, and I was like, I'm fine, and there's no problem, and of course there [was]. (I5P2)

The rationale behind the denial was predominantly fear. Informants commented on their fear of change and the fear of the unknown, which immobilized them to taking action. Two participants shared how the length of the illness also contributed to the fear of living without it:

> I think I [was] reluctant to admit it because that would mean I would have to let go of all the horrible things I have been thinking about myself for so long, and it's almost like staying with those things are safer than letting go and not having any ground to stand on. (I6P21)

> The last part was to let go, letting go of something that I had with me, for so many years, um, was you know, I recognize I was petrified of change, absolutely petrified of change. (I9P18)

One participant shared that they knew inside that something was going on but the fear of having to address it left them feeling so overwhelmed that they "just didn't want to deal with it, just didn't want to deal with it" (I6P3). Respondents identified that coming out of denial and finding the strength to address it was the first phase they needed to master on their healing journey.

A Window of Hope

Oftentimes, individuals who are suffering from an eating disorder are told that they will have this illness for the rest of their life; that they need to learn how to cope with it, and control it, rather than learn how to let it go. This, participants shared, provides an environment devoid of hope and motivation to change. The development of hope instead tapped into informants' resiliency and provided them with the strength to address their core issues. One participant shared how she was in denial and fear until she attended an information session where she heard those who had healed share their story:

> I sat in the corner with my arms crossed staring at the floor until about half way through and then my arms kind of came uncrossed, and I was kind of like, [this is] interesting. I didn't quite know what to think about it still...but that make me go, well something's working...I called to set up an intake appointment the following week. (I5P6)

Another respondent echoed this perception as she talked about those things that ultimately lead her to commit to the program:

> ...I think a big part of it was seeing the other people, hearing their stories and seeing that hope. (I4P7)

Many respondents talked about how the sharing of hope led to discovering a part of themselves that wanted to survive and live a life free of an eating disorder:

> I ...that's what the piece is, is really somewhere inside you, it doesn't have to be a huge thing, but there [is] a part of you inside, I always use the metaphor of a window of opportunity in the person right, there's that small part of themselves that are still left that still want to be alive and be heard. (I5P23)

It is from this position that they begin to uncover their internal strength and open to the potential of healing. A young woman who suffered with anorexia for over ten years shared that her journey started with this:

> For me, it was opening myself up to the possibility that there is another way of dealing with the eating disorder stuff and dealing with other behaviours, that it wasn't hopeless, that I could change (I2P35).

Informants cohesively pointed to the development of hope as one of the major turning points in their healing process. The window of hope allowed participants to see their disease in a new light; they could begin to visualize their life without an eating disorder. This in turn encouraged participants to commit to the process of healing. As a result they created the space within themselves to address the underlying motivating forces of their eating disorder.

Finding the Pathways to Healing

Quiet Time: Agent of Change

Many respondents shared that their 'minds' were "going 24/7, constantly thinking" and that "it was no wonder I felt like I was going crazy" (I7P5). In order to

address issues on a deep level there needs to be room in one's mind and spirit. Learning to quiet the mind was a pinnacle strategy participants needed to develop and maintain in order to facilitate healing. One informant used the metaphor of a city bus to explain how her mind operated and how quiet time worked for her:

> There was a bus metaphor that I heard once that resonated with me. Its that I'm driving the bus, and there are all these people on it, my parents, friends, family, bosses, teachers, all these people and they are yelling at me, telling me which way to go, like what to do in my life. So I spend most of my time either standing still trying to decide what to do, or driving everywhere but getting nowhere. So quiet time is like letting everyone off the bus, so that the only person left is me, which is how it should be. That I am the driver of my life, that where I go is based not upon what everyone else in my life, but what I want. (I2P10)

Participants often referred to quiet time as a way of 'letting go' of all that was crowding around in their mind; to give their mind a break, and be present in their life. This reflected how respondents often felt that life was so busy that they operated on automatic pilot, merely moving from one task in their life to another with little awareness as to how their mind, body, and spirit were responding. Informants were quick to clarify that quiet time is distinctly different from meditation or yoga as one respondent commented:

> It's not like meditation or yoga that you would experience...because meditation implies that you are actively thinking about something whether it's your breathing or your body, whereas quiet time is the absence of conscious analytical thought. (I5P15).

Informants explained that they entered quiet time in much the same way as meditation, initially through patiently focusing on something such as your breathing, or a clock ticking. Instead of trying to suppress the thoughts that arise, rather one is to acknowledge them with the intention of "letting them go" (I4P18). Informants

commented that learning how to suspend active thinking was the hardest part of the healing journey, as they felt they were conditioned to always be thinking. The initial goal of quiet time is to achieve this level of silence in the mind and body for 15 minutes every day. This can then be gradually expanded to as long as you need it to be, and you can take it as often as you feel you would like to. Through repeated practice, participants advise a silence descends on the mind and the body. The process of learning how to quiet their mind, which took many participants weeks to do, provided space for true reflection and awareness to be experienced:

> ...and surrendering to the silence that is within you, that you often crave, and in doing so allowing awareness of things that were hidden to emerge. (I6P23)

It also began the process of reconnecting with their inner self that they felt was lost. Informants reflected that learning how to quiet their mind was the key tool to the process of healing; all of their learning and transformational growth emerged from this epicenter. One participant shared how salient quiet time was in her life:

> ...and when I realized that it was important to me [quiet time] ...that's when everything else started happening...and I knew within myself that I had to keep doing quiet time if I wanted to keep getting better (I5P19).

Even years later, all participants declared that they continue to do quiet time on a daily basis. The key learning that emerged from quiet time was the opening of participants' awareness, the finding and developing their sense of self, and learning how to be responsible for oneself and to oneself.

Opening Awareness

The awareness research participants refer to is not an intellectual or analytical awareness; some referred to it as a spiritual awareness, some referred to it as an intuitive awareness. All participants were clear about the distinction between the two, and all were clear that the type of awareness that you need to progress towards healing from an eating disorder is not intellectual or analytical in origin. These intuitive forms of awareness at first developed during quiet time. The level of awareness began with what informants referred to as surface awareness such as bodily awareness:

> ...there was some awareness starting, some body awareness; I'm full and I'm not going to eat anymore. (I3P11)

The awareness deepened providing informants an understanding of how their thoughts and feelings intersected with their eating disorder behaviours. One informant shared how she became aware of what she felt like while alone:

> So whenever I was alone, I was uncomfortable in my own presence, and my own skin, and I couldn't sit still for very long, and so to kind of mask and numb myself to that discomfort, being anxious, I would eat. (I6P30)

An awareness of the type of inner dialogue they engaged in also came through quiet time. One participant shared how her awareness in quiet time revealed how she was constantly talking negatively to herself, and how her developed beliefs about herself contributed to her self-harming behaviour:

> ...and understand why I was doing it, the beliefs I had developed about myself as I was growing up. Recognizing how I was thinking...not supporting myself, how I was being a really huge self critic...recognizing I was a perfectionistic person, and that I was setting myself up, I was setting myself up to not be healthy, I was setting myself up to fail and not do something well, because I couldn't manage

> doing everything and doing everything perfectly, so there was a lot of insight into how I was sabotaging myself. (I2P11)

These kinds of awareness provided participants insight into the processes that were feeding into their eating disorder. Through these awareness participants were empowered to address the 'real' issues they had repressed, moving them closer towards letting them go.

Awakening and Following the Voice Within

Seeing Through the Haze: Sensing The "Self"

A sense of self was described by participants as "...an ever present pivot point from which one can navigate the facets of one's personality and life, and that's exactly what it is, you take your self with you wherever you go" (I6P28). Similar to awareness, the sense of self as described by participants was more spiritual in nature, more organically based. According to participants it is not something that can be captured intellectually or measured using standardized tests like concepts of self-esteem or self-concept. It is an internal space that is present in their mind aside from the roles that they played in their life, the relationships they were in, the things they owned; the thoughts they had. This was exemplified by one informant who saw her sense of self as the following:

> I am completely separate from what my emotional reactions are, I am completely separate from what I say and do and think...that there is a part of me that is just me, and has nothing to do with anything else...that there is a me that stands apart from everything, that is always present". (I8P36)

Uncovering and developing a sense of self is instrumental in the healing process and was identified by informants as a key goal in the journey:

> I would say it was going back to my self...and I think all it was, was helping me shovel all the crap that was on top of who I was in the first place and rediscovering that person again and giving me room to grow. (I3P23)

This discovery of self was empowering for many participants, enabling them to take ownership in their life and developing confidence in that ownership. One participant felt that once she began to see her self as separate for what she does, what she has, and how she thinks, the path to living without an eating disorder seemed clearer to her:

> ...how my sense of self was, and that was the piece...figuring out who I was and once I knew that and understood that, the answers were already there, obvious almost. (I5P22)

The empowerment, mastery, and inner strength that a sense of self evoked in one's life was shared by a participant who had anorexia for over five years:

> Recognizing that I wasn't so lost anymore, and that I had an identity, and that I actually know what is right for me, and I know what is good for me, and I have the ability to make those decisions. I have the ability to move my life in the right direction...whereas before I didn't. (I2P24)

This sense of self increased informants' confidence in themselves and increased their knowledge of who they were. From this position of internal strength that comes from knowing one's self, participants spoke of how they could now begin to take responsibility for their choices and actions, and to see other options than engaging in eating disordered behaviour as a way of life.

Responsibility To and For One's Self

Research participants identified taking responsibility for one's self as one of the hardest challenges they faced in the healing process; it was oftentimes one of the last things to develop. This was because it was about them recognizing the control they held and gave away and why, and that ultimately they were the only person to effect change in their life. This resulted in overwhelming feelings for one participant:

> To make yourself accountable for how shitty your life is...it's absolutely petrifying, petrifying experience to have to undergo, to really look at how horrific your life had become and how horrific you are in it, and to have to go, this is, this is about me, it is not about my parents, it's about me and what I need to do differently in my life, is just, you feel overwhelmed and I think that's maybe why I avoided it so much because there is so much to be responsible for...(I2P16)

Participants began to recognize that as challenging as their lives had been, and as difficult some of their experiences had been, they were responsible to themselves to move beyond that. They began to see that blaming other people, situations, and being defensive was not going to help them heal; in order to let go of the eating disorder, they needed to let go of the defenses. Participants acknowledged that they utilized a myriad of defense mechanisms as a means of protecting themselves from the overwhelming emotions and issues that lay beneath the surface. One participant shares how difficult this was for her:

> The hardest challenge for me was to put the "I" in there and to go, this is my life, I own my life, and I need to make different choices. I need to accept that I'm the one who makes the choices, that irregardless of what's gone on in my life I have the choice whether to drink or sit with my emotions, I have a choice whether to eat the bagel or stop and figure out what's really bothering me, and that nobody has any control over that except for me. (I8P16)

The concept of supporting versus abandoning yourself revealed itself as being responsible to one's self. The mantra that "you need to adhere to your real needs and issues" (I6P15) was contrasted with abandoning yourself to destructive coping behaviors,

which only served to worsen the situation. Participants learned that you owe it to yourself to stay in the present no matter how difficult it may be, and "support yourself as you face the real issue; this was a responsibility you had to yourself" (I5P21). Defense mechanisms such as avoiding, repressing, and suppressing one could argue are common defense mechanisms. The extent to which they contribute to the development of an eating disorder and its maintenance is unknown, but respondents shared that they felt they certainly helped in keeping them "stuck in the disorder" (I 1,3,5,6,7,8).

Ongoing Construction

The process of healing is by no means an easy or a quick process. The level at which participants probed into their past, their present, and the intensity of the experiences that they shared while going through the program was evident in the findings. Every single informant went through the program more than once, and it took several months, sometimes more than a year before they considered themselves healed from their eating disorder. At the end of the first program participants reflected that their eating disorder behaviours were sometimes still present; the changes began in other areas of their being, thinking, and feeling. Informants shared the universal perspective that they intuitively knew that they had more work to do:

> ...and so when I left the group I had a better sense of some of the dynamics that had been at work and the various sorts of patterns I had followed for many years, but I wasn't quite there. (I6P1)

Though they recognized that they still had more work to do, they qualified the work as learning and that the learning was different than before. The nature of the learning to

come was framed as a building upon the laid foundation. They echoed the belief that they had made significant progress that could not be undone and left with a higher motivation and a sense that freedom from the illness was imminent:

> I felt freer than when I first started the program, a calmness and an awareness of what it is I needed to do to heal inside, and a sureness that I was on the right path. (I10P22)

One of the main themes that arose for participants to continue to build upon was a sense of internal trust that they knew what was best for them, and that this trust was stable and ever present regardless of what obstacles were to come:

> I do think that my awareness had opened up, I just wasn't acting on it, and I wasn't trusting that I knew what was really right for me. I knew my life would become a lot more comfortable and a lot less dramatic when I could trust I was making the right decision for myself (I4P25)

Participants went through the phases of healing more than once before they declared themselves healed from their eating disorder. Each step was formulated as a step towards a greater and deeper sense of self and responsibility. The positive outcomes of the healing process were far reaching in participants' lives, resulting in significant shifts for many of them. It also left them with a sense that this is an evolving process, one that they will continue to engage in independent of therapy and independent of healing from the eating disorder. The ongoing construction was formulated as a wellness model that participants identified that they have carried with them every since their healing.

The Theory of Wellness

The Wellness Model arose from informants discussing the ongoing nature of the healing process, but with distinct differences. All participants saw their wellness as more than just a journey of healing from the eating disorder. They cohesively discussed how they continue to engage in what they identified as the core components of the Theory of Healing in order to maintain wellness in their lives. This came from a direct revelation that the learning journey is never over. Several participants commented upon this directly:

> ...this is more of a life process of a life journey in the sense that it is not like to go through group and its this 8 week process are you are summed up and you are done, but that this is ongoing because life is constantly evolving. (I3P30)

> I also know that I am always going to be going through the process, because it is a choice of how I live my life, and it's a choice of how I want to be...at the end of the day it was a process of giving up the way I was living my life and choosing a better way and a way that worked for me. (I2P36)

Participants identified that there were three central dimensions of healing that they specifically carry forward to maintain their wellness: quiet time, sense of self, and taking responsibility to and for oneself. These were specifically spoken to by participants as what contributes to the balance and wellness they maintain in their life, years after their healing from the eating disorder has occurred:

> ...supporting and not abandoning myself, quiet time, staying connected to who I am is something that I carried forward to today...(I2P19)

> you use quiet time to maintain that self awareness...and I think you can always learn more, you are always in a position of developing your insight if you choose to remain aware to it, and this helps you to continue to stay true to yourself...(I3P29)
>
> ...quiet time, awareness of self, and adhering to that sense of self...so those things were instrumental in terms of getting me out of the place I was in. But now, many years later its just, I have the tools to navigate the experience of life. (I6P15)

Similarly to the healing process, informants were clear that their constant intrapersonal development was not a linear process, life still occurred with all of its obstacles and challenges. The difference lay in how they conceptualized these challenges or setbacks, and the approach they took to them:

> Nothing about the healing process is in a linear fashion, there's always going to be setbacks...its kinds of like a circle in a sense, that you go through the circle and you learn a whole bunch of new things, and then something happens and instead of it becoming a setback quote on quote, it becomes an opportunity for you to learn something else...you are always in a learning process about life. (I4P30)

> I kind of look at everything as everything happens to teach me something or show me something, its there for a reason. I may not like it, but it will bring something else in my life that I wouldn't have had if it wasn't there good or bad. (I5P35)

> You just kind of see it as this is where I need to go now and what do I need to take from that, and you are just constantly growing, and I don't know if that process will ever end for me, there is no arrival point...I'll evolve as my life will evolve with me. (I6P11)

Participants shared that through the healing process they developed the strategies (quiet time, awareness) with which to centre themselves in on a daily basis. Through this they maintain a strong sense of self and a sense of responsibility to adhere to that self and make choices from a position of strength and knowledge in who they are. This gives them the resiliency with which to approach life's challenges and obstacles. Instead of folding under the pressure, they embrace it and welcome what it has to teach them with the sense that it will contribute to their ongoing growth and development. This enables them to reduce the levels of stress and fear, avoid the use of defenses and the resiliency to address issues directly. By doing so it continues to foster an environment of health, balance and wellness.

The Process of Healing

Informants also shared broader aspects of the recovery process. These included their perspectives on their eating disorder and their experiences with interventions and the positive outcomes from their healing journey. Each of these are presented in turn.

Insider Perspectives on Eating Disorder Experiences

Respondents described their eating disorder in various ways, but all viewed their eating disorder as the secondary symptom needing to be addressed. A young women who suffered with anorexia for over ten years stated that her eating disorder:

> ... is just the surface issue, it is just the behavior, visible or invisible to everyone else, that is an indicator that you are not living your life the way you are meant to be, that there is something that you need to pay attention to and understand. (I2P3)

The overall perception that an eating disorder is a symptom rather than the primary problem oftentimes conflicted with the interventions participants took part in, including inpatient, outpatient, group therapy, psychotherapy, and self-help. The data suggests that the success of an intervention or a client's perception of it being a positive experience, is influenced by the degree to which there is a shared ideology of eating disorders between client and intervention program.

Eating Disorder as a Symptom

Virtually all research participants expressed that their eating disorder was not the main source of their problem, that the eating behaviours themselves, often the target of interventions, were merely a surface symptom or presentation of something greater that needed to be addressed. An informant who struggled with anorexia for eight years before healing commented:

> I always had the belief through all of my inpatient stuff that it was not about the food, it's never been about the food. It [was] never that I'm refusing to eat

> because I think I'm a horrific looking individual. On the surface, it's just my response, it's how I'm coping because I didn't have the capacity to cope with all the other things that were going on in my life (I2P21).

A thirty-year old woman who has been healed from an eating disorder for over five years believed that her eating disorder developed as a result of an inability to manage the difficult experiences that life presented to her:

> "...a lot of the reason I had an eating disorder was because I needed it, because I didn't have the other skills to cope with life or to navigate challenging experiences" (I6P37).

As a result participants reported that in order to truly heal from an eating disorder the underlying issues feeding the disorder need to be discovered, explored, and healed themselves. "If you actually deal with the underlying and the core issues that are driving the eating disorder behaviour then you don't need to engage in the behavior anymore." (I2P26). This is not denying that interventions that address the eating behaviours such as weight restoration and nutrition counseling do not effect change. Rather they do not effect sustainable change, providing the individual freedom from any eating disorder effect. For instance, one informant felt that simply addressing the eating disorder itself was a stop-gap measure:

> ...the process is almost seeing the eating disorder as a symptom and an indication that you are not where you are supposed to be, and all the focus needs to go to getting you where you are supposed to be instead of focusing on the eating disorder which is really just a band aid approach, you will never heal from an eating disorder by focusing on it directly. (I4P24)

These viewpoints support interventions that focus on unearthing the underlying issues of an eating disorder, and impacting change on this level, as opposed to addressing the eating disorder behavior itself as the core focus.

Eating Disorder as Loss of Self

Almost all participants noted that one of the primary core issues underlying their eating disorder was their sense of self or lack thereof. Many research participants identified a point in their life in which they lost a sense of self, described as an internal connection and knowledge of who they truly are, separate from the roles in their life, the things they own and what they do. One respondent commented that she had no sense of self, but rather was the projected image of what she thought she needed to be:

> I am only what I present, I am only what I do, I am only what I eat and what I don't eat, and whether I exercise and what I do, my whole life was based on that person and there was, there was no substance to me whatsoever ....I was a chameleon, where you can, you can mold, I just became whatever person the person standing in front of me needed me to be...there was no me in anything. (I2P24)

The same participant identified this lack of a self as the core issue needing to be addressed in therapy:

> Part of what is the core problem is that you don't have a core, you have no identity no sense of self, you are completely on auto pilot managing your life as best as you know how through your head, and without any sense of self at all.

Another respondent echoed the "chameleon" effect of trying to project the ideal version of herself, again suggesting that an absence of a sense of self is an underlying factor contributing to the development of an eating disorder:

> ...I was lost, my self was lost, I had no idea who I was, I was just going around trying to be whatever anybody wanted me to be, and it took a toll. (I4P16).

Participants connected this loss of self to an accompanying pattern of overwhelming analytical thinking. One respondent recollected how exhausting this felt:

> ...the thoughts were racing in my head constantly because I was constantly thinking about food and exercise and calories and vitamins and anything to do with my body and food and I was preoccupied with that. So I was mentally exhausted, never mind feeling empty and unfulfilled and lost in the world and so sad. (I6P11).

The same respondent recalls how this contributed to her loss of self through the development of disconnection and distancing feelings of isolation:

> ...I was still feeling isolated from myself which bothered me more than feeling isolated from those around me, I did feel isolated from them, but it was the self isolation that was so jarring. (I6P12).

These insider perspectives on the potential internal root of their eating disorders supports interventions that are geared at addressing the intrapersonal causes of an eating disorder rather than its presenting symptomology.

Eating Disorder Interventions:

The data suggest that the degree to which interventions shared their ideology of the causes of eating disorders mediated the effectiveness of the intervention. It certainly contributed to informants perception of what they found to be helpful versus unhelpful. Research participants had varied experiences with intervention efforts, including inpatient

hospital and institutions, outpatient psychiatric and psychotherapy care, and group therapy. The one commonality amongst participants was that they all were clients of The Wellness Center, which provided a holistic approach to the treatment of eating disorders. Below is a summary of their experiences with intervention efforts and what they found most helpful in their healing journey.

The Road Most Taken: Addressing the Symptom

The data indicated that those participants who sought treatment via the traditional methods currently supported in the literature found these interventions to be ineffective in effecting lasting change. This contributed to feelings of disillusionment and disempowerment in regards to the potential to heal. For instance one research participant shared how her hope of recovery was shattered as she met weekly with a psychiatrist at a very reputable inpatient program in southern Ontario:

> ...and he was apparently supposed to be the best and treated everyone and was the best one to go to, and I never felt like he got it, I just felt really really frustrated. I would try to tell him something and he would just bring it back to well you should just eat more and that frustrated me...I felt that if this guy is the best and he doesn't get it then no one will get it and there is no hope whatsoever...(I5P4).

This sentiment was echoed by another participant who spoke of how hopeless she felt after being told that she would never heal from her depression or her eating disorder:

> ...so I'd seen doctors and other people, and that year, I had doctors tell me that because I was depressed my mind works differently and you have to accept that and once you're depressed you'll always be at risk for depression and once you

> have an eating disorder you will always have an eating disorder...that's a hopeless thing to hear (I6P8).

Along with feeling disillusioned, informants spoke of how they often felt their voice was dismissed in the treatment process, as if they had no insight into their illness. One participant shared how she had been through ten different inpatient/outpatient programs with little success:

> ...I found I was like a horrific client in everything I did, I was always non compliant and I was always, they were always questioning whether or not I really wanted to get better, and I was kicked out of the programs most of the time...the one thing that was consistent across everybody was that they absolutely and completely discredited any insight that I had...(I1P7).

On respondent shared how even though she had a degree in nutrition herself she was made to attend nutritional counseling despite her petitions:

> I was working with a nutritionist too, but that wasn't helping. She was trying to put me on a food plan, trying to educate me about nutrition, but I ...already knew all of this...I really felt it was a waste of my time...and I hated going. (I4P2).

Data also indicate that respondents often felt that they were rushed through their treatment processes, and that professionals were not present during sessions with them:

> ...I felt a lot in the medical community that I was a survey data sheet and they had this piece of paper and here are the mandatory 28 questions you need to ask this person, being me, and there was no real thought it how it was for [me] the person who has to answer those questions and no real awareness of that fact that if [I] already knew all the answers to these questions, [I] probably wouldn't be there, [I'd] probably already be on [my] way to getting better, but [I] don't know any of this stuff so this is why [I] am here talking to this person, and there, and there's just this real hurried approach, I always felt I was on the time clock...(I5P11).

Therefore it appears that attempts at addressing the symptoms and behavioural manifestations of an eating disorder resulted in participants feeling disillusioned, disempowered and dismissed. Not surprisingly then, participants did not feel motivated or committed to change and there was no confidence in the professionals they were dealing with. One participant even commented that if she had chosen to remain in hospital treatment programs she would "...either be dead or still have an eating disorder...I would have stayed lost, we would never have talked about the real problems. (I4P25).

The Road Less Taken: Addressing the Cause

When informants met with professionals or programs that shared the perspective that the eating disorder was not the central issue to contend with, it resulted in feelings of relief, acceptance, and positive rapport. Informants indicated that one of the main elements that supported their healing process was a shared egalitarian relationship with the primary therapist. One participant commented directly on how this egalitarian approach in therapy motivated her to become committed to the healing process:

> ...is that she doesn't try to control things like my food and she doesn't control my weight, we're not going to be talking about diets...and that was such a refreshing relief that I think that was my biggest motivator to work with her. Was that here I was, finally going to have somebody who was not going to try to challenge me on the very things that I struggled most to control. (I2P18).

They also spoke to the program being client driven contributing to informants feeling like they had some control over their own healing:

> Even when we were looking at really challenging issues I was never forced, I could come to my own realizations in my own time, and we were talking about really important topics…like sense of self, responsibility…and I don't know why there are not a part of the other models. (I4P24).

Additionally, participants directly supported the effectiveness of the program based on its ability to address the cause of the eating disorder, particularly in a holistic way:

> …and I think that's why the program works so well, its because it didn't deal with the symptoms, it dealt with what was at the core of the problem. (I2P26)

> This was the program that was going to help me with all areas of my life, not just the eating. (I8P21).

The shared ideology of the etiology of an eating disorder, coupled with an egalitarian, client-centered and client-drive approach to the treatment process provide positive experiences for participants in therapy and a sense of empowerment over their healing process.

The Power of an Insider

In conjunction with the values and philosophy of the treatment program, one very clear finding from the data is the positive powerful effect having an "insider" as the therapist. Nine out of the ten participants specifically spoke to the ability of the therapist to empathize from a position of experiential knowledge providing hope, confidence, and proof that healing is possible. The instilling of hope of healing was especially salient for participants who had been told many times before that an eating disorder is an addiction

for life, merely to be coped with and managed. One participant shared how this helped her progress through the process of healing:

> ...it was her being able to provide me with this insight because she had access to her own awareness, in the way you were learning to, not because she had access to a manual or a methodology, and this was what really helped me help myself get to the next step. (I6P6).

Having a therapist that is the living embodiment of the outcome of the program itself leant efficacy and faith to the program, allowing participants to believe and commit to the program further:

> ...and it helped me to have someone who had lived the program because...I don't want to speak poorly of other teachers and counselors, but as someone who is searching for wellness, it is hard to have faith if the person you are with isn't exuding and embodying the qualities that they are telling you are possible. (I6P32).

Another informant shared this perspective:

> Not just because sometimes you need to ask them a question and they can give you an insightful answer...but because you need to see a living example of what's possible. (I9,P18).

These two factors, shared ideology and having an insider therapist, promoted a positive therapeutic relationship with participants and encouraged their commitment to the program. Commitment to change and the therapeutic alliance are long standing noted predictors of program success in literature.

Summary

The data revealed that eating disorders themselves were not viewed as the problem that needed solving or intervention. Rather, the most predominant underlying issue noted in the current study is participant's loss in their connection to sense of self. As a result those intervention programs that supported this ideology offered the most supportive environment and significantly contributed to the success of the participants healing. In the next section I discuss the lasting positive outcomes participants noted that resulted from their healing process.

Launching the Healed Self

Healing from the perspective of the participants consistently involved looking at their disorder from a holistic perspective, incorporating their selves, their family, friends, community and larger societal beliefs. As a result the changes that resulted in the participants' were holistic in nature as well. There are many integral ways in which the participants changed, but the most prevalent noted in the data was in their growth of deep awareness and sense of self, rebalancing, letting go of the crutches, and their shift in values.

Deep Awareness & Sense of Self

As participants continued to engage in quiet time on a regular basis they expressed how their awareness continued to deepen, and they began to take issues, concerns, and insecurities into quiet time to develop their awareness of them. This enabled them to deal with the issues in a positive, non-judgmental, and supportive

manner that "originated from their center" (I6P10). As the practice of quiet time became more second nature to participants they revealed how quiet time became a way in which they could connect with their inner self. This helped them to maintain a strong sense of self that would no longer waiver in the face of life challenges, again operating from a secure base. One participant summed up how she views her sense of self now that she is healed from her eating disorder:

> I have thoughts, but I am not my thoughts, I have feelings, but I am not my feelings. I have desires, but I am not my desires. I have a body, but I am not my body. I am a self, a center of pure consciousness. (I6P22)

Having this awareness of one's self provided participants the security and trust to move forward in life without fear, and without needing the crutch of an eating disorder to shelter them (I4P12). For instance one participant commented how her strong sense of self helped her navigate the inevitable life challenges she faced in her life:

> ...it's not about not ever getting yourself into a jam or not having challenges, or being perfect. It's about knowing that you have the inner resources to deal with the situations life throws at you, and have the courage to be open to experiences rather than fear of a future pain or rejection. (I7P25)

The connection to their sense of self also allowed informants to identify and address the real issues that cropped up in their lives, and an awareness that would not allow them to escape from themselves through defense mechanisms. But it also provided them with a non-judgmental awareness of their strengths and limitations and to see creative solutions to such problems.

Rebalancing of Perspectives

Clouded judgment was prevalent amongst research participants prior to their healing. Informants reflected an inability to see things clearly, and to possess a pessimistic and blaming perspective. This contributed they felt, to the entrenchment in the eating disorder. The extent to which this perspective operated in their lives was not fully understood until they began practicing quiet time. Through quiet time participants reflect how their perspective shifted, the lens through which they saw things became clearer, resulting in options of responding as opposed to reacting:

> ...this slowing down of the mind that you practice in quiet time then enables you to have a clearer mind when you are out of quiet time...you are better equipped...to see things as they are and choose to respond if appropriate and as appropriate rather than reacting...(I6P23)

The perspective is akin to stepping back and pausing in the moment to reflect on the dynamics that are being presented and see things through the eyes of many viewpoints. One participant commented on how quiet time enabled her to reflect before responding to situations, resulting in less turmoil, less conflict, and less "drama" in her life:

> ...now I have the tools to slow down and say what's happened, why do I feel this way, and what is my intention if I do that, or what is the pay off, and I am able to do all of that but wouldn't be able to do that if I wasn't able to slow down my mind, and that has to do with the mind training you do in quiet time (I9P24)

This perspective taking supported participants in improving their relationships with their family and friends, reduce the level of conflict they engaged in, and also increased the level of empathy they shared (I5P20).

Letting Go of the Crutches

Eating disorders were viewed by many participants as crutches in their life; something they leaned on as a tool to cope. Letting the crutches go was a slow process, and not one that the respondents maintained conscious awareness of. One informant shared her process of letting go:

> ...giving up the eating behaviours, that it was a process, and realizing I was no longer engaging in those types of behaviours without actually tackling any of them head on. That over time, slowly through the process, you know, and working at the quiet time, and working at uncovering the realizations and developing my awareness and my insights into who I was, and where I was and where I needed to go, that, um, the eating behaviours didn't need to be a crux anymore for me and so let them go. And I let them go without consciously recognizing I was letting them go. (I2P23)

Not one participant was able to articulate when exactly their eating became healthy again, when the thoughts about eating and body image and body weight ceased to be a part of their stream of consciousness. The when evaded them. One informant described it as just waking up and realizing that it was no longer an issue:

> It just kind of went away over time. I remember waking up one day, right, so I actually just became aware of the fact that it wasn't an issue, but I never consciously tackled it. I never decided that today I am going to eat such and such. (I5P34)

As participants continued to work on the other issues in their life, the disordered eating diminished on their own until they no longer existed, and none the wiser were the participants as to this seemingly unconscious process.

Value Shift

The data indicate that participants underwent significant shifts in their identified values from before healing through the eating disorder to after. Many informants shared that prior to healing they valued superficial, socially sanctioned things such as status

symbols. For example, one participant shared how she valued those things that she felt other people valued, those things that would others would appraise her for:

> ...I was just completely atheist, really just motivated by money and power and my looks, and my body and marks. I would cheat to get high grades, and didn't even care about learning anything, just wanted to get high grades. (I4P20)

This theme continued in another research participant who initially was choosing her career path based on how much money she thought she would get from it, rather than what she was passionate about:

> Before I was obsessed with money and wanted to be rich and look good all the time, and very superficial, that's what motivated me. Like I wanted to be a doctor or a plastic surgeon because I heard they made good money, so I had different values for sure. (I9P26)

These external values dramatically shifted into some universal themes amongst informants, particularly around the withdrawal from manufactured society, a greater connection and responsibility to the environment, and a greater value of maintaining balance in their life. For instance, one informant shared how she disowned many of the things that she valued before:

> ...my outlook is completely different...I'm not materialistic, I don't want for a lot of things...I don't buy into a lot of the social prescriptions. I don't watch TV anymore...and I don't read the headlines in newspapers...I have a much greater appreciation for life, for the environment I am in, for the simple things in life which are my relationships... (I2P31)

She further went on to talk about she will never put her health at risk the way she did in the past in order for to "get ahead" in her career:

> It's ok, it's ok for me to live my life how it works best for me, and how I can maintain my own health and well-being and identity through that, and I'll never compromise that anymore. (I2P15)

The balance that informants talked about refers to adhering to a level of self-care that they identified was absent while they were engaged in their eating disorder. It is through this moving to a value of self-care and balance in their life that resulted in participants re-evaluating what would contribute to that. There was a distinct shift of valuing and engaging in different activities that one informant noted:

> Taking care of myself, doing quiet time, spending quality time with my self, my spirituality, spending time with my family. Things like being honest and true to my self, paying attention to people, connecting with people in a real way, connecting with animals and nature, being close to the environment. (I4P21)

There is present in the data a common theme that reflects a sensitivity "towards social awareness" (I6P5) particularly as it relates to the desecration of our environment and the errs of humanity against one another. This developed through quiet time as one informant claimed that she discovered a "higher social consciousness and social connectedness" (I5P29) through quiet time.

Summary of Findings

This chapter presented the grounded Theory of Healing as well as the wellness model participants identified they carried forward with them from their healing journey. Participant's perspectives on their eating disorder and helpful and unhelpful experiences of treatment interventions as well as the enduring positive outcomes from their healing that continue to inform their growth and development were also presented.

Chapter 5. DISCUSSION

In this chapter I discuss the major findings of the study that formulated the grounded theory of healing in relation to other investigations presented in the literature. I will then relate the findings to the theoretical framework that guided the current study, and demonstrate the value of the data in understanding what the healing process from an eating disorder encapsulates. I then discuss the implications of the findings in relation to current treatment modalities for eating disorders, explore the limitations of the current study, and outline some opportunities for future research. Lastly, I will present some personal reflections of my own journey through the present study.

Review of Findings

Grounded Theory of Healing

Opening to Change

Participants all identified that they spent some variable amount of time in denial of the fact that they were suffering with an eating disorder. Respondents shared that they denied they were suffering to themselves, to their families, friends, and even members of the medical community. Denial is recognized in the literature as a common stage amongst all addiction-oriented disorders, though with greater emphasis. Denial is cited frequently as being one of the most pervasive concerns of eating disorders as it presents a significant barrier to recovery (McHugh, 2007; Wilson, Grilo & Vitousek, 2007; Steinhausen, 2002). Conversely, participants in the present study spoke very little of their denial period, acknowledging that it existed but failed to have it account as a barrier

to healing. Rather the absence of hope in treatment interventions played a larger role in their motivation and commitment to work towards recovery.

In order for individuals to move out of denial and into a position of willingness to acknowledge their disorder and enter treatment there needs to be a hope for something better than what they have. The concept of hope has been gaining strength in models of recovery and wellness within mental health (Deegan, 2001). Hope is seen as a "primary necessity...it sustains the survivor...for the long journey that lies ahead" (Linge, 1990) and has been correlated with reduced recidivism (Irving, Seidner, & Burliz, 1998).

Hope is noticeably absent from the literature on eating disorders. Oftentimes individuals are constantly being toldmessaged that eating disorders are a life long illness; that one can never fully heal from them. It is curious as to whether this public messaging and medical "wisdom" contributes at all to individual's reluctance to acknowledge that they have an eating disorder. How many individuals charged with non-compliance or an unwillingness to address their eating disorder are simply de-motivated because healing is promoted as not possible? Certainly for the participants in this study, the witnessing of stories of healing from others presented as a key transformational moment. It resulted in bringing some out of denial and to a position of openness towards healing. This increased motivation and commitment to working towards change.

Finding the Pathways to Healing

There were two key phases identified by participants that laid the foundation for subsequent healing: quiet time and awareness. Research participants shared that learning to quiet their mind was to suspend analytical thinking for the purpose of creating room

for insight and a connection to self. Through quiet time informants advised that they were able to deepen their awareness and sense of self, which were key elements to their healing.

There has been little research investigating the use of reflection, meditation or quiet time in the healing process of eating disorders. The participant in a case study by Matoff & Matoff (2001) identified the use of reflection time as a means of reconnecting with her emotions, which reduced relapses. However, due to the difficulty in operationalizing quiet time, it is hard to know for certain whether we are comparing qualitatively similar concepts. The closest approximation to quiet time in the treatment of eating disorders is with the use of prayer in theistic approaches to eating disorders (Berrett, Hardman, O'Grady & Richards, 2007; Hardman, Berrett, & Richards, 2008). This however places reflection within connections to religiosity versus the connections to self as described by participants.

Quiet time is seen by participants as a means towards spiritual connection with their deepest self. Though there has been a rise in spiritual connection amongst Western society, very little has been done to incorporate it into forms of healing in eating disorder research. This is particularly true as the type of spirituality discussed by informants is not one tied to religion. Garrett (1996) is the only other study to emphasize connections between mind and body on a spiritual non-religious plane, however does not identify the process by which to accomplish this. Quiet time as proposed by research participants in the present study is the means to do so.

All ten participants identified the development and deepening of their awareness as a requirement for their healing process. An awareness and understanding of oneself

and the disorder is arguably common sense if one hopes to move beyond the disorder. The awareness that participants spoke about in this study reflected an awareness both of the internal workings of the individual, and of the wider environment and societal climate that they are a part of.

Similar to quiet time, the use of awareness has received little attention in the literature on recovery from eating disorders. Research on awareness and eating disorder has primarily focused on the emotional awareness, predominantly the presence of alexithymia in eating disorders (Spiranza et al., 2007; Montebarocci et al., 2006). Alexithymia is a disorder by which an individual struggles in understanding, processing or describing emotions. Present in the literature is a recognition that the current treatment of eating disorders does not necessarily address alexithymia (Iancu et al., 2006). There has also been a recent emergence of "mindfulness" in regards to eating practices with inpatient treatments. This however, is akin to bodily awareness, which although is certainly an element discussed by participants, it is viewed only as surface awareness.

It can be argued that awareness is present in cognitive behavioural treatment approaches, however the focus is generally on the cognitive restructuring of the individual. Cognitive behavioural treatments have shown efficacy in altering eating disorder symptoms such as weight and shape concerns (Cooper, 2003), negative affect (Wilson, Fairburn, Agras, Walsh, & Kraemer, 2000), body image distortion (Bowers, 2008) and need for control (Fairburn, Shafram & Cooper, 1998). Alternatively, participants here used awareness to gain access to deeper insights into the issues underlying their eating disorder and the ways in which their own choices are supporting the maintenance of the eating disorder behaviours. Body-image distortion and negative

affect are seen as surface symptoms of a deeper underlying issue. Recovery along these dimensions will not result in healing from an eating disorder.

Awakening and Following the Voice Within

Seeing through the haze: Sensing Self

Finding and developing a sense of self was recognized as both an outcome of quiet time, and also as the means by which participants began to rebuild their lives in the absence of an eating disorder. Virtually all participants spoke of how lost they were in the beginning, a lack of knowledge about who they were, what they were about, or where they were going. This impacted informants' ability to make positive choices from a position of wisdom. This served to further their isolation from their self, and promoted the continuation of the eating disorder, as they did not have the trust and connection to self to see other options.

Most research on sense of self is imbedded in psychological research of self-regulation (Schupak-Neuberg & Nemeroff, 1992), self-concept (Barth, 1989; Barth, 1988) identity (Winston, 2005) or self-esteem (Granek, 2007). The 'self' that is defined by participants is qualitatively different than the way it has been conceptualized in the research noted above. The 'self' as described by participants is not a concept that can be studied or measured; it is an internal awareness of a constant presence. Participants struggled to define their sense of self, as most felt it was un-definable, only knowable through experiential means. This is probably why literature on the study of self has operationalized self along a continuum of esteem, worth, or identity. Despite its

challenges of definition, the role of self in the treatment of eating disorder fails to be explored as a relevant construct in treatment literature.

Responsibility To and For One's Self

Learning the ability to take responsibility for one's thoughts, feelings, and choices, was something that could only begin to be accomplished once informants had at least begun to develop their awareness and sense of self through quiet time. The self-responsibility proposed by the informants in this study is different than the dimension of control, which is discussed at length within the eating disorder discourse (Fairburn, Cooper, & Shafran, 2003; Garner, Vitousek, & Pike, 1997). The responsibility that participants shared in the present study discusses not only a responsibility for one's self and the choices one makes, but also the responsibility one has to one self. This is a relatively new concept that cannot be located within in eating disorder literature.

The notion that one has a responsibility to oneself incorporates the belief that we owe it to ourselves to be true to who we are first, to honour our inner nature, to listen to our inner voice, to love ourselves and follow our intuitions. Once we fulfill this responsibility to our selves, it is easier to be responsible for ourselves, as our choices, actions and decisions will be made from a position of inner strength, awareness and knowledge. The only use of responsibility in recovery literature is a discussion of how to develop more personal responsibility in the recovery process (Troop, Schmidt, Turnbull, & Treasure, 2000; Wilson et al., 2000) or of how responsible mental health professionals can hold individuals for developing their addictive disorder.

Ongoing Construction

It is extremely clear in the literature that the short-term numbered sessions devoted towards recovery from an eating disorder do not necessarily equate with successful outcome measures (Steinhausen, 2002; Striegel-Moore & Cachelin, 2001; Silverman, 1997). Yet across the board most inpatient and outpatient individual or group treatment programs are controlled for how many sessions or weeks. The concept of learning as an ongoing process has been intimated in other research into the recovery process, however there remains an end point in which recovery has been achieved (D'Abundo & Chally, 2004). The ongoing nature of the learning process identified by participants in the current study is unique in the literature on eating disorder treatment and recovery. This is especially true as the ongoing nature is more reflective on an evolving spiritual journey that is akin to journeys of faith as discussed in theistic literature (Richards, Hardman, & Berrett, 2007).

The Wellness Model

The model of wellness as proposed by the current study is a unique contribution to the literature on recovery of eating disorders. Currently, there are no models published that outline the ways in which those who have healed from an eating disorder maintain their level of wellness. The literature is fraught however with publications identifying the rarity of lasting recovery and the nature of recidivism (Halmi, Agras, Crow, Mitchell & Wilson, 2005; Crow & Nyman, 2004; Ben-Tovin, Walker, Gilchrist, Freeman, Kalucy & Esterman, 2001; Hertzog, Dorer, Keel, Selwyn, Ekeblad et al., 1999). This is a result of the research focus currently being on the etiology of eating disorder, its prevalence, and

resistance to treatment. Very few studies focus on those who have healed from an eating disorder (Lamoureux & Bottorff, 2004).

The wellness model builds upon the phase of ongoing construction within the healing model; that life is an evolving journey of self healing. Participants viewed themselves and their interaction in the world as a constantly evolving complex system, where learning about oneself and their external world was always in progress. Years after they considered themselves healed from the eating disorder, they continue to do quiet time and talk about remaining connected to self. This then allows them to be "true to themselves"; honouring who they are on a deep level and never ignoring the needs and issues that ultimately arise in their life. These are the foundations of wellness. Of significance is the recognition participants paid to the "never ending" nature of their evolving healing. This ongoing healing does not have an end date or point of completion as is postulated in some other theories such as Maslow's "trancendance". Rather the participants' recognize that as long as you remain open to the potential of growth, growth will occur. The language used in research on post-traumatic growth, the concept of "ongoing healing", is in a similar vain to what participants describe in the present study (Calhoun & Tedeschi, 1998).

Insider Perspectives on Eating Disorders and their Interventions

Participants were very clear on their view of an eating disorder as being the secondary issue needing to be addressed in therapeutic interventions. Food, nutrition, healthy exercise, and re-framing of their body image distortion were just the surface issues. Rather, they saw the eating disorder itself as a symptom, as a physical

manifestation of the interpersonal turmoil that was going on within. Of particular note, the underlying issue commonly cited was a loss of sense of self. The sense of isolation and alienation they felt from themselves, and a lack of intimate and intuitive understanding of who they were, separate from their roles and possession was paramount. As a result they "fell into" an eating disorder as a crutch, as a coping tool to help them navigate the challenging experiences of life, and protect themselves from the painful reality of not knowing who they are.

Not surprisingly then participants identified that any program that focuses on the symptomology of an eating disorder such as body image, weight restoration or nutrition counseling, was ultimately unhelpful in healing. However, this is not to say that these approaches are not helpful at all. Rather it is my interpretation that it is the sequencing of therapy approaches that needs to be considered. I would suggest that if these interventions were presented either in conjunction with the work on the deeper underlying issues, or were presented after the healing process began, they would be better received.

Secondary to shared ideology of an eating disorder participants identified that having an insider as a therapist positively increased rapport and trust in the program. This is supported in literature as many studies have recognized that the therapeutic alliance is the greatest predictor of treatment outcome (Kim, Kim &Boren, 2008; Barrowclough & Donmall, 2005; Howgegolm, Yellowlees, Own, Meldrum & Dark, 2003). Additionally, many other treatment programs, particularly addiction oriented programs, employ recovered addicts as counselors. This lends to the efficacy of the treatment and promotes hope and commitment amongst the clients. What is unique about

eating disorder treatment is that most programs, especially inpatient programs will not permit past clients to volunteer or be employed as counselors in the program. The reasoning behind this is not entirely clear; however one could assume that the philosophy of "never fully recovered" that surrounds eating disorders may contribute to this standpoint. Ultimately respondents identified that in order for a treatment intervention to be effective there needs to be a shared ideology of the meaning of the eating disorder, an egalitarian and empowerment focus of the program, and a genuine therapeutic relationship rooted in empathy and hope.

Launching the Healed Self

Very little research has been conducted to reveal the outcomes of healing beyond that of the dissemination of the eating disorder behaviours. Most common outcome measures of recovery programs speak to weight restoration, improved affect, and reduced body image distortion (Fairburn, 2005; Halmi et al., 2005; Nilsson & Hagglof, 2005). What is most interesting is the stark omission of these outcomes by participants in the present study. Though participants shared that eating disorder behaviours disappeared slowly, they identified the healing that occurred in other areas of their life was what ultimately led to the release of the eating disorder behaviours. There were three aspects of the healing outcomes that were most striking. The first was the strong security in knowing that they would never return to their eating disorder behaviour. This falls in the face of a significant body of research that would support the opposite – that "recovery" is possible, but often realistically, not sustainable.

The second was the nature in which the eating disorder behaviours were 'let go'. Participants shared that they did not consciously and actively work on changing their eating disordered behaviours because this was not encompassed within the program. This was something that they uniformly stated was a positive aspect of the program. Instead of working directly on the eating disorder behaviours they worked at developing their awareness, their sense of self and their ability to take ownership for their decisions and ultimately their lives. This resulted in the slow withdrawal of the eating disorder behaviour; with increased awareness and sense of self came a decrease in the need to engage in those behaviours.

Lastly, the shift in values experienced by participants is noteworthy both because of the dramatic nature of the change, but also in the consistency across participants. Participants identified that their value system shifted from an extrinsic base such as money, prestige, and status towards more intrinsically valued ideals. These included the value of silence, time, family, and the environment. What is significant about this transition is that the newly held values were common amongst the majority of participants. This speaks to the power of becoming connected to oneself and the connection to a deeper collective consciousness that guides their value systems.

Findings in Relation to Theoretical Framework

As presented in Chapter 2, three theories were used to guide the development and implementation of the current research: psychodynamic theory, ecological systems theory, and resiliency and post-traumatic growth. A review of the findings yield a lack of fit with the theoretical framework presented. Each will be discussed in turn.

Jungian self-psychology, a branch of psychodynamic theory, the notion of striving for individuation and self-realization was somewhat supported by the data. Participants discussed their evolving journey of growth and development, which may be seen as akin to self-realization. The difference is that unlike Jung, the data do not support and "end point" in the journey of growth and development that is identified in self-psychology. The ways in which life struggles and obstacles are framed are also different between the two. Self-psychology views "troubles" as failures of the process of individuation to be resolved. Conversely, the participants view "troubles" as opportunities to learn and grow and integrate on the road to wellness. The goal of self-psychology is the individuation of the self, the process by which one becomes differentiated and an indivisible whole. The goal of the theory of healing and the wellness model is to develop a sense of self through awareness and quiet time and to navigate through life from this centre. This will help support balance and wellness in the person's internal being and interpersonal relationships.

Little support was found for the use of ecological systems theory in the healing process from an eating disorder. Similar to the theory of healing, ecological systems theory supports that the self interacts with all systems the individual is a part of. This impacts and alters the systemic relationships within and between each system. The ecological systems theory however, fails to address the notion of self itself, which is considered paramount in the healing from an eating disorder. There is no discourse on the system of the 'self' or the relationship one has with oneself. It missed the core relationship upon which healing occurs: the relationship with self. Without a sense of

self one cannot begin to enact change within the other systems present in the individual's life.

Resiliency is certainly present in the participants in the present study. It is not however the framework that best describes the process of healing. The findings support that through the development and awareness of self, the ability to see options for oneself and one's inner resources are discovered. But the process as described in the data is more congruent with a spiritual journey of awakening and strengthening. The use of the word spirit in the study is not in a religious context. Rather it is reflective of the fact that participants see themselves as spiritual beings that possess a constant inner presence that is self.

Interestingly, spirituality is recognized as both a protective factor when facing adversity and as a resource to utilize when recovering from trauma (Richards, Hardman & Berrett, 2007; Berrett, Hardman, O'Grady, & Richards, 2007). Spirituality in the literature still falls primarily amongst the field of religion, and though research does acknowledge openness to other meanings of spirituality it still primarily views spirituality as a "belief or connection to God or a Higher Power" (Richards, Hardman & Berrett, 2007, p.11.). There are recent trends in Social Work literature to incorporate spiritual concepts such as mindfulness in the therapeutic milieu which may prove useful in future research (Birnbaum & Birnbaum, 2008). Though the meaning of spirituality described by participants is not religious in nature, the use of spirituality in the healing process of eating disorder should be investigated further. The literature use of spirituality is still placing the curative factors leading to healing outside the individual, whereas participants clearly located the resources for healing within themselves.

Implications of Findings for Treatment and Intervention

The present study offers valuable new perspectives into the recovery process of an eating disorder. The findings firstly support that healing from an eating disorder is possible. Treatment for eating disorders needs to embrace and promote the hope of healing first and foremost in order to instill individuals with the belief that they do not have to suffer for life.

Treatment approaches need to support long-term therapy options for individuals suffering with eating disorders. Currently, most programming for eating disorders are outpatient, group format, and of limited duration. Since the behaviours associated with eating disorders are not the issue requiring change, a longer therapeutic process is needed to uncover the underlying issues resulting in the eating disorder. The focus on controlling for and changing eating disorder behaviours, specifically around food intake and exercise are to be avoided. The overall health of the individual needs to be monitored and health concerns addressed as they arise. However engagement in nutritional counseling and/or exercise programming should be implemented during the termination phase of treatment.

The focus of treatment needs to be on developing the individual's awareness and insight into the internal dynamics driving their eating disorder behaviour. As reflected by participants, specific attention should be paid to attending to the individual's sense of self. This includes both developing the connection to self and also in fostering its growth. The use of some form of reflective practice such as quiet time is vital to developing the individual's awareness and connection to sense of self. This awareness is

to be used to guide the treatment focus. The primary therapist needs to engage the individual in a shared process of treatment, allowing their thoughts, feelings and insights to guide the treatment process.

Lastly, the findings suggest that the individual leading the program needs to have direct or at the very least indirect firsthand experience with an eating disorder and their own healing process. One of the factors that contributed to negative experiences with treatment approaches for participants is that therapists and programs they initially went to did not have knowledge and understanding of eating disorders. The program leader should also be engaging in the same practices as promoted within the treatment program: active use of quiet time or other reflective practice, maintaining a deep connection to self and an open awareness. This lends both efficacy to the treatment program as well as promoting therapeutic alliance with individuals seeking help.

In terms of intervention the study's findings suggest that it is the fragmentation of self that created an added vulnerability towards developing an eating disorder. Consequently, strategies aimed at building and maintaining a sense of self may be a significant protective factor against the development of an eating disorder. This speaks to the implications of Western society's political and cultural landscape and values. The present value of individualism and competition in Western society promotes a disconnection from our environment and our inner states of being. The constant fast paced nature of the work and social environments we are a part of promote and some would say demand an ignorance of the needs of the self. These all correlate to the rise in both physical and mental illness that Western society has been witness to over the last two decades. There needs to be a shift in our culture that embraces and values individual

needs and provides the room to accommodate them. This can be implemented in a variety of creative ways. Building in scheduled breaks throughout the work day which management authentically support and encourage, or providing "quiet" spaces for employees to retreat to are only two suggestions. Alternatively, promoting more mindful based activities in conjunction with the physical fitness that some companies provide to their employees.

The value of analytical and logical thinking also promotes a disconnection between an individual's mind, body and spirit. Beginning with a woman's entry into formal education systems, she is encouraged to place a higher value on her cognitive abilities over socio-emotional ones. One could suggest that promoting of other ways of using one's mind, as is found in quiet time in the present study would help foster a connection to self that remains present throughout one's development. This can be achieved by schools continuing to promote a "quiet time" within the curriculum. In junior and senior kindergarten children are encourage to take a "time out" during the day whereby they sit or lay down quietly, as a means of giving both body and mind alike a rest. There is no reason why this could not be continued into the higher grades, instilling a valuing of taking time out of one's day to reconnect with one's self. These are just some of the ways to implement strategies aimed at fostering a continuous connection to self.

Limitations

This study focused primarily at developing a theoretical framework that describes the process of healing from an eating disorder. Of primary limitation is the sample used

for the present study. The sample consisted of only ten women who all participated in the same treatment program. It is imperative that the experiences of healing occurring through other treatment avenues be explored and examined in their own right. Similarities and differences need to be analyzed for a more comprehensive understanding of the process of healing.

The primary therapist at The Wellness Centre was healed herself from an eating disorder. This provided a powerful effect in engaging participant's trust and belief of healing in the program. This is a treatment limitation as many treatment programs are offered by individuals who have not suffered from an eating disorder nor healed from it. Subsequently, the effect is variable.

Additionally, the experiences of men may be qualitatively different than their female counterparts and deserve their own focus of study. The present research involved only one woman who was not from European descent. The impact of culture on eating disorder healing remains unknown and requires further investigation.

The study only explored the experience of recovery from the perspective of anorexia. The healing process from bulimia or binge eating may present as qualitatively different. However, it is noted that the data omitted by the one participant who healed from binge eating was consistent with those healed from anorexia, in terms of the process of healing itself, as well as the overarching themes presented here.

Throughout the present study I was committed to allowing the voices of the women to prevail. However, being the researcher I brought biases into the research. Ultimately, I chose what data to include and exclude. Readers may make their own interpretation of the data presented.

Lastly, though the focus of the research was to develop a deeper understanding of the experiences of healing from an eating disorder to assist in formulating a theory of healing, the "how" was not fully explored in the present study. The particular content of the program the women participated in was not analyzed, nor the ways in which the participants psychologically worked through the issues they identified throughout the healing process. Key insights might be discovered that could further refine the theory of healing through a closer examination of the psychological work participants experienced as part of their healing process.

Future Research Opportunities

There is limited research on the healing process from an eating disorder from the perspective of those who have healed. A replication of the present study with other individuals who consider themselves healed from an eating disorder would be beneficial. Of particular importance will be to expand the sample of participants to include those who have healed through other means or other intervention programs besides The Wellness Centre. It would be beneficial to compare the themes that emerge as well as the phases of healing identified. This will enable clarification of the process of healing which will provide practitioners a better understanding with which to implement treatment interventions.

Additionally, more research is needed that is specific to the different typologies of eating disorder. It is my contention that though the presentation of the eating disorder behaviour may be different, the underlying causes and effective treatments are not

necessarily mutually exclusive. More research is obviously needed to substantiate or refute this hypothesis.

Research on the process of healing using participants from different ethnic and cultural backgrounds is sorely needed. The impact of culture on the healing process needs to be investigated and captured, specifically through the lens of spirituality, which can be more prevalent in other cultures than in Western society. The process of healing from the perspective of a male's lens is also glaringly absent from the current research. Whether gender plays a distinct variable in the process of healing is presently unknown, as no qualitative study has been undertaken that looks at men who have healed from an eating disorder and the process by which they healed.

Summary

This chapter compared the process of recovery and the phases noted within with existing literature. Some support was found for the different dimensions within the theory of healing, however the present study purport findings that deviate quite strongly from established literature on the treatment of eating disorders. This it is felt reflects the sparse literature on the recovery process itself and that from the perspective of individuals who have recovered. The treatment implications were discussed as well as the limitations of the study. Finally recommendations for future research were outlined based on the findings of the present study and gaps that remain in the treatment literature.

Conclusion

This study has looked at the process of healing from an eating disorder from the standpoint of those who have healed. Ten women who have self-declared as recovered

were interviewed about their personal experiences. Grounded theory was used to code and analyze the responses of the participants. The theory that emerged identified three phases of healing. These phases include: Opening to Change; Finding the Pathways to Healing; and Awakening and Following the Voice Within. These three phases encompassed seven sub-phases of recovery which included: Denial; A Window of Hope; Quiet Time: Agent of Change; Opening Awareness; Seeing through the Haze: Sensing Self; Responsibility To and For One's Self; and Ongoing Construction. These phases occur in a non-linear, recursive fashion, whereby participants developed learning and insight and continued to build upon that as they continued to move through these phases again, in an iterative interaction.

Ongoing construction lead to the development of a Wellness Model that supported Quiet Time, Sense of Self and Responsibility To and For One's Self as dimensions those participants utilized on an ongoing basis through which to continue their evolving growth and development.

The findings from this study suggest that the eating disorder behaviour is merely the surface physical manifestation of deeper interpersonal issues that need to be explored and processed. It suggests that a lack of sense of self is a pinnacle issue to be addressed in treatment. The findings further suggest that transformational change, which is possible through an eating disorder need to encompass all areas of an individual's life, not just the behaviours themselves. Despite numerous challenges towards healing many positive outcomes are experienced. Some prevalent aspects include the following: developing a deep connection to self, dramatic shift in values from externally to internally oriented, and clarity of one's perspective devoid of judgment.

The results of this study provide a positive framework of hope through which to heal from an eating disorder. Not only can one overcome an eating disorder but also one can live without fear of ever having to return to it. It provides a framework that suggests that if one takes the time to deal with the underlying issues of one's eating disorder that sustainable change is possible.

Personal Reflections

Due to the intimate nature of qualitative research, the process of undertaking a qualitative study places significant demands on the researcher. The researcher essentially lives with the data for long periods of time. As a result the researcher often goes through her own process much like informants in a grounded theory study. This section discusses my own journey through this research process.

Since creating a theory of healing from an eating disorder I felt as if I went through my own transformational process. This process started with feelings of doubt about my efficacy as a qualitative researcher. Coupled with this was a sense of overwhelming fear that I would never finish the thesis on time. Coming from a predominantly quantitative background in psychology I very quickly learned that qualitative work is a beast in its own right, expecting much of the researcher in order to maximize the value of the projects contribution. Many times throughout the project I wondered why it is that I did not choose something simpler, like a quantitative project to get me through my two years of study. Yet I knew intrinsically that this was the route that I needed to go. A qualitative grounded theory study was the only way to emancipate

the voices of those recovered, and present findings that would hopefully fill the gaping voids in the current literature.

I also became aware that my own personal journey of healing though would often be the source of continual motivation was also a source of great pressure – I needed to get this right. Interacting with the data and the informants of this study served as reminders that I already possessed the resources within me to help support me through whatever obstacles were presented. I found that I needed to engage in quiet time on a more frequent basis in order to remain grounded and to remain separate from the research. I am not the outcome of this research; it does not represent who I am. Having said this I also became aware that I had significant biases coming into this research that I needed to maintain a conscious awareness of. I engaged in a lot of stream of conscious memoing in order to process through the various emotions and thoughts I experienced through this process.

I realized that I had a preconceived notion of what the theory of healing would be, based on my own journey through healing. I needed to set that aside and continually challenge myself on whether or not I was interpreting the data through that lens or not. This active awareness coupled with ongoing quiet time enabled me to say with confidence that the findings presented here are representative of the participants in this research and do not serve to promote my own agenda. I learned that I am not here to get it "right" I am here to present a vision of healing through an eating disorder, to present an alternative perspective on eating disorder treatment, to hopefully open the doors enough to find room for more conversations to be had. I learned that this research is not about me, it is not about my being a 'perfect' researcher or a 'perfect' writer, it is about them,

the voices of the women who I interviewed, and it is about the power of their story and their voice. It is about my ability to represent them, and I think I have done them well.

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Appendix A

Recruitment Letter

Dear Prospective Participant,

I am a student at Laurier University, completing my master's degree in Social Work; and conducting my master's thesis on eating disorders and recovery.

I am looking for women who have currently recovered from anorexia nervosa to participate in a 1 ½ to 2 hour research interview. The interview will be arranged at a mutually convenient day and time; and can take place at a site that is convenient and comfortable for you.

All of the information collected in the interview and subsequent conversations will be held in the strictest confidence, and all reported data will remain anonymous. You will be provided an opportunity to give feedback to me, the researcher, regarding the resulting paper prior to submission. My hope is that the interviews will beneficial to you, by giving voice to your journey, and to the eating disorder community as a whole. Hopefully a deeper understanding of the recovery process can assist in the development of treatment programming for anorexia nervosa.

If you are interested in participating or would like further information, please contact me at 519-831-9905 or email elishavanharte@hotmail.com. I appreciate your time and consideration.

Kindest Regards,

Elisha Van Harte, MSW (candidate)

Appendix B

WILFRID LAURIER UNIVERSITY
INFORMED CONSENT STATEMENT
Voices of Anorexia Uncovered: The Healing Journey Unveiled

Researcher: Elisha Van Harte
Phone: 519-831-9905
Email: elishavanharte@hotmail.com
Supervisor: Dr. Robert Basso, Wilfrid Laurier University, Faculty of Social Work
Email: rbasso@wlu.ca

This form provides you with information about the research project you have voluntarily chosen to be a participant in and to obtain your informed consent.

PURPOSE

Anorexia nervosa can be a life threatening illness to those who suffer from it. Current research in the field primarily has looked at the etiology of the illness. Outcome studies are primarily quantitative in nature and have revealed that there is no treatment modality that consistently results in longitudinal recovery. What appears to be absent from the literature is the exploration of the recovery process from the perspective of those who have recovered. The purpose of this study is to gain a better understanding of women's recovery process from anorexia nervosa. Information gained from this study will be utilized to inform future research on women's recovery of anorexia nervosa, as well as guide treatment approaches for women suffering with anorexia nervosa.

PROCEDURES

Interviews will include women who have recovered from a diagnosis of anorexia nervosa and are between the ages of 18-30. Interviews will take place at a mutually convenient time and location that is comfortable for you. The interview will require approximately 1 ½ to 2 hours of your time. The focus of the interview will be on understanding from your perspective the experience of recovery. A follow up focus group requiring approximately one hour of your time will provide a platform from which your feedback on the interpretation and consolidation of your story with that of others participating in the study will be heard. This is to ensure accuracy of representation and validity of the findings.

RISKS

The risks involved in the research are considered minimal. Although the questions are not intended to make you uncomfortable, you may experience some discomfort from participating in the interview. Recollections of past experiences that may be unpleasant, and the feelings associated with those experiences may evoke feelings of sadness, anger, etc. Your participation in this research is voluntary and you may withdraw from participation at any time. You may also refuse to answer any questions that you do not

feel comfortable answering. Involvement in the focus group may also increase anxiety, as your identity will be disclosed to those who are participating in the focus group. Again, participation is voluntary, may be withdrawn at any time, and feedback can be provided in a written or private meeting with me if you do not feel comfortable participating in the focus group. In addition, if such discomfort arises, that you feel the need to end the interview and require the assistance of professional help, The Wellness Centre has agreed to be available for debriefing.

BENEFITS

Your participation will provide the following information that may be helpful to others suffering with anorexia nervosa, as well as professionals in the treatment field, and researchers. The study will provide information about the unique characteristics of the recovery experience, including the benefits and challenges of the experience. The study will provide you with an opportunity to give voice to your experience of anorexia nervosa and the recovery from it. Lastly, this study will further the understanding of the experience of recovery from anorexia and will contribute to future research in this area.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study. Anonymity will be maintained. Some circumstances where disclosure is required by law include: where there is reasonable suspicion of child, dependent adult, or elder abuse or neglect; and where a participant presents a danger to self, or others.

Although this study requires an identifier to distinguish between respondents, participants may use a pseudonym. In other words, participants may invent a name for themselves, which they will use continuously throughout the project.

The interviews will be audiotaped. These tapes and all subsequent data will be coded by numbers, and stored securely. The interviews will also be transcribed such that any identifying information will be removed. Written consent must be obtained from you prior to the inclusion of any direct quotation from the interview or focus group in any verbal or written summation of the study's findings.

Within the context of the focus group, all participants must verbally agree to uphold the confidentiality of any information or identity of each participant present that is learned.

COMPENSATION

No payment will be offered for participation in this research project.

CONTACT

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study) you may contact the researcher, Elisha Van Harte, at 519-831-9905. This project has been reviewed and approved by the University Research Ethics Board. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, extension 2468.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without any consequence. If you decide to participate, you may withdraw from the study at any time without consequence. If you withdraw from the study before the data collection is completed your data will be returned to you or destroyed. You have the right to omit any questions or procedures you choose.

FEEDBACK AND PUBLICATION

The research results will be summarized in a master's thesis format, the summary of which will be verbally presented, and possibly submitted for publication in a reputable journal. A copy of the thesis will be provided to you via email no more than six months post study completion. An email will be sent to you indicating when the data collection has been completed.

CONSENT

My signature below indicates that I have read and understand the above information, and any questions I have, have been satisfactorily addressed. I agree to participate in this study until I decide otherwise. I acknowledge having received a copy of this agreement.

Participant's signature _____ Date _____

Researcher signature _____ Date _____

Signing below provides the primary researcher the approval to incorporate and include direct quotations obtained from the interview to provide a richer, in-depth anecdotal recounting of your story. No quotation will contain identifying information in order to retain your privacy and anonymity.

Participant's signature _____ Date _____

Appendix C

Interview Guide

1. Tell me as much as you can about your recovery process.
2. What does recovery mean to you?
3. What would you say are some of the best moments of your recovery?
4. What would you say are some of the challenges you experienced as part of your recovery?
5. How would you say the process of recovery has changed you as a person if at all?
6. How would you say the process of recovery has changed the way you life your life if at all?

Appendix D

Debrief Form

WILFRID LAURIER UNIVERSITY
DEBRIEF FORM
Voices of Anorexia Uncovered: The Healing Journey Unveiled

The main goal of this current project is to gain a better understanding of the experience of recovery from anorexia nervosa from the perspective of those who have recovered.

There are a number of implications to this study. This research will add to the existing eating disorder literature by providing a deeper and more comprehensive understanding of the recovery process. Recovery is a universal goal of professionals who work with individuals suffering with anorexia nervosa, a life threatening illness. Little research has investigated the experience of recovery from this perspective, mainly focusing on the etiology of the illness.

As well, the results will be useful in providing an alternative perspective on recovery that may be useful in prompting further investigation or possible incorporation into treatment programming for anorexia nervosa. This is of high importance given the low level of longitudinal success in treatment efficacy in anorexia nervosa as currently supported in the literature.

Thank you for your participation in this study. We appreciate your contribution to our program of research. A summary of the survey results should be available in September 2009.

If you have any further questions about the study, please contact:

Project Advisor: Dr. Robert Basso rbasso@wlu.ca Faculty of Social Work Wilfrid Laurier University 519-884-0710	Primary Researcher: Elisha Van Harte elishavanharte@hotmail.com Department of Social Work Wilfrid Laurier University