UNIVERSITY OF ALBERTA

HELPFUL AND HARMFUL FACTORS IN RECOVERY FROM ANOREXIA NERVOSA: AFFLICTED WOMEN SPEAK OUT

By

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A PROJECT REPORT

SUBMITTED TO THE DEPARTMENT OF EDUCATIONAL PSYCHOLOGY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE DEGREE OF

MASTER OF EDUCATION

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

SPRING 2013

UNIVERSITY OF ALBERTA
RELEASE FORM

NAME OF AUTHOR: Nicol Patricny

TITLE OF PROJECT: Helpful and Harmful Factors in Recovery from Anorexia Nervosa: Afflicted Women Speak Out

DEGREE: Master of Education

YEAR THIS DEGREE GRANTED: 2013

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, a Project Report entitled "Helpful and Harmful Factors in Recovery from Anorexia Nervosa: Afflicted Women Speak Out" submitted by Nicol Patricny in partial fulfillment of the requirements for the degree of MASTER OF EDUCATION in Counselling Psychology.

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Abstract

This study reports on results from 58 women's subjective reports of their recovery process from anorexia nervosa (AN). Participants were either recovered or in the process of recovering from AN and had received varying levels and types of treatment. Participants were interviewed about the factors that they found most helpful and harmful in overcoming their AN. Data were analyzed using thematic analysis and revealed several common factors that were reported among participants as most helpful and harmful in overcoming AN. These factors were both psychological and external. Helpful factors included: *support from others*, *motivation to recover*, *participation in activities*, and *self-insight*. Harmful factors included: *drive towards AN*, *society*, *stress*, *negative relations*, *high standards*, and *self-critic*. Dual factors—including *emotion*, *treatment experiences*, *major life change*, *exposure to others with AN*, and *identity*—were those that had both helpful and harmful aspects. Results are discussed in terms of their implications for women with AN during their recovery.

Keywords: anorexia nervosa, recovery, women, thematic content analysis

Acknowledgements

I would like to thank Dr. Michelle Emmerling, for making this project possible through her enormous efforts on her dissertation, and for her willingness in providing me with guidance as a second reader. I would also like to thank Dr. William Whelton, for allowing me to take on this project. Additionally, I would like to acknowledge the Department of Educational Psychology at the University of Alberta for providing financial support for this project through the Queen Elizabeth II Scholarship. I would also like to thank the participants of this study for having the courage and openness to share their experiences, thereby contributing to the knowledge of understanding recovery from AN and helping others with their recovery. Finally, I would like to thank my supervisor, Dr. Derek Truscott, for providing valuable encouragement, support, and guidance on this project.

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Helpful and Harmful Factors in Recovery from Anorexia Nervosa:

Afflicted Women Speak Out

Anorexia Nervosa (AN) is a potentially life-threatening eating disorder that is characterized by a refusal to maintain a normal body weight (American Psychiatric Association [DSM-IV-TR], 2000). More specifically, it involves a pervasive drive for thinness that leads to the maintenance of a low body weight of less than 85% of a normal weight (i.e., a Body Mass Index (BMI) less than 17.5), an intense fear of weight gain despite being underweight, a subjective disturbance in how body weight or shape is seen, and amenorrhea in postmenarcheal females (American Psychiatric Association). AN occurs in approximately 0.5% of females and usually begins between the ages of 14-18 (American Psychiatric Association). Relatively speaking, AN is rare in males, with 90% of cases of AN occurring in females (American Psychiatric Association). There are two subtypes of AN: Restricting Type (AN-R) and Binge-Eating/Purging Type (AN-BP). With AN-R, weight loss occurs from dieting, fasting, or excessive exercise, and with AN-BP, there is regular engagement in binge-eating or purging behaviour (i.e., self-induced vomiting or misuse of laxatives, diuretics, or enemas) (American Psychiatric Association).

People with AN use extreme methods of weight control—including self-induced vomiting, severe caloric restriction, laxative misuse, and excessive exercising—that lead to a state of starvation known to have negative heath consequences. Semi-starvation affects all of the organ systems and can lead to loss of essential fat tissue, low blood pressure and pulse, hair loss, hypothermia, electrolyte abnormalities, thyroid problems, and low bone density (Sidiropoulos, 2007). AN also affects mental functioning, including concentration, attention, and motor tasks (Bosanac et al., 2007). Many individuals with AN will require hospitalization for medical

complications and, of those admitted, there is a 10% mortality rate, typically due to starvation, electrolyte imbalance, or suicide (American Psychiatric Association).

Given the adverse effects on physical and mental health, much research from a multitude of perspectives (e.g., family systems, feminism, cognitive-behavioural) and has sought to better understand the course of AN from etiology to recovery. While each perspective has valuable aspects in understanding AN, none of the perspectives are comprehensive enough to fully explain the complexity of AN (Lagoudis & Bozikas, 2009). Given the gaps in our understanding of AN, our ability to treat AN effectively remains a challenge (Wilson, Grilo, & Vitousek, 2007). Some studies (e.g., Gentile, Manna, Ciceri, & Rodeschini, 2008) have made weight restoration of severely emaciated women the primary goal of treatment, and have measured the efficacy of treatment programs according to increases in BMI. While nutritional rehabilitation through weight restoration is an essential component of treatment, it is insufficient by itself for full recovery (Kaplan, 2002). When treatment of AN focuses on physical aspects, the psychological aspects are typically overlooked, with significant AN-related pathology subsequently missed (Couturier & Lock, 2006). In one study only 33% of women with AN who received treatment fully recovered, with the majority (83%) only partially recovering (Herzog et al., 1999). Moreover, of the third of women who do achieve full recovery upon completion of treatment, approximately one third will relapse after 90 months (Herzog et al., 1999). This means that only one in five women who receive treatment for AN will fully recover in the long term, whereas four out of five will relapse. Thus, further research that will lend insight towards the recovery process and relapse prevention of AN is needed.

The current study utilizes a qualitative method of interviewing a specific group of women with AN about what they found helpful and unhelpful in therapy in an attempt to gain further

insight into recovery from AN. Because physical symptoms of AN—including purging, amenorrhea, and low weight—have been found to remit before the psychological factors of disturbed body perception and obsession with weight and shape (Clausen, 2004), it is beneficial to explore the psychological aspects of recovery. To date, few studies have methodically examined recovery from AN using a qualitative perspective that focuses on the patients' perspective (Federici & Kaplan, 2008). The current study explores patients' perspectives of their AN to access the psychological aspects of their recovery. It is hoped that examining women's perspectives of helpful and harmful factors in their recovery will lead to new insights in the recovery from AN that may be helpful in guiding and implementing effective treatment.

Method

Participants

Recruitment. Participants ($N = 58$) were recruited over a 17-month period from a Canadian city using several methods. First, mental health professionals in the eating disorder field were contacted via email and asked to place posters in their treatment facilities to advertise the study to potential participants. Posters were also placed throughout a major university and in an eating disorder unit at a university hospital. Advertisement for the study was also done through local media. Women who responded to the posters and advertisements were initially screened over the telephone. Inclusion criteria included having a previous diagnosis of AN-R or AN-BP given by a mental health professional and having a BMI of 18.5 or higher. The minimum BMI was set to ensure that their physical safety and cognitive functioning was not compromised (Emmerling, 2013). Exclusion criteria included active AN, meeting criteria for substance abuse, having been diagnosed with a psychotic disorder, and having a BMI of 30 or higher. Three women were excluded from the study because they had active AN and a BMI less

than 18.5. After the screening telephone interview, all eligible participants met with a researcher individually. At this time, participants were informed more thoroughly about the purpose of the study and their rights as research participants, and any questions that they had were answered. Participants completed a basic demographics form and were interviewed by the researcher. Afterwards, participants were given $10 each as compensation for their time.

Basic demographics. Basic demographic and health information were analyzed using SPSS Version 20. Participants ranged in age from 19 to 51 years (M = 26.8 years; SD = 6.1). Further demographic information, including ethnicity, marital status, highest education level, employment status, and income, is presented in detail in Appendix A. The following summarizes the most prominent demographics among participants: most were Caucasian (N = 53); were either single and had never married (N = 22) or else were common-law or in other long-term relationships (N = 21); had grade 12 as their highest education level (N = 25); were attending school (N = 26) or else working part-time or full-time (N = 28); and made less than $10,000 in yearly income (N = 25).

Health demographics. Participants had experienced AN from 6 months to 31 years (M = 5.9 years; SD = 3.0) and were either *recovered* from AN (N = 28) or *in-recovery* (N = 30). Participants were considered *recovered* if they had an absence of both physical and psychological symptoms (Emmerling, 2013). Participants were considered *in-recovery* if they were actively working towards recovery through treatment (Emmerling, 2013). Across both of these groups, approximately half were diagnosed with AN-BP and half with AN-R. Many women had had comorbid diagnoses in addition to their AN, including depression (N = 20), anxiety (N = 5), or a combination of depression and anxiety (N = 15). Most participants had received psychotherapy (individual, family, or group) for their AN (N = 46), or saw either a

psychiatrist or a general practitioner for their AN ($N = 8$), while a few received no treatment at all ($N = 4$). Most had never been hospitalized for AN ($N = 34$), while others had been hospitalized once or twice ($N = 17$) or three or more times ($N = 7$).

Procedure

Participants were interviewed in-person by the researcher using a semi-structured format. They were asked: 1) "If you consider yourself recovered, what treatment (or other) experience(s) were the most helpful to you in overcoming AN?" 2) "What treatment (or other) experience(s) have been the most harmful to overcoming anorexia nervosa?" and 3) "Any other thoughts you may wish to share with me about your experiences regarding anorexia nervosa or treatment/recovery?" As participants answered these questions, the interviewer wrote down their responses.

Analysis

The interviews were electronically transcribed and then analysed using *thematic content analysis*. This method of analysis provides ways of systematically organizing qualitative data to increase understanding of a phenomena, provide new insights, and inform practical aspects of an issue (Krippendorff, 2013). The analyst constructs a context to make sense of the texts and answer applicable research questions (Krippendorff, 2013). Results can be used to help conceptualize the experiences and realities of certain groups (Krippendorff, 2013). Atlas.ti Version 7.0. computer software was used to aid in the coding process.

The interview transcripts were first coded into segments that conveyed meaningful concepts. Each segment comprised of a comment from a single participant, and ranged in length from a few words to a few sentences. As each transcript was coded, categories emerged. When at all possible, the categories were labelled using the participant's language. Once all data had been coded into a variety of descriptive categories, the analyst examined the similarities,

differences, and overall meaning of each category, and began to merge certain categories together and develop new categories. For example, many of the categories are a compilation of two categories, one in which the presence of a factor was noted to be helpful, and the other in which the absence of the same factor was noted to be harmful. Many of the initial categories were also maintained as subcategories within a higher-order category. This processes of fine-tuning categories allowed for a thorough exploration of the complexity of the data (Clark, Rees, & Hardy, 2004), while organizing it in way that was easier to conceptualize. Once the categories were finalized, a few of the individual segments were re-categorized. Each of the final categories was derived from the comments of at least seventeen different participants, and each subcategory contained comments from at least five participants. To enable the reader to judge the validity of the categorization of the data, direct examples are included in the results (Clark, Rees, & Hardy, 2004).

Results

Fifteen final categories emerged from the coding and analysis of the fifty-eight transcripts. All clients who were interviewed were able to articulate their perception of what was helpful and harmful in their recovery from AN, except for two participants who did not respond and were therefore not included in the study. The fifteen categories are described below. First, four categories are presented in which helpful factors in recovery from AN are identified and discussed. Second, five categories are outlined in which dual factors, that can be either helpful or harmful to recovery from AN, are presented. Finally, six categories are presented in which harmful factors in recovery from AN are discussed. Figure 1 summarizes the main factors identified in this study.

Figure 1. Summary of Helpful, Dual, and Harmful Factor in Recovery from AN

Helpful Factors:	**Determining Helpful Factor/s:**	**Dual Factors:**	**Determining Harmful Factor/s:**	**Harmful Factors:**
Support (Professionals; Family; Significant others; Friends)	(Well suited to needs; Access to treatment)	**Treatment experiences**	(Negative experiences with treatment professionals; Lack of access to treatment)	**Drive towards AN** (Emotional need for AN; Fear of food / weight gain / drive for thinness; Denial of AN)
Motivation to Recover (Internal drive; Health motivation; Impact on family)	(Emotional openness)	**Emotion**	(Emotional suppression)	**Society** (Comments about weight; Media emphasis on thinness; Stigma)
Activities (Interests; Career / major goals; Spirituality)	(Helpful life transition - more support and less stress)	**Life Change**	(Harmful life transition - less support and more stress)	**Stress**
Self-insight / Self-acceptance	(Motivation to recover; Support from friendships)	**Exposure to others with AN and diets**	(Triggering; AN-related consequences in friends)	**Negative Relations** (Family; Significant others)
	Developing a sense of self	**Identity**	Lacking identity	**High Standards for Self**
				Self-critic / Insecurity / Low self-esteem

Helpful Factors in Recovery

This cluster contains categories that participants outlined as helpful in their process of recovery from AN.

1) Support: "Having a regular support system to deal with AN."

Professionals. Many women made specific reference to seeing psychologists, psychiatrists, counsellors, social workers, dieticians, and nurses. In particular, there was an emphasis on the positive relationships and connections, that they "really trusted" these professionals, "confided" in them, and "felt heard and understood" by them. Attributes that were

helpful included "[listening] well and [being] open," "good at dealing with . . . underlying issues," "seeing [the person] and life situation," and being supportive.

Family. Many of the women mentioned that the support that they received from their family was helpful to their recovery. Specific reference was made to strong relationships with "very loving" mothers, fathers, and siblings. Family members were described as "always there for me," "really supportive," and non-judgemental. The women mentioned that they were able to "[be] honest" about their experiences with AN with their family members and that their family members "took [their AN] seriously." Family members conveyed a belief in participants' recovery and motivated them to recover.

Significant others. Many women also stressed the important role that their "loving" significant others played in supporting them through their recovery. Relationships with husbands, common-law partners, and boyfriends, were described as "helpful." These significant others were described as "very supportive of the situation," "always there for me," "encouraging," "accepting," and "positive." They were able to "see the person, not the problem."

Friends. Many of the women also emphasized their "supportive friends [in helping them] through" their recovery. The women felt "comfortable talking with [their] friends" and were able to "[be] honest," "[open] up" and "[speak] about [their]" AN. They also noted that their friends "[knew them] more for [their] personality," "treated [them as] human [beings]," and helped to "[instill] confidence and faith" in the recovery process. These women also found "listening to their [friend's] advice" helpful. Some women also mentioned friends who had overcome "similar issues" with eating disorders and who were particularly understanding and supportive of their recovery.

2) Motivation to recover: "Wanting to be recovered."

Internal drive. Many women described an inner desire of "wanting to be recovered" and "wanting to be better." This motivation came from several sources. Some women became fed up and exasperated with having AN, "I am done," "I could not do AN anymore." Other women were tired of the shame that surrounds AN, "I observed others [who were] not restricting and [were] healthy. They were valued. I was not." Some women wanted to "get better . . . to avoid [treatment program]" or else were "desperate to get out of [the] hospital." Many women also desired "[wanting] to have a life" with more "meaning" and "more purpose," rather than being "stuck in AN." Other women, for who "eating became a chore," were motivated by "watching others [without AN] live their lives" and envied their carefree attitude around eating. Some women described developing "readiness [for] recovery" and felt that they had the "courage to face it." In most cases, it appeared that participants made a conscious choice to work towards recovery that came from an internal drive to get better, that is, they "decided to own it."

Health reasons. Many of the women were motivated "to take better care of [themselves] and "be healthy." They did "not [want] to be sick anymore and [realized] that sickness comes with being at [their] small size." The women described having an "awareness of health problems" from their AN, both physical and mental, that functioned as "scare tactics" for them to recover. Specific symptoms mentioned were "trouble with memory of past events," "attention span [going] out the window," "school [being] easier before . . . AN," "missed periods," "noticing that [teeth] are sensitive," and feeling "coldness all of the time." Some women also mentioned "not wanting to die" due to physical complications, "I will die if I don't eat!" These women were motivated to recover from AN so that they could "become healthier" and "feel stronger."

Impact on family. Many of the women were motivated to recover form AN due to "guilt about the impact on parents" and other family members. For these women, family was important and they did "not want to hurt them" or "put them through [the stress associated with AN] anymore." One woman became "really scared [of] dying and [of] the impact [that her death would have] on [her] family." Another woman wanted her "little sister to have a role model," and felt that her AN may be negatively influencing her sister. These women were motivated to recover to prevent any further emotional harm to their family members.

3) Activities: "Being so busy with so many other things."

Interests. A wide variety of activities and interests were mentioned as being helpful to recovery. Among these were spirituality, music, pets, shopping, outreach work in the community, travelling, working, choir, and, cooking classes. Many of these activities gave the women a "purpose to keep [them] going" and a sense of "feeling [they] could contribute." Moreover, being "passionate about some else" other than AN, allowed them to "stop thinking about food." Athletic activities were also mentioned, including yoga, cardio training, working out, and weight lifting. Many of the women found that participating in these athletics helped them "[form] a different relationship with [their] body" that allowed them to feel "okay with gaining weight," "increase their self-confidence," and improve their body image. Moreover, some women noted that "the adrenaline [from] being physically active feels good." However, it should also be noted that many women described appearance-related athletics with "rigid rules" as harmful to their recovery. More specifically, swimming, figure skating, weight lifting, ballet, and dance were mentioned as harmful activities. Many of these women were involved in these athletics at a competitive level, and found that their "coaches and teammates had a negative influence" on their body image and AN. For example, one woman noted, "In my athletic group

people thought I had no problem [with AN] because I was the fattest," while another noted that her "coach set restrictions on her food." Therefore, athletic activities appeared in a grey area for these women, being helpful for some women but harmful for others.

Major goals and career. Many women described major goals and their careers as helpful to their recovery. Their careers and goals gave them meaning and a sense of purpose in life, "My purpose is something that is better than my [AN]." These women "cared about [their work]," wanted a "good school experience," "[wanted] children," and "[wanted] to travel," and were empowered to "work towards [their goals]." In most cases, AN was seen as a barrier to their goals and careers, for example, "I felt I could not be a nurse responsibility with AN as I felt hypocritical. [I was] scared that I could not be a nurse if I continue with AN." These women's goals and careers seemed to instil a sense of responsibility in them that "shifted [their] priorities" away from AN.

4) Changing self-perceptions: "My perceptions were off."

Many of the women described changing perceptions of themselves and their AN, for example, "[I am a] different person than I was before" or "I see things in a new way." Their new self-insight and self-perceptions allowed them to treat themselves with more respect, be more confident, and move towards recovery. Some women described their "acceptance of AN" and "being honest with [themselves]" about it, which allowed them to "be more responsible for [themselves]." Other women described going through a process of self-acceptance where they learned to "develop empathy for [themselves]," "love [themselves] in a new way," and "[grow] out of [their] anxieties and insecurities." There was also mention of "letting go of the need to control food intake" through AN and of coping in unhealthy ways. Many women also came to the realization that their "perceptions were off" and their "reality [was] so distorted," which

enabled them to challenge unhealthy thoughts by "[rationalizing] with [themselves] and fighting [their] urges" to return to AN. These women became aware of the contrast between their "irrational, eating disorder sides" and their "more rational, logical sides" and worked to "rewire the path . . . against the irrational side." They also noted the importance of "trying to trust other people [in] the [recovery] process," and allowing "someone to be [their] logic" to help "[fight] the fear" that recovery evokes.

Dual Factors in Recovery

This cluster contains categories that participants outlined as being dual factors (i.e., either helpful or harmful in their process of recovery from AN).

1) Treatment Experiences: "Having a support team looking out for me" versus "Bad inpatient experiences."

Helpful aspects. Many of the women noted that specific types of treatment were helpful to their recovery. The following treatments were mentioned: Cognitive-behavioural therapy, meal programs, psychotropic medication, ALANON, a 12-step program for AN, self-help group for stealing, art therapy, dialectical-behavioural therapy, Anorexics and Bulimics Anonymous support group, workbooks on perfectionism, emotion-focused therapy, being educated on AN by a nutritionist, group work, outpatient programs, transition groups, inpatient programs, hospitalization, and psychoeducation. Amongst the wide variety of treatments available for AN, many of the women had positive experiences across the wide spectrum and had access to specific types of treatment that suited their needs well. Some woman found the "scientific viewpoint" of AN, "understanding more [about] what [physical] processes are occurring" and "learning [about] the nutrition aspect, [that is], why [AN] is dangerous, [what] damage [it does], [and] how it causes problems in the future," to be helpful. Many women found hospitalization helpful, as it

"rescued [them] from [their] home environment, [allowed them to feel] safe," and allowed them to "eat [normally]" and "have a certain [healthier] set point of weight." Hospitalization also gave them "a support team [to look] out for [them through supervision]" and prevent them from "[becoming] stuck in recovery." Other women liked being outpatients because it gave them the autonomy to "[recover] on [their] own" and restore body weight at a rate they were comfortable with, "If I was an inpatient and put on weight too quickly, I would [have relapsed] right away." Some women also mentioned that "reading [about AN] on [their] own" "to help with understanding [AN]," for example, "how many people it affects," helped them to recover.

Harmful aspects. Many of the woman also had negative experiences with their treatment. In regards to inpatient experiences, many found that the "refeeding process was horrible and not helpful in the long term," especially when it involved tube feeding because the women made a point of losing whatever weight they gained afterwards, "[When a] general practitioner . . . put a tube down my throat and force fed [me], [my AN became] worse [and I] lost more weight after." Some woman also found the inpatient food groups, where they were "[watched by staff while] eating meals [and] not allowed to go to the washroom," to be "threatening," while other women found the inpatient program "competitive." However, some women who were outpatients "wished [they were inpatients]," "At [the] hospital as [an] outpatient . . . [I] felt I did not belong." There was also some frustration with: family therapy, "my family does not have the typical family characteristics;" electro-convulsive therapy, "lots of lost memories . . . [I have] bitterness about this;" and psychoeducational group therapy, "[it] normalized [my] behaviours [around AN]," and "[I] wasn't comfortable." It was also noted that "books about self-help [for] eating disorders and prevention pamphlets . . . [were] '*pro-ANA*,'" that is, encouraging of AN

and thus triggering. Overall, many of the woman felt that their treatment was not well-suited for their needs.

Another major theme was negative experiences with professionals. Some of the woman felt they were treated with "no individuality," and were "patronized," "dismissed," and "not [understood]" by staff. For example, "[The] nurses [believed] that AN is [a] choice," and "My psychiatrist pushed medication [on me]." Many women also mentioned going to their general practitioners and "[calling] out for help, [wanting] to be told that [they] needed help" for their AN, and instead being told, "No, you are fine [and] do not need eating disorder treatment" or "[You're not] thin enough [to have AN]." These were "unhelpful confirmations" that motivated these women "to reach [their] goal weight." Finally, many women also complained of issues with accessing treatment, including "long waiting [lists]," treatment being "too expensive," for example, "not [being] about to afford [seeing a] psychologist," or else having parents who would not readily place them in professional care.

2) Emotion: "Expressing emotions" versus "Bottling up emotion."

Openness. Many of the women described how being aware of their emotions, "learning to talk about [them]," and "being open with people," helped to aid their recovery process because it allowed them to "vent . . . [and] not [keep their] internal struggles inside." For some women, expressing their emotions and experiences came more naturally because they were raised in homes where they were encouraged to share their feelings, "[I] talked about emotion a lot growing up," or "[my mother] encouraged [talking] about emotion." For other women, the process of learning to express emotion was more difficult, because they had been conditioned through their upbringings to repress emotion. These women had some fear and discomfort

around expressing them, “It’s still hard to talk about [emotions],” but were able to do so selectively, for example, “not so much with my parents, but with my friends and boyfriends.”

Suppression of emotion. Many women described “bottling up” and “repressing” their emotions and experiences. Very often, this emotional suppression was the norm for their families, due to a tendency for emotions to be viewed as “a burden” to others. For example, “In [my] family, I was not allowed to feel [anything],” “[I was] raised in family where we did not share [emotions],” “[As a] child, [I] could not cry; [it was] not okay,” “[My] mom was Mennonite [and told me] ‘Do not express emotion,’” and “[I dealt] with anger by going to sleep . . . [so I wouldn’t be] judged [by my] parents.” Some of the women attributed their families’ tendency to supress emotion to cultural differences. Because these women were unable to express themselves fully, many felt that their experiences were not “validated.” They also became “overwhelmed by emotions” as a result of the suppression, yet continued to conform to their family norms of emotional suppression because they did “not want to affect others.” The general “taboo” around emotions resulted in many important issues, including their AN, remaining hidden and “not addressed.”

3) Life change: “Helpful to be in a new place” versus “Losing weight for graduation.”

Helpful aspects. Many of the women referred to major life transitions as being helpful to their recovery. Often these transitions involved entering into a new environment. More specifically, moving out of their parents’ home, travelling, moving provinces, moving cities, and changing schools were all noted as being helpful to recovery. Some of these women found it was “helpful to be in a new place where [they did] not know anyone and no one [knew about their] history [of AN].” Others found that their new environments were more supportive, or else

less stressful or "oppressive" than their previous environment, "I could not get better at [my parent's] home." Some women also mentioned that the death of a loved one was helpful to their recovery in that it made them reflect upon themselves and helped improve their self-perception, "After my ex-boyfriend passed away [I] changed [the] way I viewed being alone. It was a defining moment for me." A similar helpful kind of reflection occurred with women who became pregnant or had a child; these women "rethought [their] life and sense of purpose" and were able to "[see their AN] in a new way" that facilitated their recovery.

Harmful aspects. Many of the women also referred to major life transitions as being harmful to their recovery. Once again, these transitions often involved new environments for the women. However, these women experienced their new environments as "stressful," and being "away from . . . [previous sources of] support." The anonymity of being in a new place also allowed some women to lose more weight without suspicion, "People [do] not [know] how much I am supposed to weigh. [It] would have been different at home." Major life events that involve appearance-related components were also noted as harmful, for example, "[I lost] weight for graduation" or "[My] wedding [led to AN] again." These women felt pressured to lose weight and look their best for these events.

4) Exposure to AN and diets: "Not wanting to end up in her shoes" versus "Triggering"

Helpful aspects. Some women found being around other women with AN to be helpful to their recovery. These women were motivated to recover so that they would not end up like those they observed with longstanding AN, for example, "[I met] a [woman with] chronic AN and [did want] to end up in her shoes" and "[I saw] people in the program who have been [there] for 10 years [and I thought,] 'I want a life.'" Other women mentioned forming "connections"

with women who had AN, "I met [my best friend] on the ward," and supporting each other through recovery, "[It was helpful] being on a shared unit with people who wanted to get their lives back." The formation of friendships was facilitated by their common struggle with AN, which led to a reciprocal sense of understanding, "I have not had a close friend [without AN]. [My friends with AN give me] answers at a deeper level, while others [without AN] are not willing to go further."

Harmful aspects. Many women also mentioned that interaction with other women who had AN was harmful to their recovery because it was "triggering" and led to "competition" in terms of weight loss, "[As an inpatient, I was] taught . . . how to purge" and "[My] friend on the ward [was] hanging on to [the] . . . eating disorder world." Many women also reported losing weight because they wanted to look like someone who had AN, "[I] idealized an exchange student who [had] AN [and] wanted to be like her, [so I] starved myself," "[There was] competition with [my] friend [who had] AN," and "[I respected] and [admired] others with eating disorders in the public setting [and was] amazed [by] how quickly I reverted to [AN]." These women "constantly compared" themselves with other women with AN, and were triggered into losing weight to look more like them. Many of the women also described being triggered by seeing normal dieting behavior and weight loss in others (e.g., "My mother [being] on weight watchers my whole life," "[My] friend [not eating] carbohydrates," and "My father was into [counting calories]"). Some women were also exposed to tragedies that their friends from the ward experienced, including miscarriages, suicide, and death from starvation. So while friendships with women with AN were noted as helpful above, there also appears to be some inherent risks in these friendships, given the health risks associated with AN.

5) Identity: "Developing a coherent sense of self" versus "Not having an identity."

Sense of self. Many women referred to "developing a coherent sense of self" as helpful in their recovery. These women gained "understanding [into] who [they] are" and noted that they had previously been "overwhelmed with [their] eating disorder" and had let their AN "define [them]," until they came to the realization that their "recovery [could] sculpt who [they are]." These women came to realize that their "identity is not shaped by what others think of [them]" and stopped "pretending to be someone else." For example, one woman found leaving Christianity, which she referred to as "leaving the flock," as helpful in formulating a new sense of self; while she experienced "grief and loss" during this transition because she had previously identified strongly with Christianity, she was able to love her new self and progress in healing from AN. Thus for these women, the development of a strong "notion of [who they are] and what is important and drives [them]," prevented their AN from "competing for center stage."

Lack of identity. Many women also noted that having a lack of identity was harmful to their recovery from AN, "[I was] uncertain and unsure of who I am [and] who . . . God [wants] me to be," and "[I was] struggling to figure out who I am in regards to . . . my career [and] my underlying personality." These women described having "no sense of where [they] belong," having a "feeling of being different," and "not [knowing] how to fit in." As a result of "not having an identity," these women tended to "look [to] other people to define who [they] are" and use "AN [to give] a sense of self," thereby "[losing] who [they are] to that AN voice." For these women, AN seemed to fill the void of not knowing who they are, which had them holding onto their AN identity. Ironically, AN also functioned to prevent them from finding their true selves.

Harmful Factors in Recovery

This cluster contains categories that participants outlined as being harmful in their process of recovery from AN.

1) Drive for AN: "Addiction on an emotional level."

Emotional need. Many women mentioned having an "addiction [to AN] on an emotional level." These women noted that AN "gave a sense of control" that they desired since they did not feel that they had control over other aspects of their lives, "[I had a] lack of control in my family home" and wanted to "take control back through AN." For these women, AN allowed them to assert control over their bodies, an aspect of themselves that was out of the control of others, "You can't control this part of me." Some women also mentioned attaining "a sense of safety" and "comfort" through AN. For others, they described their AN as a "coping mechanism" for when "things are down" that gave them a positive "sensation [and] feeling," that is, a type of "high" that "[made them] feel great." Thus the emotional gain that these women achieved through their AN made it difficult for them to let go of their AN.

Fear of food and weight gain. Many women mentioned that their discomfort around food was harmful to their recovery. Some women felt "uncomfortable around food," while others experienced "anxiety around food-related situations." There was also some frustration that, "[You] can't take away food; [it's] always there [to deal with]," along with fear of food, "Everything I take in is questioned [and there are] certain foods that I cannot bring myself to eat." Many women also mentioned a "fear of [being] fat," for example, "I would [rather] die instead [of] reach 140 pounds," and "[My AN is triggered when I have] problems with clothes fitting." While some women knew there was "nothing external about [them] being fat, internally

[they felt like they were]." The fear of being fat in these women led to subsequent dieting behaviours like "counting calories" and preoccupation with their bodies.

Denial of AN. Many of the women described a lack of awareness around their AN and denial of having a problem as being harmful to their recovery. These women found it "very hard to see [themselves] in the AN category," saw themselves as having "functional AN," or else "had no idea [they had an] eating disorder." Some women recognized certain symptoms and behaviours in themselves but were unable to see how severe their symptoms were. For example, "I did not [realize] I was that thin. I knew I was thin, [but] not that thin" and "[I] had more [AN] behaviours than I thought." Other woman could "not see the compromise [of AN] on [their bodies]" or "the detrimental effects on [their] mental [functioning]." For many of these women, "not admitting to having a problem" allowed them to continue with their restrictive eating and remain in "denial of needing treatment."

2) Society: "'Nothing tastes as good as skinny feels,' - Victoria Beckham."

Comments about weight. Many of the women described hearing people's comments about their weight, whether positive or negative, as harmful to their recovery. When they were told that they were "too skinny," they felt judged and "self-conscious" about their bodies, "People's judgement made me hate my body more, " which in turn would lead to subsequent body preoccupation and dieting behaviour, "[I] would drop more weight after [hearing comments about my weight." At the same time, when women received positive feedback about their bodies (e.g., "you're so nice and slim") it "positively reinforced [their] weight loss," "[I was] reassured I was doing a good thing when I was not." Many women also noted that hearing others say they "look healthy" was harmful. These women "always misinterpreted what was said" and equated "healthy" with "you look bad." Some women also remembered hearing negative comments

about their weight (e.g., "fat-ass," "you're big," or "you're the biggest person in the class") or weight gain ("it's worse to gain weight than it is to lose a limb") when they were younger and had held onto these messages and internalized them; in turn, these messages helped motivate their subsequent AN. Regardless of the intention behind them, most of the women "[hated] when people [commented] on [their] weight," and the comments seemed to impede their recovery.

Media. Some of the women also mentioned that "media" and "being in a Western culture" was harmful to their recovery. In particular, the "superficial images" that appear in "magazines" and other advertisements and the "fashion world" (e.g., "[my job at an] appearance-related store") were described as "hard to ignore" and "disturbing." Certain celebrities in the media were also noted as being harmful, for example, "Princess Diana's admittance of [having an] eating disorder inspired [my AN]," "Dr. Phil . . . essentially gave me tips on how to eat disordered," and "Victoria Beckham's 'Nothing tastes as good as skinny feels' . . . [stayed] with [me]." The media bombarded these women with unrealistic images that "made [them] vulnerable" to "a belief that [their] problems would go away if [they] met [their dieting] goals."

Stigma. Some women also mentioned stigma as being harmful to their recovery. They were "afraid of being judged by others" for their AN and felt that "people [did] not [understand] what [they were] going through." The "stigma surrounding [AN]" and the "judgement around [AN issues], for example, the "stereotypical view that [people with AN are] just vain," made these women "feel . . . different" and "embarrassed." Because of the stigma attached to AN, many of the women were hesitant to seek social support from others or attend treatment programs.

3) Stress: "Having high levels of stress." Many of the women mentioned "high levels of stress" and "lots of pressure" associated with various life situations as being harmful to their recovery, "[When] stressed, AN comes up." There was mention of stress from: school and jobs, grief from the death of loved ones from both suicide and medical reasons, romantic break-ups, financial struggles, medical issues with loves ones, clinical disorders and symptoms (i.e., depression, self-injury, suicide attempts, and anxiety), and "trauma experiences" (i.e., abusive relationships, sexual abuse, having a miscarriage, and physical abuse among parents). These stressors appeared to trigger symptoms of AN in these women as a way of coping with feeling "overwhelmed," for example, "[I] responded to stress by not eating," "Research statistics [led to] crying [and a] need to run forever," and "The stress of [my] husband dying from a drunk driving accident led to feelings of permanent guilt and a need to hurt myself." On a more encouraging note, some women also described the removal of their stressor as being helpful to their recovery, "School [is] very stressful; [I] feel better when out of school," "[I] took a break [from my] Master's . . . [to] spend time with supportive people," and "[Having] time away from work [was helpful]." By reducing their stress level, the need to cope using AN lessened.

4) Negative relations: "Having a chaotic family."

Family. Many of the women referred to a "difficult home life" and negative "family relations" as being harmful to their recovery. They described having "dysfunctional" and "chaotic" families, and living in a "toxic environment," in which there was "terrible fights," "arguing at all times," "personality [clashes]," "violence," "verbal, physical, and sexual abuse," "inconsistency in parenting," negative sibling relationships, mental health issues with family members (e.g., "schizophrenic brother," "father an alcoholic," or "sister was into drugs") and separations and divorces of parents. Some of the women described feeling "very detached from

[their] family," for example, "[My parents were] not really involved in [my] life," "[I was] not close with [my] mom," and "[I] lived in a plastic family." Other women felt their "parents did not understand [them]," or were "controlling," "rigid," and "restrictive." Some women did not feel loved by their families, "[I received] conditional love from my mom; [she used to say,] 'If you embarrass the family, I will disown you,'" or "I was completely brushed to the side [by my family]." For these women, a lack of support and love from their family members was detrimental to their recovery.

Significant others. Similarly, many of the women also referred to "emotional turmoil" in unhealthy or "abusive" relationships with their significant others as being harmful to their recovery, "[My AN] was triggered by a bad relationship." Some women felt "insecure with men, "[I] have had many . . . relationships [with] men [who] seem to vanish." Other women felt "overwhelmed" by how they were treated in their negative relationships, "[My] husband talks me down [and threatens my] self-esteem and confidence," and "[My] husband threw things." Other women felt disrespected in their relationships, "I am [my husband's] slave," or unsupported in their recovery, "Boyfriends [who] forbade me [from AN were harmful to my recovery]." As with family, a lack of support, love, and understanding from significant others was detrimental to the recovery of these women.

5) High standards: "Unrealistic expectations of what was wanted of me." Many of the women noted that their "own standards of [themselves] and how [they] should be," along with their tendency to be "perfectionists," were harmful to their recovery. Most women described having "unrealistic expectations of what was wanted of [them]," for example, "I must excel or do better than I actually need to," "I am supposed to be perfect," and "[I must] always [be] the best." The women described "comparing [themselves] to other people on a daily basis"

and feeling like they "need to improve." They also described "feeling inferior" because of their high standards and tendency to "[judge themselves] based upon [their] body image." Some women also had a "need for approval" from others and a tendency to be "people pleasing," often "wanting to do what others wanted" or "worrying [about] what others thought." For example, some women described wanting to be "beautiful and attractive to males," while others noted that they were always "looking for [their] parents' approval." Some of the women also described having "perfectionist" parents with "very high standards" of them and who were "quick to judge." The women noted that this "parental criticism" and "high pressure" to achieve contributed to their perfectionistic tendencies.

6) Self-critic: "My critic is pulling me back in." Many women described their self-critic as "a constant battle" throughout the recovery process, "My self-critic is pulling me back in [to AN]." The self-critic was described as a "monster in [the] brain" that functioned to give these women body image problems (e.g., "feeling fat" or "not feeling beautiful, [that is], skinny"), which in turn led to subsequent eating disorder behaviour like "dieting and increasing exercise." These women noted that they did not feel "secure in [their] environments," had "self-esteem issues" and "low self-confidence," and felt "inferior" and "guilty." They also described feeling "like garbage inside," and having "self-hatred" and "hard self-judgements" such as "I am never good enough," "I am bad," and "I have nothing to be proud of." For these women, the self-critic impeded their recovery process by increasing their feelings of insecurity and leading to AN behaviours in an attempt to compensate.

Discussion

This study explored how women recovering and recovered from AN understand their recovery process by examining helpful and harmful factors in their recovery. The women

outlined the multifaceted nature of recovery from AN that involves many psychological processes and much more than targeting the physical symptoms and medical consequences of AN. Their description has important implications for the facilitation of recovery from AN and for relapse prevention.

1. Awareness of Psychological Factors

Interestingly, from the participants' perspective, many of the factors around recovery had little to do with the physical and behavioural aspects of AN (e.g., maintaining a healthy weight, stopping purging, resuming menstruation). Instead, the factors were overwhelmingly psychological. From an outsider's perspective, helpful changes in these psychological factors (e.g., motivation to recover, development of self-insight and self-acceptance, and development of a sense of self) may not be readily observable and progress towards recovery may go unnoticed. Conversely, regression in recovery may occur unnoticed when harmful psychological factors like stress, high standards, self-critic and low self-esteem, suppression of emotion, emotional need for AN, and lack of identity are activated. Therefore, families and clinicians should consider that the external presentation of AN may not always match the psychological manifestation of AN when it comes to recovery. Recovering women may not engage in dieting behaviour yet may still struggle with psychological aspects of AN. Conversely, a woman who continues to maintain a low weight and has amenorrhea but is developing a sense of self and becoming more emotionally open with others may be moving strongly in the direction of recovery, even though it may not readily appear so.

2. Exploration of External Factors

Many of the factors around recovery were also external and were linked strongly to interpersonal contexts. These factors warrant exploration. For example, it may be helpful to

determine whether a woman with AN has support from others, either professional or personal; ask her whether she is finding her AN treatment helpful; explore her favorite life activities and interests; and ask about whether she has had any positive major life transitions. Similarly, the harmful external factors may also be more readily observable to others, but nonetheless still require exploration. These include conflict with family and significant others, exposure to negative societal influences on weight, treatment that she is finding harmful or unsuitable for her needs, exposure to others with AN or on diets that she is finding triggering, and negative or stressful life transitions.

3. Personalized Treatment

The results reinforce the value of personalized treatment. The women in this study spoke about the utility of having their autonomy respected when it comes to deciding which treatment is suitable for them. Understandably, there may be times when intensive hospitalization and tube feeding is necessary as a way of sustaining life in women who are severely emancipated. However, when it is medically stable to do so, clinicians and their families may benefit from attempting to give women some choice in the type of treatment they receive to help encourage these women to be more motivated in their treatment.

4. Supporting the Individual

Amongst all the types of treatment that were noted as helpful, there was a universal emphasis on the supportive and caring nature of the clinicians. This is in line with the notion that the therapeutic alliance accounts for a larger proportion of improvement in psychotherapy (30%) than specific technique and model factors (15%) (Asay & Lambert, 1999). Outside of the treatment realm, support was also provided to many of the women by family members, significant others, and friends. Women who failed to receive support from sources outside of

their treatment program noted that this lack of support was harmful to their recovery. This type of support can be considered part of client variables and extra-therapeutic events that account for 40% of improvement in psychotherapy clients (Assay & Lambert, 1999). Thus, regardless of their treatment modality, treatment providers should aim to be supportive to clients, and also seek out and utilize external sources of support that clients may have to maximize the effectiveness of psychotherapy.

Conclusion

This study provides useful information to clinicians and families about the factors that women with AN find helpful and harmful to their recovery. Across the many women who spoke about their experiences with the recovery process, there were similarities that outlined the important role of psychological processes, external life factors, and treatment experiences. Future qualitative researchers may want to examine patients' perspectives of discrepancies between their physical and psychological recovery, how to better individualize treatment to best meet patients' perceived needs, and how to best develop and utilize patients' external support networks.

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Appendix A

Demographic Characteristics of Participants

Variables	All Participants (N = 58)
Ethnicity	
Caucasian	N = 53
Asian	N = 3
Hispanic	N = 1
Aboriginal	N = 1
Marital Status	
Single, never married	N = 22
Common-law or other long-term relationship	N = 21
Married	N = 12
Separated or divorced	N = 3
Education	
Grade 12	N = 25
College or technical school training	N = 9
Undergraduate university degree	N = 13
Graduate university degree	N = 11
Employment	
Attending school	N = 26
Employed either part-time	N = 14
Employed full-time	N = 14
Unemployed	N = 3
Income	
Less than $10 000	N = 25
Between $10 000 and $30 000	N = 11
Between $30 000 and $50 000	N = 13
Over $50 000	N = 8
Unknown	N = 1