Awakned To A Life: An Existential-Phenomenological Examination Of The Lived Experience Of Recovery From Eating Disorders

Anthony Micheal Boone

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Awakened to a Life: An Existential-Phenomenological Examination of the Lived Experience of Recovery from Eating Disorders

A Dissertation

Submitted to the School Of Education

Duquesne University

In partial fulfillment of the requirements for the degree of Doctor of Philosophy

By

Anthony Boone

August, 2014
DUQUESNE UNIVERSITY
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Department of Counseling, Psychology and Special Education

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Executive Counselor Education and Supervision Program

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AWAKENED TO A LIFE: AN EXISTENTIAL-PHENOMENOLOGICAL EXAMINATION
OF THE LIVED EXPERIENCE OF RECOVERY FROM EATING DISORDERS

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ABSTRACT

AWAKNED TO A LIFE: AN EXISTENTIAL-PHENOMENOLOGICAL EXAMINATION OF THE LIVED EXPERIENCE OF RECOVERY FROM EATING DISORDERS

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Anthony Boone
August 2014

Dissertation supervised by Dr. Lisa Lopez Levers

Eating disorders have become an ever-increasing phenomenon in the cultural landscape. The irony of a culture of abundance that produces either abnormally abstemious or indulgent food practices is staggering. This study is a qualitative analysis of recovery from three major eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder. It is a phenomenological and existential analysis of the lifeworld of those who have had relief from the symptoms for three years or longer. The Maintenance phase recovery in the Stages of a Change model is used as criteria for participation in this study. Terror Management Theory was used as one lens to elucidate that experience to better understand the psychological and emotional changes the subjects encountered throughout their recovery process. Additionally, Van Manen’s (1997) four lifeworld existentials defined the phenomenological glance that the study sought to understand the experience of recovery. Five main themes emerged from the data. These themes characterized the experience of the recovered person. These main themes were (a) a change in
self-esteem based on honesty towards self and others, (b) a new relationship with the body, (c) a positive change in family relationships, (d) a new autonomy and competence/spirituality, and (e) optimism in the face of adversity/spirituality. A discussion of implications for and uses in counseling and of further research possibilities conclude this dissertation.
DEDICATION

I would like to dedicate this dissertation to my late father, Francis Carol Boone, who passed away before he could see his son complete this work. Dad, I wish you could have been here to see this happen. I would equally like to dedicate this to my mother, Jane Marilyn Boone. Her love and grace through suffering continues to inspire my career. Finally, I would like to dedicate this work to the eating disordered child, adolescent, or adult who still suffers. I hope this work will be one contribution among the many that seek a way through darkness and into the light of a brighter life.
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I have a deeply held belief that people encounter others for a deeper purpose. As I reflect on this project others must be included. I simply could not have done it without their aid and patience.

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CHAPTER 1: THE PROBLEM

A wide variety of eating disorders has increasingly become part of the social and cultural discourse in the Western world since the 1970s. Western society, however, had been grappling with such disorders since the rise of modern science, and the problems continue in the 21st century (Bordo, 2004; Bray, 2003; Brewis, 2010; Bruch, 1974, 2010; Delpeuch, 2012; Gillman, 2008; Nasser and Katzman, 2003; Vandereycken, 1994, 2002). Plausible arguments concerning the etiology of eating disorders range from the physiological—hence the use of medical models to discuss them—to the idea that they are simply cultural constructions (Bordo, 2004; Brewis, 2010). The origins and manifestations of eating disorders, though, are enigmatic because they seem to be modern phenomena that arose at the turn of the 20th century. Starting around that time, the appearance of the body in society and the intake of food necessary to sustain life became serious issues (Brumberg, 2000). Because of the strong connection between Western culture and eating disorders, these disorders will be presented here as artifacts of western culture and modern medicine.

Consistent with the idea of eating disorders as a cultural construct is that manifestations of such disorders can be explained as mental disorders or as created by cultural conditions (Bordo, 2004; Gillman, 2008; Nasser, 2003). Even if mental disorders are not wholly created by cultural conditions, we can say that culture is certainly a powerful determinant of their shape and form. Because of such uncertainties in their origins, definitions concerning eating disorders are continually changing and adjusting as cultural awareness of and scientific approaches to eating disorders also change. Given the difficulties in definition, which stem from the many perspectives on eating disorders, a phenomenological approach to recovery from such disorders is necessary.
Observed from the outside, the world of a person suffering from an eating disorder seems to be dark. When one encounters an individual gripped by an eating disorder, one may feel that one is talking to a shell, a corpse, perhaps even a profoundly split self—a condition that has been the object of much speculation as being a factor in mental illness in general (Bruch, 1974, 2001; Laing 1971). A person within a disorder appears to be divided from the self, from others, from time, and even from corporal existence, the body seeming to be a distant thing that the person inhabits. Time and self consciousness appear to be distorted in order to support a disordered structure of behavior (Bruch, 1979).

An encounter with a recovered person, on the other hand, may be strikingly different. When encountering a person who has recovered from an eating disorder, one has a sense that the person has undergone a vital existential transformation. The lived experience of those in active recovery appears to be very different from that of persons who are still suffering. Behaviors and habits that once possessed those who are recovered seem are ameliorated by a different awareness. They exist as if in a different world. If we may say that certain aspects of life—such as the constitution of the self, others, and the body—are interconnected with an awareness of mortality, it would appear that a part of the journey for those who have recovered has been to face down their own finiteness and to have experienced a transformation through recovery from their life-threatening condition (Becker, 1973; Miller & C’de Baca, 2001; Pyszczynski, 1999).

Existential and humanistic psychology have asserted that transformation and change are intrinsic to the individual’s understanding of himself or herself within a wider social, psychological, and spiritual context (Frankle, 1946; Heidegger, 1927; May, 1969, Miller & C’d Baca, 2001). However, when applied to eating disorders, the theories of change and growth in the counseling literature are incomplete. Existential phenomenological inquiries concerning
recovery from eating disorders are becoming urgently necessary in the counseling literature in order to illuminate crucial features that other methods of inquiry overlook. There is also a growing call in the counseling field to find models of transformation that are more holistic and complete than the “information processing models” currently researched (Greenberg, Koole, & Pyszczynski, 2004). Our understanding of the recovery process is incomplete without models that show human beings in flux. Thus, part of the aim of this inquiry is to inspire a respect for the complexity and profundity of the transformation process.

The present inquiry is concerned with the existential meaning of recovery from eating disorders. For investigating this approach, I concentrated on developed a holistic understanding of disorders that have to do with food intake and body distortions, which can be either real or imaged. In this study, I looked at eating disorders as a whole because I wished to examine the lived experience of those who embody a sense of recovery from the various clusters of symptoms that accompany such disorders. I attempted to arrive at the kind of exhaustive phenomenological description of the eating disorder recovery process that is necessary for an adequate understanding of and respect for this life and death process.

For purposes of this inquiry, I defined “recovery” as the time in which a person’s symptoms are continually ameliorating. The participants endorsed a three years without eating disordered behavior. Though I occasionally referred to a “recovered” person, I did so with the understanding—common to such conditions as eating disorders and alcoholism—that the person is not in a state where relapse is not possible or even probable. Hence, “recovered” is used to mean the state in which a person is able to live without relapsing, either for long periods of time or perhaps never.
This phenomenological analysis of recovery further linked eating disorders to the awareness of mortality. Terror Management Theory, an existential vision of psychological processes related to fears of death is used to ground the examination of the lived experiences of those in recovery. This existential theory provides us with another perspective on the recovery from eating disorders. A phenomenological examination of recovery also allows us to bring to light the lived experience of such psychological processes as self-esteem, anxiety, motivation, and other basic psychological categories commonly used to describe the various eating disorders in the more quantitative descriptions of psychopathology.

**Background of the Problem**

As a background to examining eating disorders, we first look at least briefly at the epidemic of obesity that is constantly referred to in popular culture and which is baffling the medical profession. Recently, the World Health Organization (WHO) created the moniker “globesity” to describe all the facets of the obesity epidemic (Delpeuch, 2012; Melnyck, 2010). In America alone, the Center for Disease Control (CDC) reports that more than one-third of all adults are obese (CDC, 2013). Although some variations can be observed in economic status and ethnicity, overall rates in the United State remain consistent and have increased each decade. Obesity rates among children in the United States have tripled since 1980, from 6% to 17%, albeit stabilizing during the past decade. The WHO estimates 180 million adults are obese (i.e., having a body mass index (BMI) of 30 to 35) and that twice as many have a BMI of 25 to 30, which qualifies them as overweight. Concomitantly, heroic medical interventions such as bariatric surgeries and its variations are increasingly used in order to respond to the epidemic.

Given these numbers, obesity may seem like a new epidemic, but its appearance as a medical problem began two centuries ago. Definitions and concepts of obesity as a problem
appear in the 17th century when the Italian physician Santorio quantified humans’ energy and metabolic rates. It then became possible to ascribe medical definitions to the processes involved in the obese individual. In the 18th century two English physicians, Short and Flemyng, produced the first comprehensive study on obesity including possible behavioral causes and treatments (Bray, 2002, 2003, 2004).

In the 19th century, then, the biology and measurement of obesity were defined. The beginning of that century marked the phenomena of obesity as a recognized social and medical issue (Bray, 2003; Gillman, 2008). Advances in the study of anatomical structures allowed for the description of the growth of adipose tissue. Quetelet, a Belgian statistician, invented the BMI still in use today (Bray, 2002, 2003). Western culture began to produce forerunners to what we might now call the diet industry. Various movements to define obesity took shape, both religious and secular, along with a public health movement in general (Gilman, 2008). The social stigma of obesity and its psychological impact on the individual is only now being recognized within the human services field (Puhl & Brownell, 2003).

Even though obesity has been recognized as a phenomenon throughout history, Western society’s concern regarding obesity has shifted in the modern era. It has been only relatively recently that obesity has been correlated with binge eating, a newly recognized disorder in which the intake of food is much larger than the needed amount. Binge eating disorder (BED) was recognized by Stunkard in 1959 during research on night eating syndrome (Grillo, 2002; Mitchell, 2008). Recent studies have suggested that BED and obesity are co-morbid in as much as 25% of the population (Mitchell, 2008; Yanovski, 2003), therefore providing a strong link between BED and obesity.
Aside from the problem of obesity as a possible eating disorder itself, obesity can and sometimes does give rise to eating disorders, and there is a fairly high correlation between obesity and eating disorders other than BED. However, it is also quite likely that a person having a BMI that falls within the average range may fall prey to an eating disorder, an observation that demonstrates the need to define eating disorders through behavioral and physiological criteria. The purpose of this study was to lend a voice to the phenomenological evaluation of one aspect of recovery without reducing it to its constituent parts; hence it refrained from engaging in a reductive approach (Mitchell, 2008).

Anorexia nervosa, a disorder characterized by self-imposed starvation that may threaten one’s health, also has a complex history. Food refusal and emaciation were seen by the medical and psychiatric community as the sequelae of other physical and psychiatric disorders that were undifferentiated in a distinct category of their own by the end of the 19th century (Bruch, 1974; Brumberg, 2000; Vandereycken, 1994). In 1873, Lesegue and Gull published accounts of a disorder involving symptoms that were concentrated around food refusal. Previously, the obsessive refusal of food was witnessed most often in asylums and was thought to exist in conjunction with “melancholia.” Emaciation and death from self starvation, called “sitophobia,” did appear randomly within the petite bourgeoisie of the Victorian era before Gull and Lesegue did their research; however, it was not reported as a widespread phenomenon. Often the symptoms were viewed as aligned with neurotic conditions reinforced by cultural expectations of frailty and parsimony that were prized values in Victorian era women (Brumberg, 2004). By the turn of the 20th century, various contemporary but independent sources show an emerging recognition of anorexia as a unique psychological phenomenon.
At the beginning of the 20th century, however, lesions on the pituitary gland were mistaken for the cause of the disorder and interest in psychological descriptions of anorexia began to wane in the scientific community. An exception was the Continental Existential tradition, in which Ludwig Binswanger used phenomenology to present the case study of Ellen West. In the 1940s, her food refusal resulted in death (Binswanger, 1994). After the “mistaken identity” of the 1940s and 1950s was clarified, eating disorders began to reemerge as psychological phenomena in the Western industrialized world of the 1960s.

The current understanding of anorexia in the psychiatric community is largely dominated by the thought of American psychiatrist Hilde Bruch (1974, 2001), who expanded the awareness of anorexia as a distinct and primary disorder in both theory and practice (Bruch, 1974, 2001).

Throughout her work Bruch stressed the formation of individual personality and factors within the family that preconditioned the patient to respond...by means of under eating or overeating...for the first time, individuals who ate excessively and those who restricted their intake to the point of dangerous emaciation were linked together as part of a therapeutic puzzle. (Brumberg, 2000, p. 228)

Bruch initially responded to eating disorders with holistic treatment models. She synthesized many of the incomplete or reductive models, such as biology, medicine, and psychiatry, with humanistic models of treatment. Ironically, her vision of holistic treatment, which incorporated humanistic and ego/self psychological principles, faded as cognitive-behavioral models became popular. In so doing, Bruch maintained sensitivity to the complexity of the awareness, identity, and motivation required in recovery. Part of the aim of this study is to return to and elaborate (and re-narrate) some of what Bruch started in the late 1970s (Bruch, 1979, 1982).
Western society has become increasingly aware of anorexia since Bruch began her work. Anorexia affects around .09% of the female adolescent and adult populations, and .03% of the male population (Hudson, Hiripi, Pope, & Kessler, 2007; Nielson, 2001). Mortality rates for anorexia are approximately 5% of those reported to suffer from eating disorders (Sullivan, 1995).

Bulimia nervosa, a condition characterized by periodic overeating accompanied by self-induced vomiting (known as “purging”), has much the same murky history as anorexia. Until the 1970s, it was considered to be a part of other neurotic conditions or a physiological malfunction. In the 1970s, a discrete cluster of symptoms of bulimia was identified, distinguishable from anorexia and obesity. Clinicians increasingly reported women who binged on copious amounts of food but who maintained their weight within the normal range by inducing vomiting, abusing laxatives, or constant dieting (Vandereyeck, 2002).

Along with the overt behavior of bingeing and purging, clinicians noticed co-morbid psychological distortions, such as disembodiment, clinical levels of anxiety about getting fat, obsessive features of the personality, and body dysmorphia. Bulimia was first defined and classified in the DSM III. The complex classifications and descriptions of various eating disorders reveal how entangled they are with history and culture. The basis if this study asserted that such disorders defy neat classification and, at some point, depend upon the existential meaning given to them by the subjects. Thus, a phenomenology reveals different aspects of eating disorder that normative and nomothetic approaches ignore.

**Statement of the Problem**

Eating disorders are well known in modern industrialized societies. The abundance of food in society implies safety and freedom from deprivation, yet the compulsive misuse of food by segments of the population threatens society’s existence. Furthermore, the counseling culture
relies upon strict quantitative and medical models that do not accurately describe the recovered person. A strict reliance on medical models leads to an unfortunate misunderstanding of eating disorders, effective interventions, and appropriate treatment. Palmer (2003) states,

The nosology of mental disorders inevitably dithers between the wish to delineate useful categories and the hope of discovering natural kinds. It would be good to achieve both, but each aspiration alone is elusive enough…. There is a tendency to emphasize the pragmatic and descriptive… Yet there is a nagging feeling that there are “real” disorders out there to be discovered rather than merely defined. (p. 1)

To reaffirm, methodological confusion seems to reign over how to conceptualize eating disorders, and the medical model definitions of eating disorders are limited. The overwhelming need to classify and quantify has taken precedence over the manifestations of the disorder itself. The “natural kinds” Palmer (2003) speaks of may indeed be definable through a rigorous phenomenology as much as via a scientific methodology. If researchers would pay closer attention to the phenomena of eating disorders as they appear in recovered individuals, they would likely make greater progress in articulating useful and comprehensive models of treatment. Concepts of recovery stemming from the quantification and classification of a medical model tend to focus clinicians’ attention on such indicators of recovery as bodyweight or the absence of overt symptoms, such as purging or binging, thus limiting effective treatment of the disorder. Though it can be argued that body weight measurements and the absence of abnormal food behavior are important results of recovery, they are not sufficient psychological indicators of health and well-being.

Limited conceptions of the disorder give rise to some striking results. First, if the concept of the disorder is limited, it follows that the concept of recovery from will also be limited,
expressly in the terms stated above. Second, treatment models will be equally limited because a broad conceptualization of the phenomena does not exist. Eating disorders, as they appear in our culture, are becoming more complex and affecting more diverse populations. Conceptualizations of the disorder should respond to its complexity, but despite the prevalence of eating disorders, no phenomenological study is known to have addressed recovery from the disorder.

Finally, eating disorders and obesity affect an ever-widening range of diverse populations, and a phenomenological exploration is likely to be sensitive to the multicultural dimensions of eating disorders. Eating disorders as a whole, including correlations with obesity, are affecting more diverse social classes, age groups, gender and age categories, and racial subgroups. The CDC reports that a third of low income children are obese. Likewise, socio-economic status is negatively correlated with obesity. The poorer a woman is, the more likely she is to be obese. The demographics of eating disorders in the United States reveal that a little less than half of those who report are males, contradicting the possible stereotype that such disorders affect mostly women. The same under-reporting by males occurs in the subcategories of BED. Statistics show that both obesity and eating disorders, if grouped together as a phenomenon, threaten the physical and mental health of very diverse groups of people within a culture (Freedman, 2005; Hudson, et al. 2007; McLaren, 2007; Sobal, 1989; Whitaker, 1998). Voices from these varied subgroups deserve to be heard. An existential phenomenological study of recovery that recognizes these voices will allow researchers and counselors to respond more effectively and in broader, more diverse ways to the disorder.

**Purpose of the Study**

The purpose of this study is to explore the lived experience of those who are recovering from eating disorders and to develop an in-depth understanding of the features of the existential
factors that contribute to recovery. The goal of the study is to find commonalities in themes, perceptions, thoughts, and understandings relating to recovery from various eating disorders. In this study “lived experience” refers to the contextualized “whole picture” of the recovered person’s world. This inquiry is based on the idea that those who have sustained recovery from eating disorders inhabit a particular experience or world. In other words, an attempt is made to describe what it is like to experience successful recovery from eating disorders. Such a description is derived from a faithful and accurate accounting of the narratives of those who have lived through the daily process of growth in recovery from eating disorders.

Of particular importance within a phenomenological investigation of the lived experience of recovery is the concept of change and transformation because recovery will not occur without it. The word transformation implies a deep change, especially a thoroughgoing or radical one, even a conversion of sorts. Thus an individual’s transformation will normally involve more than the body. The body’s recovery is only a physical manifestation of interpersonal and intrapersonal shifts within the individual. This investigation focuses on the particular essence of the transformation process in recovery from eating disorders. Simply, this study strives to describe the lived transformation experiences of people who have recovered from their disorders. Therefore, this inquiry will pay close attention to the individual’s contextualized everyday lived experience.

**Research Questions**

The guiding question in this research study is as follows: What is the lived experience of those who are going through long-term recovery from eating disorders? This broad question leads to a series of associated questions, which include:

1. What do people conceptualize as transformation and growth in the recovery process?
2. What do people who are in the ongoing process of recovery specify as essential to their recovery?

3. How do those in recovery express their recovery in other spheres of their life?

4. What are the most important existential factors that are present in the recovery process?

5. How has self-esteem or selfhood been changed by recovery?

**Theoretical Framework**

**Existential Phenomenology**

Phenomenology provides the foundation for this research study. Van Manen (1997) describes phenomenology as “the study of the Lifeworld—the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it. Phenomenology aims at gaining an understanding of the nature and meaning of everyday experiences” (p. 8). Recovery from eating disorders contains its own reality or “lifeworld” that is qualitatively different from that of one who has not suffered the illness. A phenomenological analysis of recovery from eating disorders attends to the latent meaning of the healing process that is entailed in recovery. By observing the lifeworld in its varied aspects, this study attempts to establish common aspects of recovery.

Moreover, a study of the lifeworld that is shared and contextualized in everyday experience requires attention to the existential nature of the subject of inquiry. Existentials are fundamental categories of existence. They appear as themes in individuals’ lifeworlds. Therefore, an investigation of these existential themes may uncover the lived experience of the recovering person. Existentials are lived structures of experience that are always contextualized by the individual. Life, Death, Being, and Otherness are all examples of existential structures that
provided the ground for common human experience (Van Manen, 1997). Meaning is derived from within the narratives of subjects’ lived experiences. Smith et al. (2009) state that an account of the lived experience of a subject is

[a]n illustration that demonstrates a hierarchy to experience. At the most elemental level, we are constantly caught up, unselfconsciously, in the everyday flow of experience. As soon as we become aware of what is happening, we have the beginnings of what we can describe as “an experience” as opposed to just experience…the parts are separated in time but “linked with a common meaning” and the aim of the interview would be to recall the parts and their connections and discover the common meaning. (p. 2)

This account of phenomenology establishes the subjective understanding of the individual as a primary source of knowledge. Rather than assigning categories from intellectualist constructs, phenomenology gives priority to the meaning individuals place on their experiences. A phenomenological analysis of recovery from eating disorders is be an examination of the lived experience of individuals who consider recovery to be a change (or transformation) in the meaning of their experience. This study finds that the recovered person views life as having an altered meaning and value. A faithful account of the experience reveals that those who have suffered from eating disorders regard their recovery as an immense achievement in their lives.

In conjunction with an examination of these thematic structures, a more specific theory of existentialism can help us to understand the recovery process. Existential theories of human subjectivity are sympathetic to holistic examinations of individuals within their environment, culture being one aspect of the environment. The existential subject defines meaning and significance through personal experience. The transformation of self and world are lived
existentially, through a subjective understanding of being-in-the-world. Hierarchy, as referred to here, is meant to distinguish phenomena related to recovery from the lived experience of those who have not recovered. It is reasonable to assume the lived experiences of those who have recovered are qualitatively different from those who still suffer.

It is useful to construct a model of the operational definitions of the existential experience of meaning in the recovery from eating disorders, hereafter referred to as recovery. Recovery entails the transformation of individuals across various levels of their lives. Individuals who have successfully engaged this transformation have reordered their experience or sense of self (self-esteem).

**Terror Management Theory and Eating Disorder**

Terror, whether it appears as anxiety, as panic, or within suicidology (i.e., the management of terror through annihilation) is an elemental part of eating disorders (Bruch, 1974; Farber, 2008; Heatherton, 1991; Kaye, 2004; Hinrickson, 2003). The management of anxiety and terror (panic), and the struggle for self-esteem appears as a key feature. Therefore, Terror Management Theory (TMT) is the theoretical construct that guides this study. TMT is based on the work of Ernest Becker, who asserts that the nascent awareness of mortality guides many psychological processes (Greenberg et al. 1986; Greenberg et al. 1997; Pyszczynski et al. 2004; Solomon et al. 2004). The construction of the self is welded into one’s social, ideological, or literal cultural constructs, which buffer one’s anxiety about non-being. Thus, TMT asserts that self-esteem is, in part, identification with one’s cultural milieu.

Central to psychological events, then, is the construction of the self, or self-esteem (Greenberg et al., 1986; Greenberg et al., 1997; Pyszczynski et al., 2004; Solomon et al., 2004). Terror, through developmental processes in childhood, is a universal threat to self-esteem. The
unconscious terror of death (mortality salience) is managed by self-esteem. Anxiety from that repressed fear is pervasive and foundational in all psychological processes. If the individual identifies with certain concepts, cultural ethos, or group opinions, however, the terror of death can be ameliorated or repressed (Becker, 1973). TMT attributes much of developmental and motivational psychological functions in the repression of death. The terror of death functioning as a Freudian Oedipal repression would in psychoanalytic theory. Individuals with higher self-esteem are able to stave off or manage threats to mortality imposed by worldly demands (Becker, 1973; Solomon et al. 1992). As Greenberg (1992) explained,

The roots of the connection between self-esteem and protection from anxiety reside in the individual’s early interactions with his or her parents and other socializing agents of the culture…. [I]n early childhood the need fulfillment, love, and protection afforded by the parents compromise the virtually helpless child’s primary basis of security…. [T]hese commodities become increasingly contingent on meeting parental standards of goodness and value. As these standards become internalized, this contingency leads to an association between the perception that one is meeting internalized standards of value (self-esteem) and feelings of safety and security. This association is reinforced throughout life, both directly, and vicariously, through cultural teachings and myths in which the virtuous are rewarded and the evil are punished. (pp. 913–914)

It follows that, if culture buffers the terror of death by allowing the individual to construct his or her self-esteem, then the loss of that cultural identity, or social death, is linked to literal death. Psychologically, they are the same. In the various manifestations of food disorders, one will find, if one seeks it, a relationship with the avoidance of social death (Arndt, Cook, & Routledge, 2004). Psychological processes, either positive or maladaptive, are linked to this
fundamental anxiety. Observations of change in fundamental processes—such as self-esteem, mastery, coping styles, and positive changes in philosophy—are linked to reorganization in the psyche of this fundamental anxiety as well (Leary, Schreindorfer & Haupt, 1995; Pyszczynski, Greenberg, and Solomon, 1999).

**Rationale for the Study**

The principal reason for this study was that the phenomenology of how persons make meaning in recovery is not fully understood. Meaning making within recovery is an essential feature for change (Mahoney, 1999; May, 1973; Rogers, 1961; Yalom, 1931). A sensitivity to the existential meaning of recovery is absent within professional and clinical dialogue; consequently, the essential features of what it means to heal from the disease of eating disorders is often hidden from us. Subsequently, the counseling literature on recovery is limited to quantitative and predictive orientations of research outcomes. Longitudinal studies that use quantitative methods and that might provide information on long-term recovery from various disorders are incomplete in two significant ways: (a) they are reductionist insofar as they focus upon clinical measures that do not capture the lived experience of recovery, and (b) they are focused more upon quantifying pathology rather than on aspects of the growth and diversity of experience that existential and hermeneutical studies provide (Herzog et al., 1999; Pike, 1998; Sullivan, 2002).

Extant longitudinal studies are focused on inference and causality. Most clinical studies on recovery from eating disorders focus on such indicators as body weight, suicidology, co-morbidity, and relapse (Dietz, 1997; Herzog, 1999; Pike, 1998; Strober, 1997). The general contexts of these studies are concerned with predicting future behavior and categorizing medical phenomena. Though we have many definitions that quantify highly discrete aspects of a
disordered life, we have little information on the psychological reality produced by the very subjects we are trying to describe.

For instance, Herzog et al. (1999) conducted a 7 ½ year longitudinal and naturalistic study of anorexia and bulimia, hoping to reveal aspects of the course of long-term treatment of the disorder. These researchers distinguished categories of “full recovery,” “partial recovery,” and “relapse.” Indicators were confined in this study to categories such as body weight, history of major depression, co-morbidity with Axis-I disorders, and substance abuse history. Though these categories may denote something that is helpful in understanding the disorder, the everyday structure of the experience of the subjects is largely ignored, as is their idea about the experience these categories presume to describe. Hence, a picture of the “lifeworld” of recovery that patients seek and that therapists try to inspire in their work is absent in these studies of long term recovery.

Pike (1998) admitted that “there is no predictable or normative long-term course associated with anorexia nervosa” (p. 1). However, she insisted that developing a normative and quantitative language will capture the recovery process. Her conclusion is striking in so far as she points to the limits of quantitative language and then goes on to reassert the need for more refined statistical categories in the examination of recovery. It would seem that, instead, non-reductive and phenomenological models for inquiry into recovery should be asserted when we reach such a methodological impasse. Though quantitative language is important for describing some facets of recovery from eating disorders, it is not exhaustive.

In addition, studies that address the psychological reality of recovery from binge eating and the obesity counseling literature are reductive. Research about recovery focuses either on eating habits (primarily) or describes the lived experience in terms of “risk factors” that correlate
with increased body weight (Neumark-Sztainer, 2006, 2007; Stice, 2002). General terms such as “quality of life” often characterize qualitative models; however, the reality of those who must maintain and adjust to the disorder is not elaborated upon in these studies, and the lived experience relating to the psychological reality of those in recovery is untouched. In sum, much attention has been paid to nomothetic and quantitative approaches to recovery. The aforementioned studies present statistically significant relationships among various aspects of recovery, but they do not illuminate its essential features or overall nature.

A phenomenology of the lived experience of those with eating disorders helps to provide an in-depth understanding of the disorder. For an individual who has recovered, recovery is grounded in meaning making instead of in the maladaptive aspects of the disease upon which most research inquires are focused. By understanding the lived experience of those who have recovered from an eating disorder, we can reveal the tapestry of the entire life of those who have recovered. Weaknesses, strengths, and the aspects of growth and change that are common to the lived experience of recovery can be viewed as the fabric of everyday life.

Finally, my personal experience as a counselor who has treated the disorder compelled me to look for wider definitions of recovery from the disease. When I have interacted with individuals who have been engulfed by the disorder and have prevailed, they do not speak of themselves as a collection of symptoms. In fact, if they recollect their experience, it is within a wider context of freedom, change, and burgeoning awareness of personal growth. Often the change is ineffable. The persons who try to grasp the essence of their recovery, which is always an ongoing project, seem to adopt a new perspective. Ironically, part of that perspective seems to be an eschewing of the clinical or scientific models that attempt to confine them. In short, they have achieved a broader definition of their place in the universe rather than being confined
merely to a model for managing their body weight. Quite simply, we might be tempted say that they have “changed their lifestyle.”

However, even this characterization would be a disservice to those who daily live free from this disease. One gets the sense, both literally and figuratively, that something more fundamental has been transformed, which has resulted in a change in their lifestyle rather than the other way around as the materialist might insist. The present study examined these facets of phenomena related to recovery with the dignity and respect they deserve.

**Significance of the Study**

A study on the phenomenology of recovery from eating disorders has two inter-related aspects. First, it contributes to the scholarly literature, which is lacking such an inquiry. Second, it provides a necessary contribution for those who counsel clients with eating disorders. Understanding the perspective of those who have recovered is crucial in developing a treatment for the disorder, yet the essence of what it is like to sustain recovery from an eating disorder has not been thoroughly researched. This inquiry established a wider context of recovery for counselors working with eating disordered individuals. This study illustrated how the lived experience of the client informs treatment goals, therapeutic interactions, and the supervision of counselors who are treating clients with the disorder.

In general, the study endeavored to give a voice to those who are recovering from eating disorders. It seeks to understand what recovery “means” to those in recovery. This study illuminated aspects of recovery that are frequently overlooked by other research methods. It provided an understanding for clinicians of what to expect within recovery-growth, relapse, and its vicissitudes, unfettered by quantitative abstractions. The study also outlined what clients might strive for in the transformation process without resorting to reductionist language.
Therefore, this research may affect the treatment of eating disorders through its definition of holistic and realistic outcomes of success within the context of the participants’ own experience. Research inquiries that focus exclusively on symptoms and physical attributes do not capture the essence of the recovery process from eating disorders. Existential themes such as self-esteem, authenticity, and freedom, among others, needed to be integrated into holistic models of counseling and supervision.

Human science research proposes that an accurate account of our experience is free of value-laden constructs that hinder the understanding of experience. Congruent with this perspective is that we do not represent ourselves as mere objects in the world (Van Manen, 1992). Therefore, lived experience is a concept that is non-objectifying. The exploration of the lived experience of recovery in this inquiry gave a faithful account of that experience without offering “causal explanations or interpretative generalizations of…experience” (Van Manen, 1992, p. 5). A phenomenological existential approach is crucial because individuals who have an eating disorder already treat themselves as objects. Research, supervision, and counseling models that derive their understanding from models that objectify the individual complicate recovery from the disorder. At the very least, contemporary models of counseling and supervision do not include a basic understanding of ameliorating the disorder. Thus, a phenomenological existential study that demonstrates respect for the subjectivity of the eating disordered individual makes a significant contribution to the literature.

Further, this inquiry attempted to provide insight into basic ideas about the change process (Mahoney, 1991). A phenomenology of recovery will illustrate for researchers and practitioners the lived experience of change that other research models reduce to variables. The
growth and enduring character change that recovery entails came into focus within this inquiry, thereby adding to the tools available to the professional who regularly treats eating disorders.

Additionally, this study will assist counselors in understanding the essential features of the lived experience of those who have recovered. Counselors need to grasp the holistic nature of the project of recovery to provide competent services. The study should also have practical applications for mental health professionals who wish to understand certain aspects of recovery from the maladies of their patients. A phenomenology of recovery allows for a better use of psychotherapeutic models sensitive to human science themes (Ellenberger, 1958; Giorgi, 2006; Laing, 2010; May, 1938; Van den Berg, 1980).

In the last two decades, models of recovery that are linked to an overall psychological theory have centered mostly on quantitative and cognitive/behavioral approaches. They remain tertiary, lacking the depth and gravity that a phenomenological analysis can provide. Most recent studies have focused upon short-term, cognitive-based interventions and their effectiveness (Fairburn, 1981, 2008; Fairburn, Shafran & Cooper, 1999; Garner, Bemis, 1982; Pike, Walsh, & Vitousek, 2003; Telch, Agras, & Linehan, 2000, 2001).

In addition, although recent studies have pointed out important aspects of treatment and counselor interaction, they have not addressed the existential or humanistic themes of growth and transformation that are necessary for understanding recovery. The process of transformation from a traumatic symptomology to a state of healing and growth is rarely encountered in the literature on eating disorders. Bruch (1982) did establish a semi-qualitative approach to the study of anorexia, but then the cognitive turn in psychology undermined attempts to understand recovery from eating disorders within other contexts. This cognitive turn toward information
processing models established a false sense of concreteness that does not present a holistic picture of recovery.

Existential and humanistic psychology, among other models, asserts that the reworking of an individual’s relationship to existence has a healing and transformative function. Greater autonomy, freedom, and recognition of values in the face of existence are consequences of individuals’ encounters with figurative and literal mortality (Rogers, 1995; Schneider, 2001; Yalom, 1980). Minimal categorical models of psychotherapeutic interaction, which have examined merely the relief of symptoms, have failed to grasp the importance of growth or intrinsic goal setting in the individual (Deci & Ryan, 2010; Tedeschi, 1998). Basic management of symptoms does not represent the true aim of counseling and of psychotherapeutic models of intervention. The concept of recovery implies an enduring character change, which is the desired result of therapeutic interaction.

**Definition of Terms**

**Addiction:** Compulsive behavior, experienced as beyond a person’s control; associated with various unhealthy psychological and emotional states.

**Anorexia nervosa:** A condition of self-inflicted starvation that precipitates drastic and possibly life-threatening weight loss. It manifests as the relentless pursuit of thinness at any psychosocial or physical cost.

**Body dysmorphia:** The distortion of body image in which individuals believe they have excess adipose tissue on their bodies. Feelings of loss of control, remorse, and guilt often accompany the behavior.
**Bulimia nervosa:** A condition of dysfunctional eating marked by cyclical episodes of gorging on food and purging. Feelings of loss of control, remorse, and guilt often accompany the behavior.

**Binge eating disorder:** A condition of dysfunctional eating marked by rapid consumption of food in greater amounts than the individual would need for bodily health. Feelings of loss of control, remorse, and guilt accompany the disorder.

**Constructivism:** A theory or diverse set of theories that recognizes psychological processes and human agency as interrelated. Therefore, there is a “social-symbolic relatedness” (Mahoney, 2003, p. 4) that can describe social phenomena, psychological disorders, and concepts that surround and predict behavior. In this study, it means a theoretical tool that aids the researcher in understanding the lifeworld of the eating disordered person.

**Eating disorder:** A cluster of symptoms, related to food intake and possibly life-threatening, that pose problems to an individual’s health and well being.

**Existentialism:** “[A] philosophy that confronts the human situation in its totality to ask what the basic conditions of human existence are and how man can establish his own meaning out of these conditions” (Barret, 1959, p.126). Moreover, totality here examines the cultural and symbolic world out of which humans make meaning through their interactions as a self-aware agents (Pyszczynski et al. 2004).

**Self-esteem:** An overall cohesive sense of self efficacy and security felt by an individual and predicated on existential, cultural, and developmental factors. Self- Esteem is related to other humanistic concepts, such as actualization and growth (Greenberg, 1997; Maslow, 1968; Polkinghorne, 2001; Rogers, 1961).
**Lifeworld:** “The world of lived experience…‘the world of immediate experience’, the world as ‘already there’…as experienced in the primordial attitude, that of ‘original natural life’” (Van Manen, 1997, p. 182).

**Lived meaning:** “The way a person experiences and understands his or her world as real and meaningful. Lived meanings describe those aspects of a situation as experienced by the person in it” (Van Manen, 1997, p.183).

**Recovery:** A lifestyle pattern that entails the significant amelioration of symptoms from a disorder.

**Transformation:** A pattern of positive change in character, disposition, or experience.

**Organization of the Proposal**

This research in this dissertation begins with a background of the topic and then proceeded to a statement of the problem, a rationale, and the study’s significance to the counseling literature. Chapter 2 provides a comprehensive overview of the available relevant literature. Because the topic of recovery from eating disorders draws upon many diverse fields of interest, I begin with a further exploration of the concepts related to eating disorders from the historical inception of the diagnosis until the modern era. Recovery as both a distinct phenomenon and a process is discussed in the literature review. The various ways in which psychological treatment models describe recovery from eating disorders are also covered. The study then attends to the more specific models of existential psychotherapy and their relevance to transformation in recovery.

The review then focuses on the main theoretical models used to shape the themes (data) in this inquiry. Namely, Van Manen’s (1992) approach to existential phenomenology is discussed, and the concomitant literature also briefly presented. Further, a specific approach to
existential theory called Terror Management Theory, derived from the work of Ernest Becker (1973, 1975), is expounded. This theory is then linked to the understanding of eating disorders and its relevance to the recovery process reviewed.

Chapter 3 further elaborates on the qualitative research design of this study and the specific theoretical foundation that it uses to conduct the inquiry. Techniques for collecting data, selecting participants, and analyzing data are presented. Specific attention is paid to strengthening the reliability of the results acquired in data interpretation. Exact procedures for entering the fields, coding data, and selecting participants are explained. Finally, ethical considerations are outlined in this chapter.

Chapter 4 presents the findings this research has produced. Summaries are derived from the transcripts and presented in narrative form. From the narratives, meaning units are organized through the major theoretical perspective of the four existentials, Terror Management Theory, and the social constructivist’s perspectives on eating disorders. From those meaning units, the main themes are derived, which illustrate a cross case analysis of the lifeworld of recovery. The analysis followed the phenomenological and existential frameworks defined in Chapter 2 of this inquiry.

Chapter 5 discusses in detail the main themes that appeared across the cases. Each theme is paired with the research question it best answers, and the research questions are elaborated upon and answered via these emergent themes. After each research question is answered, the implications and relevance for counseling are discussed. The inquiry concludes with the limitations of this research, and a list of possible research hypotheses that it has generated for future research.
CHAPTER II: LITERATURE REVIEW

The purpose of this literature review is to provide the knowledge necessary for a better understanding of the lived experience of recovery from eating disorders. There are many narratives in the popular literature on eating disorders. Furthermore, some minimal accounts exist in the counseling literature on the phenomenological and social processes of eating disorders (Brewerton, 1995; Chernin, 1994, 2007; Claude-Pierre, 1997; Garrett, 1998; Hardin, 2003; McElroy, 1994; Pettit, 2006; Sours, 1980; Woolf, 2013). However, as mentioned in Chapter 1, there is no schematized account of the recovery from eating disorders—that is, a rigorous qualitative inquiry provided by, for example, phenomenology.

Some authors have elaborated on the use of the phenomenological existential model for the investigation of anorexia (Binswanger; 1958; Bowden; 2012a, 2012b, 2012c; Lee & Lee, 2000; Meurleu-Ponty, 1964; Mulveen & Hepworth, 2006; Strober, 1991). These authors are presented as part of this literature review. However, their contributions mostly concern the phenomenology of the disorder itself without addressing the phenomena of recovery. The research derived from this inquiry is conceptualized to add to this body of work. The hermeneutic phenomenology of recovery from eating disorders proposed in this inquiry may begin to fill in this gap.

The phenomenology of recovery from eating disorders and obesity requires an inquiry that spans various fields of study. This review of the current literature commences with the history and conceptualization of eating disorders, first anorexia and then bulimia and binge eating disorder (BED). The historical and psychosocial aspects of each disorder will be presented, the current professional concepts of the disorders will be reviewed, and their cultural contexts will be examined for a better understanding of the experience of the individual. The
extant literature on the phenomenology of eating disorders is also be reviewed. Each disorder is presented in its social and cultural context, and special attention is given to the social and cultural construction of the disorder and its relationship to the lived experience of the disorder.

I then move onto models for recovery and its relationship with the change process. The way in which the counseling field defines the recovery process is presented, and the Stages of Change model is explained. Further, the study links recovery, as both a sudden transformation and a long term process, with concepts of transformation and healing. An adequate account of the models of recovery may bolster the understanding of the lived experience of recovery from eating disorder.

Finally, the theoretical constructs that guides this inquiry, TMT, is reviewed, and the theory’s relationship to the recovery from eating disorders and obesity is presented. TMT can provide a link to the existential themes that appear within the recovery literature. Additionally, this inquiry’s use of the phenomenological method is explained.

**Anorexia Nervosa**

**The History of Anorexia**

The historical understanding of anorexia nervosa is complex. As Vandereyecken (2002) observes, “Throughout history we can recognize the heterogeneous manifestation of disturbed eating behavior. Whereas the terms ‘bulimia’ and ‘anorexia’ have been used for ages, their nosological status has continually been a challenge” (p.151).

The DSM 5 classifies several diagnostic criteria for anorexia nervosa. The first is a restriction of food significantly below the necessary intake to maintain a healthy body weight as per the person’s age and height. The BMI standard measure is used, the number ranging from 17 to 15 according to whether the disorder is mild, moderate, or severe listed in the DSM 5. Second,
the intense fear of gaining weight despite objective criteria for low body weight has been established, and the accompanying behavior that drives the body weight down is included. The third criterion is the way the body shape is experienced and the degree to which its influence on self evaluation is distorted. The DSM 5 is vague on what constitutes the criterion of distortion. As we shall see later in this literature review, the word “distorted,” in referring to body image, has different meanings. It usually involves the idea that a person’s self-evaluation of “too fat” leads to life threatening behaviors. Additionally, two subtypes of anorexia have been identified: (a) a restricting type in which there is an absence of compensatory behaviors, such as purging and misuse of drugs to maintain a low body weight, and (b) a binge-eating, purging sub-type that includes these compensatory behaviors (DSM-5, 2013).

Presently, a controversy rages over the exact definition of anorexia. The new DSM 5 establishes further criteria for diagnoses, but it still remains a nosology that, despite its attempts at precision, remains inexact. When it is read rigidly as a medical text, some argue, it hinders the understanding of all disorders. The medical model approach currently reifies its own nosology. As Gordon (2010) states,

Unfortunately, researchers tend to adopt a rigid DSM definition of a given mental disorder when conducting empirical studies, and this practice has likely hindered the progression of knowledge about the disorder’s etiology and treatment…. Eating disorders experts have encouraged clinicians and researchers to stop reifying the DSM. (p. 17)

Given the current controversy, it is necessary to gain an understanding of anorexia and other eating disorders in their historical context. Viewed from an historical and thereby cultural stance, the origin, definition, and course of the disease can be seen as socially constructed. The opinions derived from the nosological classifications over the years range from Bell’s (1985)
treatment of it as a trans-historical, psychological condition, to other authors’ more social constructivist view that historical accounts of self-starvation have different meanings in different historical contexts (Brumberg, 2000, 2004; Habermas, 1989; Hepworth, 1999; Malson, 1997). The social constructivist view of anorexia challenges the medical model of the phenomena that is accepted in our current counseling nomenclature. The following account traces the history of self-starvation and places anorexia in some of the above-mentioned contexts.

According to many authors, food behavior in Western culture has always been linked to some form of transformational or social ideal (Brumberg, 2000, 2004; Habermas, 1989; Hepworth, 1999; Malson, 1997; Vandereycken, 1994, 2002). Until the beginning of the 19th century, the phenomena of self-starvation were confined mostly to religious practices. Brumberg (2000) and Vandereycken (1994) observed that the early practitioners of self-starvation did not have the depravity and humiliation of the modern anorexic. Both authors described a transformation of self starvation from a religious phenomenon, to a public spectacle, to its eventual medicalization at end of the 19th century.

Self-starvation in the medieval period was confined to religious practices. The term *anorexia mirabilis* is used to describe the distinction between the use of self-starvation for enlightenment and its disordered counterpart (Brumberg, 2000). Fasts in the Catholic Church had prescribed and circumscribed rules. The rules most likely existed so that the devout would not eventually perish. The ability to control one’s appetite was seen as a holy act and as part of a sacrifice to a larger purpose. It was viewed as a heroic asceticism (Vandereycken, 1994).

The saints who waged war against their own bodies so relentlessly were treated by many of their credulous contemporaries with reverence and awe. In the eyes of many, their extended
fasts did not originate from self-interest; they were a form of expiation of the sin of all, for just like the Christ, they took the sins of mankind upon themselves (Vandereycken, 1994, p. 25).

For some, the only difference between what we now call anorexia and the self-starvation of the Middle Ages is the social context. However, in viewing eating disorders from a social context, elucidated in Chapter 2 of this inquiry, the social construction of the disease separates self-starvation from what is now labeled “anorexia nervosa.” While a heroic view of self-starvation was taken by that age, the reverse could also be true in the minds of men of that age. Many of these ascetics were seen as instruments of the devil, or in the case of women ascetics, as practitioners of witchcraft (Brumberg, 2000; Vandereycken, 1994). Anorexia nervosa was largely thought of as a woman’s disease, and even today male sufferers who identify as anorexics in contemporary culture are few (Hudson et al. 2007). Thus, self-starvation seems to have been a phenomenon related mostly to women even in the medieval period. As Western culture progressed, the phenomena of self-starvation transformed in culture in two ways. First, it became an almost exclusively female occurrence. Second, it lost its character as being considered anorexia mirabilis and morphed into anorexia nervosa.

From the Middle Ages until sometime in the 1600s, self-starvation changed its character from that of a holy fast to a public spectacle. Vandereycken (1994) argued that the private ritual of the holy fasts began to lose its religious connotations and to take on aspects of a social event. At the very least, the motivations of individual practitioners were mixed. Until the mid-1600s, self-starvation had not been understood as anorexia nervosa. Therefore, it was not a condition from which to recover; rather, it was chosen, an act of the will. Brumberg (2000) and Vandereycken (1994, 2000) described the subtle transformation of anorexia from a social phenomenon that brought notoriety, during the Middle Ages and for 200 years or so afterward, to
a full-fledged psychiatric disorder in the modern era. In between these two historical points, anorexia was considered the result of underlying psychiatric disorders without its own identity.

Anorexia nervosa as a psychiatric condition or as part of any nosological scheme was adopted by the English physician Richard Morton. “His depiction of atrophia or phthisis nervosas in 1689 was credited as the first medical description of the current concept of anorexia nervosa” (Vandereycken, 1994, p. 118). Although Morton did not detail exact symptoms and though he probably thought of it as a result of some underlying condition of which he was unaware, he did identify primary feature of starvation as neurosis. While these symptoms may have appeared to be synonymous with the origins of anorexia, controversy remained regarding the true origin of anorexia, according to Morton. Brumberg (2000) has objected to the idea that Morton discovered what we now call anorexia nervosa. She asserted that the evidence is inconclusive at best, and she does not believe that what Morton was describing were cases of anorexia nervosa. Brumberg relied more on a social constructivist perspective in describing anorexia throughout history.

Though tracking the phenomena of anorexia in history is subject to interpretation, it is a historical fact that the modern diagnosis of anorexia nervosa was established in 1873. Earlier in the century, physicians had noticed cases in which their patients had died as a result of self-starvation and in which no other medical cause had been observed. The diagnosis “nervous consumption,” or “sitophobia” began to appear in the 19th century. These cases were not, however, a part of the creation of anorexia as a modern diagnosis (Silverman, 1989; Vandereycken, 1994, 2002,).

The term anorexia nervosa finally appeared in the medical literature in 1873. There is controversy concerning who discovered the syndrome. In 1868, the eminent English doctor
William Wilty Gull presented a case wherein self-starvation stood on its own as a syndrome unexplained by other medical criteria, although the article did not explicitly use the term *anorexia*. Whereas Morton had been concerned with eating behavior, Gull observed that the patients he was treating had are not exhibited symptoms owing to any problem with their digestive system. Five years later another professional would begin to outline the modern disease.

In April of 1873, Ernest Charles Lesegue, a French psychiatrist, published an article entitled “De l’anorexie hysterique,” in which he presented the case studies of eight women. In his publication, Lesegue described what we now recognize as the classic symptoms associated with the modern diagnosis of anorexia: food refusal, lack of a menstrual cycle, intense fears of getting fat, and other associated symptoms. Whereas Gull was the first to publish his findings, Lesegue was credited with creating the term *anorexia* and outlining its formal symptoms. Therefore, both men are considered to be co-discoverers of the disease. According to Vandereycken (2002), “A century after Gull and Lesegue’s [findings]…the principle signs of anorexia nervosa have not essentially changed…the publications…acquired and almost immediate and widespread acceptance within medical circles” (p.165).

Hence, the currently accepted modern classification of anorexia nervosa began with Lesegue and Gull. There are various arguments about how anorexia was conceptualized as a disease during the 19th century until Hilde Bruch (1978, 1979) explored anorexia in a more comprehensive way. What is important here is, given that anorexia arose as a disorder in the 19th century, the definition may be regarded are malleable according to the cultural context. The basic fact that anorexia, as well as other eating disorders, is one of several serious emotional and psychological maladies does not belie the awareness that they are also socially constructed.
Concerns about anorexia nervosa and its treatment resurfaced in the United States during the 1970s and 1980s. Two women psychiatrists, Maria Selvini-Palazzoli and Hilde Bruch, began to reformulate the concepts and treatment models for anorexia. Selvini-Palazzoli is discussed later in this chapter in regard to her contribution to the family etiology of the anorexic. Bruch, however, began to treat the spectrum of eating disorders from anorexia to obesity. In her classic book on the subject, Bruch (1978) discounted the arguable Freudian view that anorexia can be understood as the result of a disruption in the oral stage of development. Furthermore, while being sensitive to the idea of disruptions of the self, she observed that anorexia and obesity do function like addictions and/or compulsions.

Treatment models that are successful are found to start at this level of the illness. One might say that this is not a holistic viewpoint. On the contrary, Bruch’s works are seminal because she engages all levels of inquiry to grasp the idea of the self in the clutches of an eating disorder. While Bruch was primarily a neo-Freudian, she is seminal because she understands the complexity of anorexia and all eating disorders. Her work is sensitive to the cultural, biological, and developmental paradigms that help construct the epidemiology. Though Brumberg (1988) defined her as a neo-Freudian, her contributions reached farther into the territory than the limited psychiatric model can or does. Bruch called for a synthesis of cultural, biological, and developmental ideas to provide a better understanding of and treatment for eating disorders (Bruch, 1940, 1962, 1971, 1975, 1978, 1979; Brumberg, 1988).

Within the framework of this inquiry, she was one of the first authors to understand the complexity and breadth of an eating disorder as a lifetime course of treatment. Bruch (1978) states that
[e]ven modern authors recommend their approach…on the speed and magnitude of weight change. It has been known for a long time that it is relatively easy to effect short-term weight changes, both in obesity and anorexia, and this can be done with practically any method. The real problem is whether this represents a lasting improvement. (p. 377)

I believe that the author here began the modern discussion on the complex understanding of eating disorders that must be derived from multiple paradigms. Bruch (1978) spoke to the information and cognitive-behavioral models that comprise many of our current treatment methods. The phenomenological and hermeneutic analysis that constitutes this inquiry may contribute to a deeper understanding of recovery from the disorder. In contrast to the information processing and behaviorist models, which are relatively successful at producing short term amelioration of symptoms, this inquiry will seek to understand through its methods the essential features of lasting improvement that Bruch (1978) called for in her work. For a more comprehensive view of the relevant literature, I now turn to other voices within the existential and phenomenological paradigm.

**Phenomenology and Anorexia**

A review of the existential phenomenological literature on the lived experience of anorexia nervosa, though the literature itself is scant, must include a brief description of Ellen West. At age 20 when she developed the symptoms of anorexia, Ellen became a patient of the psychiatrist Ludwig Binswanger (1958), who wrote a long and moving account of this woman’s struggle. Despondent over her illness, she committed suicide at age 35 after a long course of treatment. In his analysis, Binswanger attempted to use terms that related to Ellen’s being-in-the-world to give shape and understanding to her death.
Frequently in his account, Binswanger (1958) was assiduously sensitive in describing Ellen’s world. In doing so, he outlined some of the basic existential dread and anxiety that burden and anorexic’s life, and demonstrated how it is situated within the context of that person’s world. For instance, he wrote,

Ellen West’s desperate defiance in wishing to be herself, but as a different being from the one into which she has actually been thrown from the ground of her existence, shows itself not only in revolt and battle against her fate (her being a woman, her home, her social class, her desire for sweets, her tendency to get fat, and finally her illness) but also a revolt and battle against time. Insofar as she refuse to become old, dull, and ugly, in a word “fat,” she wants to stop time, or as the saying goes refuses to “pay her tribute” to time. (Binswanger, 1958, p. 299)

Likewise, in keeping with a hermeneutical phenomenological tradition, he provided a somewhat sketchy analysis of lived time in the case of Ellen West. He pointed out experiences, such as the denial necessary for the compulsivity disordered eating. He observes that the past, present, and future within the disorder remained subservient to the eating disorder process. In the end, Binswanger did not explain the suicide of Ellen West. Nonetheless, his account stands as an exhaustive phenomenological case study that illustrates a person’s suffering from the illness (Binswanger, 1958).

An addendum to the case comes from Carl Rogers (1958). Rogers recast the case in terms of the existential loneliness that Ellen West felt. Rogers, true to his person-centered approach, believed that Ellen West’s symptoms turned upon the axis of loneliness, and being alienated from others; he regarded Ellen as a profoundly alienated young woman. He also presaged some of the social and feminist constructivist positions presented later in this section. Roger’s focus on
loneliness highlighted the lived experience of others (although Rogers does not call it this) that Binswanger (1958) did not address in his work.

Neither thinker, of course, exemplified the phenomenology of recovery. Ellen West, at no time in her life, presented a consistent picture of recovery from the disease. Tragically, the only freedom that Binswanger (1958) reported comes at the end of West’s life, just preceding her suicide. A phenomenology of recovery will thus present a more comprehensive picture from that found in Binswanger’s case study. This inquiry will attempt to provide an analysis of the recovery from the disorder.

A much more recent phenomenological analysis of anorexia has been presented by Bowden (2012). This author used a phenomenological approach to understand the lived relationship of the body within the lived experience of the anorexic. In particular, she examined the pathological corporatization of the body in those who suffer from the illness. Her analysis is relevant to a phenomenology of recovery because it provides a picture of one aspect of the lifeworld existentials of the anorexic. In doing, so she references Sartre’s conception of shame, and Merleau-Ponty’s description of the lived body to help understand anorexic experience.

Bowden (2012) observed that the distinctions between normal and abnormal, absence and presence in psychiatry are not accurate tools for describing the experience of the anorexic’s distorted body image. Her objections are mainly due to the descriptions of anorexia in psychiatry that are removed from a cultural context. She pointed out that the lived experience of the body, even in so-called non-pathological persons, is distorted and viewed as larger than normal. Therefore, negative judgments appear in the non-pathological person’s image of the body. The obvious argument that the difference between pathological and non-pathological perception is a matter of degree does not provide a clear picture of the phenomena.
Rather, Bowden (2012) suggested that “there is a shift in the way the body is experienced...in anorexia nervosa...the body shifts to the forefront of the anorectic’s attention in an objectified manner” (p. 233). The way of being-in-the-world for the anorexic is to be hyper aware of the body. The objectified nature of the experience leads to the possibility of shame; it is not the experience of shame itself. This distinction is crucial because the experience becomes culture bound. Being hyper aware is the phenomenology; however, the feeling of “fat” is the experience of shame around the body as a social and cultural construction. Moreover, the definition of shame becomes reorganized. Rather than an internal process, “shame” over the body becomes a possibility derived from the lived experience of the body in its relationship to the other. Shame is a socially constructed category for the anorexic.

Bowden (2012) argued that the experience of not fitting into one’s body, feeling it as an objectified presence that is “fat” by cultural standards, gets labeled as shame. When one is lost in shame, the body “feels incredibly visible...it appears to me it is taking up too much space” (p. 234). Whether this “shame” is thought of as some cover for a pathological childhood relationship or whether it functions as some other compensation cannot be known. We can see however, that the feeling of the objectified body becomes morphed into the sense of being fat through the cultural web within which the anorexic exists.

Giordano (2012) amended Bowden’s arguments and accused her of applying categories such as “irrational” and “pathological” to the experience of the anorexic. She added that anorexia is the relentless pursuit of lightness. The author related the feeling to a sense of being unburdened and perhaps free. Giordano contributed to the phenomenology of the disorder by proposing some essential themes that are present in the condition. She asserted that the aforementioned feeling (transposed into fantasy) is not irrational and, thus, that it seemingly
should not be made into pathology. However, while her analysis was insightful, she missed the fundamental fact that anorexia is a condition that, if not arrested, leads to death. Hence, the perceptions and fantasies that maintain the disorder can be understood and yet remain pathological.

Bowden (2012) grasped that the world of the anorexic is in need of change. It is in this spirit that the present inquiry seeks a phenomenology of recovery. Bowden’s focus on phenomenology and constructivist psychology matches the spirit of the inquiry. While it is crucial that the outside observer seek to give a faithful account of the experience, doing so does not mean that the experience is judgment free (Van Manen, 1997). By grasping the lifeworld of one suffering from an eating disorder, the individual can understand the necessary transformation of that world. Accurate descriptions of the disorder—and, in this inquiry, the recovery—provide for accuracy in formulating treatment models.

The phenomenological approach recasts the idea of treatment models for anorexia nervosa. In common psychological nomenclature, the strategy of preferred methods of treatment, such as cognitive behavioral therapy, has been to change thoughts and thereby change perceptions. An anorexic would presumably perform some internal cognitive operation (or one suggested by a therapist) which would develop positive self talk about the body, and develop routines in thinking that would be positive instead of negative subjective interactions (Butler, 2006; Fairbain, 2003; Garner, 1997; Pike, 2003). However, if the issue is not negativity and shame, but hyperawareness, then treatment models must change accordingly.

Phenomenological and constructivist views concerning the treatment of anorexia are less authoritarian and direct that such psychological approaches. These models take into account that there is a dynamic relationship between the individual and the social world. Accordingly,
understanding the process of healing or amelioration of a problem in any change process requires considering a self-interpreted meaning rather than the process depending on discreet operations that change behavior (Mahoney, 1991, 2004).

In her phenomenological awareness of anorexia, Bowden (2012) turned to a social constructivist view of anorexia to give shape and form to the lived meaning of at least part of the experience of the anorexic. She explained that the aforementioned description of “the experience of the body as fat is partially culturally informed” (Bowden, 2012, p. 234). This inquiry will also focus upon social constructivism in relation to the lived experience of eating disorders.

Social Constructivism and Lived Experience

A review of constructivist theory is included in this section because the literature on eating disorders reveals distinct social structures that surround the disorder. I assert that if one is to understand the lived meaning of recovery from an eating disorder, the social contexts of the disorder must be included. The lived meaning is experienced in the subjective experience of the everyday life of the individual. Berger (1961) explained,

Everyday life presents itself as a reality interpreted by men and subjectively meaningful to them as a coherent world…. The world of everyday life is not only taken for granted as a reality by the ordinary members of society in the subjectively meaningful conduct of their lives. It is a world that originates in their thoughts and actions, and is maintained as real by these…by which the intersubjective commonsense world is constructed…. A detailed phenomenological analysis would uncover the various layers of experience, and the different structures of meaning…in the common intentional character of all consciousness. (p. 9)
In this study, inferences will be drawn between the social construction of everyday life and Van Manen’s (1997) conceptualization of lived experience. Both methods contain a stance that is not reductive. Specifically, they do not place eating disordered behavior within the individual, either by asserting a genetic causality or by a behaviorist/information-processing model of development. It is expected that the narratives of those who are recovering from the disorder will reference a dynamic relationship with the social world. Social constructivism is a theory that identifies the creation of psychological processes, and behaviors are enmeshed social constructs. These social constructs are historical, given the simple fact that society changes over time. When we apply this idea to eating disorders, subjective meanings are experienced by those with disorders and are often assigned in a cultural context. The lived experience of the eating disordered person, as for any person, is manifest in the socially constructed everyday life. Lived meaning also arises from the encounter with everyday life.

Where eating disorders are concerned, for instance, Western culture in particular is preoccupied with bodily appearance and physical attractiveness. These are other examples of social processes. These psychological processes make up the lived experience of the individual. Within the modern socio-cultural context, body weight, eating, and appearance have become vital social determinants for success and social efficacy. Cultural messages such as “thin people are good” and “fat people are bad” are profuse in our cultural awareness. Fat people are seen as “psychologically disturbed,” “lacking in willpower,” and “lazy.” The inverse then follows that thin people are powerful, energetic, and psychologically stable (Malson, 1992, p. 80).

Similarly, developing a “good” body image and being perceived as attractive in culture “can shape personal and interpersonal experiences over the lifespan” (Cash, 2002, p. 277). Given these kinds of social-cultural messages, it is readily inferred that the anorexic’s desire to be thin
is not a genetically determined event; rather it is a social creation derived from society’s expectations of normalcy, efficacy, and/or power.

The social constructivist/constructionist, referred to henceforth as constructivists and the concepts as constructivism, offer important revisions in the theory of eating disorders. These theorists did not place the phenomena within the individual per se. Rather, they asserted that the subject has a complex interaction with the social structures encountered in culture, history, and society. In doing so, they linked social understanding with phenomenological and intersubjective stances (Combes, 1996; Cunliffe, 2008; Gergen, 1975, 1992; Hacking, 1999; Kortoba, 2002; Miranda & Saunders, 2003).

In asserting the primacy of social interaction, social constructivists either dismissed or amended the commonly held views of the etiology of eating disorders as placed within a genetic framework or in strictly individual psychological processes. Since constructivist theorist ideas span a wide variety of theoretical orientations, it is necessary to provide a general definition.

For this study, what is meant by “social constructivism” is the theory that at least some portion of human agency can be explained by the individual’s placement in culture and history (Berger, 2011; Gergen, 1985; Kegan, 1985). Mahoney (1991) described constructivism as “a portrayal of the organism as an active agent in its ongoing development, and as a means of highlighting the social contexts that construct and orient our efforts of knowing, communicating, and becoming” (p. 96).

Even though subjects may have freedom and will in their environments, the fact remains that they are immersed within cultural and historical structures. The psychological processes in the everyday lives of individuals comprise encounters with intellectual and societal givens. These societal givens are historically produced and are codified in symbols and language.
In the case of eating disorders the social norms or givens include attitudes about body weight, beauty, normalcy, and mental illness (Bordo, 2004; Berger, 2011; Cash, 2002; Foucault, 1973; Hepworth, 1999, Malson, 1997; Reischer, 2004; Weiss, 1999).

Social constructivists pointed out two intertwined aspects of the phenomenon of eating disorders. The first is the creation of eating disorders as a diagnosis. As we have seen, self-starvation has taken on different meanings throughout history according to the social forces that surround the individual. Within the sciences, the positivist assertion that anorexia nervosa and all eating disorders are a genetically inherited trait challenges the commonly accepted social categories. It is clear that within the phenomena of self-starvation, some of the classic DSM IV-R categories can be inferred, while others are not present (Brumberg, 2000; Gremillion, 1992; Hepworth, 1999). Whereas some constructivists and post-modern thinkers completely disregarded genetics as an explanation of psychological states or descriptions of mental illness, others may have conceded some importance to them and advocate for a system that accommodates all explanations of eating disorder frameworks.

The defining factors for constructivists in understanding the phenomena are the social, cultural, and historical contexts. The existential dimension of persons’ awareness is affected by the interaction with social structures. While epistemological arguments of the limits of human agency or authorship are present in constructivism, we can agree with Mahoney (1991) for the purposes of this study in the following statement:

We are, in fact, both subject and object of our own personal knowing, and aware of only a few of the processes that underlie our efforts. The tacit rules by which we live (eat, breathe, intuit) — in other words, the scaffolding of personal realities — limit what we do and do not know and what we can and cannot experience. (p. 113)
The second aspect of constructivist awareness is the other societal structures that surround the everyday reality of the eating disordered individual. In any given society, the constructions of gender, the attitudes of the body in culture, and the concepts of self, to name a few, affect conceptions of eating disorders. Gergen (1975) explained,

It begins with the radical doubt for the taken-for-granted world—whether in the sciences or in everyday life—and its specialized form act as a social critique. Constructivism asks one to suspend belief that commonly accepted categories or understandings receive their warrant through observation. Thus, it invites one to challenge the objective basis of conventional knowledge. (p. 4)

The “radical doubt” that social constructivists introduce into the understanding of eating disorders has many facets. One is the skepticism conserving natural categories of illness. This skepticism invites a challenge to the commonly perceived and accepted standards of beauty, embodiment, and identity in a culture that can foster the illness.

Therefore, a complex synthesis of agency and social processes exist within each social phenomenon. Within such social phenomena as eating disorders, one who wishes to understand the lived experience will be suspicious of etiological models that assert something other than a socially constructed paradigm. A useful concept in understanding eating disorders within the context of culture is the concept of a human kind. Hacking (1986, 1999) asserted that categories that appear in culture are also categories that persons become aware of consciously. Therefore, they can become a classification in culture, what Hacking calls a human kind.

Hacking (1999) was aware of the implications for eating disorders. He wrote, “In any intuitive understanding of ‘social construction,’ anorexia must be part of some social construction. It is...a transient mental illness, flourishing only in some places at some times” (p.
2). Hacking admitted that the processes are real, that an outside power grips the sufferer. What he has proposed is a dynamic nominalism in which persons who are labeled as a particular “kind” are also aware of the possibilities and social parameters of this label. He eschewed a simple compromise between nature and nurture ideologies for a complex set of social construction ideas and their enmeshment with human agency.

Within the natural sciences, Hacking pointed out those categories of persons that can be created by different fields of discipline. For instance, in the above section we have seen the different manifestations of anorexia within a social and historical context. Identifying some combination of genes that are responsible for the process of anorexia seems facile. Rather, in a philosophy of human kinds, persons become aware of their behavior and alter it according to the possibilities that are present in the culture. Therefore, the essential element in the creation of such a disorder as anorexia is a self-interpretation made by the subject. Hence, this awareness led Malson (2001) and Hepworth (1999) to talk of different modes of anorexia in the modern cultural milieu.

Likewise, Bowden (2012) used Hacking’s concept of “human kind” to help explain the possibility of the corporatization of the body in consciousness. She asserted that the feeling the anorectic has of being dispossess in the body is her meaning the word “fat.” Therefore, the interpretation and the construct come together to create the anorexic’s feelings around the body. The anorexic would then add onto that word other multiple meanings of the word “fat” that exists within the culture. Hence, the anorexic’s identity becomes congruent with the multiple meaning of “fat” in the social milieu. This inquiry asserts that the constructivist definitions of dynamic nominalism can be valuable for understanding the entire lifeworld of an eating disordered person. If that person is co-constituted by self interpretation, as Hacking (1995)
asserted, then the person’s subjective experience can be understood partially through constructivist theory. The processes and interpretations of the social world appear in lifeworld existentials, and therefore, become relevant for recovery.

**Social Constructivism, Lived Experience, and Anorexia Nervosa**

This inquiry asserts that the social forces that help generate anorexia in our culture are now multifarious. It attempts to unearth the hidden social forces and their transformation by examining the narratives of the anorexic in an ongoing recovery process. In the modern era, we have travelled from the few isolated cases that Lesegue discovered to recognizing anorexia as widespread cross-cultural phenomena. The constructivist and feminist authors of the modern era have observed that much of Western cultures’ tenets and values have helped to perpetuate the behavioral and psychiatric definitions of the disorder (Bordo, 2004; Brumberg, 2000; Gremillion, 1992; Hacking, 1995; Malson, 1997, 1999). In Hacking’s ideas of dynamic nominalism, he noted that the social ethos enters into common discourse to help create a kind of persons. When we look at the experience of anorexics, we must also look at the larger social constructs that surround the phenomena because of its complexity and variety.

Bruch (1978), Brumberg (2002), and Malson (1997) regarded the phenomena of anorexia as coinciding with societal changes about female body weight and shape. The tremendous social pressures that these authors outlined are echoed in social consciousness (Bordo, 1998; Prince, 1985; Swartz, 1985). The social constructivist viewpoint helps to illuminate the experience of those who suffer from anorexia nervosa. Looking through the lens of the social constructivists creates a better understanding of the development and creation of symptoms. Furthermore, it provides a fuller understanding of the cultural forces that the eating disordered person battles. Understanding constructivism allows us a better understanding of the recovery process from
eating disorders. The social constructivists’ understanding of historical conditions offers the same respect for the context of experience that phenomenology allows the researcher (Berger, 2011; Mahoney, 1991).

In her book *The Thin Woman*, Malson (1997) argued that anorexia nervosa has moved from the intersection between medical discourse and stereotyping the subservient woman into “an increasing variety of different discourses and different disciplines which have variously constituted it as a psychosomatic, psychological and/or organic disorder” (p. 77).

Malson (1997) proposed that we view anorexia nervosa as a cluster of “anorexias” that correspond to the different areas of knowledge that constitute its description, referring to each discipline: medical, sociological, feminist, and psychiatric. She did not believe that these “discourses” constitute one facet of a distinct clinical entity. Rather, she believed that each description constructs a social reality that the individual may participate in on various levels. She discounted any thesis that might say anorexia is “complex” and that one must research this trans-historical condition from many different sources. Her view on anorexia correlated with Hacking’s (1999) dynamic nominalism.

According to Malson (1997), anorexics must be viewed as part of a socially constructed system, without immersing them in any one explanation while openly discounting others. She looked skeptically at positivists’ methods that explain anorexia in terms of disease models or genetic predispositions. She concluded that attributing anorexia to biology ignores the social forces that drive the modern anorexic towards the behavior, which are the need for self-respect and efficacy within an alienated society.

I have argued in this inquiry that a constructivist perspective, such as that of Hacking (1997), attempted to account for the agency of the subject even in constructed psychiatric
disorders. Malson’s (1997) description of anorexia reached into explanations that are not causal according to social constructivist theory.

Malson’s (1997) assertions are intriguing because they established a basis for understanding anorexia from a variety of different phenomenological stances. The anorexic is not simply a person who, through a series of stressful social circumstances, unlocks a psychopathology. The subject in her constructivist view is co-constituted by societal forces that build a way of life that eventually becomes self-destructive. Her post-modern analysis is able to critique the biases of each discourse that reduces the individual with anorexia to its own paradigm. Therefore, her social constructivist stance parallels the phenomenological critique that seeks that same holistic stance when viewing anorexia nervosa.

In the case of anorexia nervosa, the cultural context of its creation and perpetuation is striking. Brumberg (2000) elaborated the plight of the modern anorexic:

The existence of the tradition of anorexia…does have implications for how we understand anorexia nervosa…. It becomes evident that certain social and cultural systems, at different points in time, encourage and promote appetite in women, but for different reasons and purposes. In the modern period, female control of appetite is embedded in patterns of class, gender, and family relations established in the 19th century; the modern anorexic strives for perfection in terms of society’s ideal of physical, rather than spiritual, perfection. (pp. 47–48)

Brumberg (1998) humanized anorexia in ways that psychiatric models cannot. If one asserts that anorexia is exclusively to genetics it can discount the possibility of its being a combination of social forces that can assign a personality to the sufferer. The social construction of anorexia is a layered one that includes the relentless pursuit of perfection, and a host of other
themes that merge to create the motivating forces for anorexic behavior (Malson, 1997).

Therefore, Malson asserted,

Anorexia is meaningful at a societal as well as a phenomenological level. Like other illnesses…, it can be understood as a metaphor for, and a manifestation of, contemporary socio-cultural concerns and dilemmas…. ‘Anorexia’ may be expressive of societal concerns with consumption, personal display, feminist politics, the fashion for diet and slimness and the individualistic competitiveness of late capitalism… and can therefore be construed as profoundly culture-bound…representing public concerns as well as personal predicaments. (p. 94)

Malson (1997) gave a stirring account of the social construction of anorexia nervosa. Their genealogical approach, which focused upon the shifting discourses of power and social structures, countered the reductionist ideas of positivists’ approaches to the phenomenon. On a human level, the constructionist view allows researchers to expand their understanding of the complexity of the malady. The constructivist view illustrates that modern anorexics have to cope with a host of societal and personal factors present within their lived experience. We can see by the social understanding of anorexia how the subject is thoroughly embedded in a culture. The embedded nature of anorexia- and possibly other types of eating disorders- would likely appear within the narrative experience of those who have recovered. The aim of this inquiry is to grasp how lived experience may appear as themes in the awareness of individuals as they interface with culture.

While it is true that we can look to societal and historical forces to help explain part of the unknown etiology of anorexia, specific social structures should be examined to understand the processes involved. Modern theorists look most often at two socially constructed
determinants of the individual to understand anorexia. This next section of the literature review will present the two most focused upon social determinants in the literature: family and the concept of gender.

**The Family and Anorexia Nervosa**

In the preceding sections we have seen that the etiology of eating disorders such as anorexia has a social basis. Within the social construction of anorexia, then, we can identify the structures that the literature regards as crucial for understanding anorexia, one of which is the family. It has been said that the family, whatever its constitution, is the social structure that has primacy in the transmission and creation of psychological phenomena. Friedrich (2005) summed up the place of the family in culture when he stated, “Families are ecosystems within a larger ecological level pertaining to the institutionalized attitudinal patterns of culture and subculture” (p. 407).

The family has been thought of as a prominent feature in anorexia at the time of its creation. The earliest descriptions of anorexia nervosa in both the English and the French literature ascribe a crucial role to how the patient and the family interact and the way that this interaction influences the development and outcome of the illness. In 1873, Gull described the family of the anorexic patient as the “worst of attendants” in their care, while Charcot went a step further, describing the parents as “particularly pernicious.” Lesegue had a more positive view of the family influence when he said one should always consider the “preoccupations of the parents side by side with that of the patient” (LeGrange, 2005, p. 150).

Since that time, psychology and systems theory, in particular, have increasingly viewed the family as providing the chief context in which subjects learn to construct and interpret reality. The attempt to solve psychological problems in the family through the manipulation of the body,
henceforth called somatoform features, is part of the life of eating disordered families (Bruch, 1978; Minuchin, 1978). Researchers have paid close attention to the experience of the family in anorexic persons, especially young women, and to the family messages in all troubled families, so they can understand the effect that the aberrant messages might contribute to the condition (Bruch; 1978, 1979; Laing & Esterson, 1970; Minuchin, 1978).

Anorexia, on one level, is a fundamental misinterpretation of reality. Bruch (1978) believed the misinterpretation to be so severe as to be comparable to schizophrenia. The reality is often connected to the social reality of the sufferer. When the family is viewed as one social structure among many that conveys early social messages to the individual, it is another important aspect of understanding the experience of anorexia in culture. In the modern era, Bruch’s (1974) composite of the typical female anorexic has been a perfect mirror for the ideals of petit bourgeoisie society. Believing that anorexia is an outgrowth of the family, Bruch (1978) stated that

> [t]he development of anorexia is so closely related to abnormal patterns of family interaction that successful treatment must always involve resolution of the underlying family problems, which may not be identified as open conflicts…. Clarification of the underlying family problem is a necessary part of treatment. (p. 106)

Her work described typical anorexics as having all the advantages that affluent society can provide. They strive in early childhood to be perfect in the eyes of their parents. However, behind the façade of enlightened values that the leisure of the affluent family might provide is an emphasis and preoccupation on outward and appearance and physical beauty rather than inner integrity (Bruch, 1978, 1979).
Closer study also revealed that encouragement of self expression is deficient, and thus reliance on anorexics’ own inner resources, ideas, or autonomous decisions had remained undeveloped. Pleasing and compliance had become their way of life, and they had functioned with a façade of normality, which, when progressive development demanded more than conforming obedience, then turned into indiscriminate negativism, the most apparent symptom after the illness had developed (Bruch, 1978).

We have learned much about the psychological reality of anorexics from Bruch’s (1940, 1962, 1971, 1973, 1979) works. The phenomenological experience anorexia was assumed to be linked with the outgrowth of the personality structures developed within the anorexic’s family of origin. The overwhelming negativism and lack of efficacy these anorexics experience is contained within the family structure. Bruch’s work pointed out the parallelism between dysfunctional family messages and anorexic symptoms. In doing so, she opened the door for a deeper understanding of the disease that is tied to the developmental process of the individual while eschewing reductionist explanations of the disorder.

The literature on abnormal attachment patterns in the anorexic family and on structural family therapy positions on anorexia has endorsed Bruch’s (1940, 1962, 1971, 1973, 1979) original assertions about the nature of the malady (Minuchin, 1978; O’Kearney, 1995). The abnormal themes that commonly occur involve power, control, and (conversely) helplessness within the family of the anorexic. These themes, it is argued, are integrated into the personality and identity of the anorexic member of the family.

Of the ideas that are asserted in system theory, Salvador Minuchin’s (1978) idea on the interactions of the anorexic family is arguably the most comprehensive. According to Minuchin, somatic maladies can be produced and reified by the complex interaction of the anorexic with
her family. Family functioning conveys aberrant themes that place importance and meaning upon the somatic. Minuchin outlined features of the typical anorexic that has having a high degree of enmeshment, yet paradoxically, the family system is often rigid. Rigidity is expressed in the system by minimizing the impact of conflict and always “putting on” a public face. The false self developed for societal approval takes the place of authentic self expression. The ideals and values of the “perfect family” for presentation to the larger community usurp values of openness, individuality, and self-determination. Instead, and it is unclear exactly why, the family places value on appearance (especially bodily appearance) before the larger world. Minuchin would say that the covert family rule in the anorexic family—a common feature they share with substance abuse families—is not to let the larger community know that the family is sick. The family system encourages the somatoform features of anorexia that underlie family conflicts. In doing so, the poor coping strategies of the family and lack of conflict tolerance in the system can be maintained (homeostasis) (Beidel et al., 2010; Minuchin, 1978; Le Grange, 2005).

In Minuchin’s (1978) theory, the process of internalizing family dynamics is subtle. Minuchin explained,

The anorexic family is typically child-oriented. The child grows up carefully protected by her parents, who focus on her well being. Parental concern is expressed in hyper-vigilance of the child’s movements and intense observation of her psychobiological needs…in turn she develops vigilance over her own actions. Since the evaluation of what she does is in another’s domain, the child develops an obsessive concern for perfection. (p. 59)

The anorexic in the system set out by Minuchin (1978) is doomed to failure owing to this ideal of perfection—because such perfection is an ideal that can never be reached. But more
covertly, the anorexic child is embroiled in the hidden conflicts of the parents’ and their own struggles with perfectionism. The child may either ally itself with one parent or become subservient, or the parents may divert their energy in a dyad to blame the child for the psychological dysfunctions of individual family members. The latter explanation is important because “this family characteristic implies the operation of a more complex and multidimensional process” (Le Grange, 2005, p. 155). Minuchin’s theory was an attempt to explain the integration of those family processes into the individual psychological process of the family.

Since perfect families, perfect bodies, and perfect selves become conflated within the value system of the family, the anorexic’s experience is dismal and hollow indeed. Within the social structure of the family, the anorexic takes on an identity. The family of the typical anorexic Minuchin (1978) describes it is not simply one that commands social conformity; it is one that transmits covert messages that blur reality. “Control is maintained under the cloak of concern…; disagreement and even initiative become acts of betrayal” (Minuchin, 1978, p. 60). Therefore, any values expressed outside of the values of the family are negated. It is important to remember that in this system, Minchin is speaking of a developmental process that is extremely subtle and, as stated, multi-dimensional.

Bruch’s (1974, 1979) and Minuchin’s (1978) accounts of the features of anorexia are comprehensive and sensitive. Their aim in developing their theories was to put anorexia into an understandable, and hence treatable, context. These theories help the inquirer to grasp some of the psychological processes involved in the anorexic family. I believe they also give the inquirer a deeper understanding of the personal experience of the anorexic. These accounts help to situate the descriptions of the self (existential) within a context, and thereby account for that loss of self,
or at the very least, the dysfunctional adaptation to her lifeworld. Minuchin, especially, helped to outline the typical experience of the anorexic.

However, Minuchin’s (1978) theory has come under criticism exactly because it assumes a typical anorexic family. Just as confining anorexia to typical features is not helpful in understanding the individual, typifying the anorexic family has its limitations. Kog and Vandereycken (1989) pointed out that attempts to establish a typical or universal kind of anorexic family are very limited in their usefulness. Kog, Vertomen, and Vandereycken (1987) also found that there are only mixed validity results for the structural aspects of Minuchin’s model, such as rigidity, enmeshment, and over-protectiveness. These researchers found that many “families were… similar to Minuchin’s models, but others showed less extreme or even opposite kinds of interaction” (Friedrich, 2004, p. 409).

Likewise, Dare (1994, 2006) used quantitative assessment scales to evaluate Minuchin’s (1978) model of the psychosomatic family. Dare demonstrated some agreement with his structural model, yet pointed out that it may not include a universal type; rather, it simply amplifies some speculations concerning anorexic families while ignoring others (Le Grange, 2005).

These revisions of Minuchin’s (1978) model may point toward the complexity of the experience of the anorexic person. Defining such a person by our psychological models instead of understanding our psychological models through her experience seems a futile endeavor. Hence, the purpose of this study is a phenomenological inquiry into the lived experience of recovery from eating disorders, including anorexia nervosa. I examine the narratives of the long-term recovery of those who have sustained a qualitatively better life. These narratives yield references to the formative experiences within the family of the anorexic. The experiences that
Bruch (1998, 1979) and Minuchin (1978) described parallel the social process of the anorexic described in the social constructivists’ understanding of anorexia. A phenomenology of it recovery would include a variety of aspects that appear, and have been transformed, in that person’s lifeworld.

**Anorexia Nervosa and Gender**

The first two sections of this literature review on anorexia nervosa have illustrated how psychiatric disorders have been created in history. We have also reviewed possible ways in which the family, as a social structure that parallels the wider cultural ethos, interacts to create the identity of the sufferer of anorexia. Part of this inquiry is the recognition that anorexia as a set of behaviors and psychological events is social in nature. Rather than dismissing the agency of the subject, I have asserted that the interaction between the culture and the self has created anorexia. Hacking (1999) defined well the nuances of social construction that results when the concern is with psychiatric diagnosis:

> Here I am concerned with kinds of people, their behavior, and their experiences involving action, awareness, agency, and self-awareness. The awareness may be personal, but more commonly is an awareness shared and developed through a group of people, embedded in practices and institutions to which they are assigned in virtue of the way in which they are classified... [and] when known by people or those around them and put to work in institutions, change the ways in which individuals experience themselves, and may even lead people to evolve their feelings and behavior in part because they are so classified. (p. 104)

Hacking’s (1999) explication of the construction of persons, their identities, emotions, processes, and beliefs helps illustrate the complex interactions that create a set of behaviors and
beliefs, such as anorexia nervosa. Feminist authors have noted that women’s bodies have become a canvas upon which culture has painted its values.

The examination of gender in the eating disorder literature has contributed immensely to the understating of anorexic persons and their awareness of their lifeworlds. Susan Bordo (2004) wrote extensively about this intersection between gender and culture that creates disordered eating. Bordo (2004) noted that “the words and diaries of patients were enormously illuminating, whereas] most of the clinical theory was not very helpful…. The absence of the cultural perspective…was striking” (p.137).

In this last section on anorexia, I briefly review Bordo’s (2004) work to complete the understanding of the experience of anorexia in our contemporary culture. This work is invaluable because Bordo is exquisitely sensitive to the social construction of anorexia and its integration into the experience of the anorexic. Bordo (2004) saw within the social construction of anorexia a variety of forces, and she codified these forces into what she calls “axes of continuity” (p.143). These axes connect larger historical trends that resemble anorexic practice with other historical practices. For instance, she observed that while it is true that anorexia is related to the fashion industry’s rise to dominance, a deeper question needs to be explored concerning the development of western culture’s obsessive desire for “keeping our bodies slim, tight, and young…and the connection if explored could be significant, demystifying, instructive (Bordo, 2004, p. 141).

To help us understand the formation of modern anorexia, Bordo (2004) defined three axes that help us interpret anorexia through the intersections of power, history, and culture: the Dualist, the Control, and the Gender/Power axis. These concepts provide ways for us to understand anorexia from a cultural as well as an individual framework. The axes create the framework for the personal experience. More disturbing, however, given these discursive
practices that mesh with social structures, the eating disorder behavior has a normative basis rather than a pathological one (Bordo, 2004, 2009).

The Dualist axis is the assertion in Western culture that that the body and mind are best understood as separate. The long tradition in the West of separating the two has a striking similarity to the typical experience of the anorexic. First, the anorexic body is experienced as an alien or “not-self.” The experience of the body is described as “ontologically distinct from the inner self” (Bordo, 2004, p.146). Bordo went on to say that the West, from Plato to Descartes, has supported this fundamental experience. Logically, it makes sense then that our social constructs reinforce the body as alien, along with all the other aspects of dualism, as a fundamental experience. Second, the body is experienced as confinement. As Bruch has noted by the very title of her book The Golden Cage, the anorexic is stuck within the body. At the same time she tries to perfect it, she also wishes to escape ultimately from its confinement. Bordo (2004) compared this desire to the long-standing platonic tradition of seeing the body as the prison of the soul.

Concomitantly, the third aspect of the dualist axis is that the body of the anorexic becomes the enemy. Again, Bordo cited Plato, who viewed the decay and vulnerability of the body is an obstruction to purity. Food, water, sexual desire, and all other physical vulnerabilities are trappings that frustrate the quest for truth. The body as object threatens attempts at control. After all, Descartes denied the senses of the body as a way to understand truth. By denying it, he created a method that allowed for the mastery of the physical world—albeit through knowledge of geometry, but an attempt at control nonetheless. Bordo (2004) went on to say that these aspects of the dualist tradition mirror the psychological condition of the practicing anorexic.
So important is control in the anorexic system that Bordo (2004) gave it a subcategory of the cultural themes she was trying to explain and also listed it as a major axis of Western culture. The Control axis, as Bordo defined it, is the incessant need for control over nature. Practices such as diet and exercise are merely outward manifestations of a general need to master the environment. Bordo ultimately connected this need for control with mastery over death. The body fetish, that anorexia is a perhaps the ultimate example “reflects our alliance with culture against…the death of the body” (Bordo, 2004, p. 153). This alliance is pervasive in the culture, and affects the experience of all, not just those lost in the anorexic system. She asserted that the anorexic system is an extreme pole of a larger cultural ideal of seeking a timeless state that is impervious to the realities of the physical world.

Finally, Bordo defined the Gender/Power axis. Malson (1997) linked the term anorexia nervosa with a larger historical event that labeled all problematic behavior as feminine. Anorexia nervosa, regardless of the gender it afflicts, is largely thought of as a woman’s disease. Male sufferers who identify as anorexics in contemporary culture are few (Hudson et al., 2007). Even those who do identify are often seen as “feminized” by having the nervous disorder. So, for our purposes, we can see that the cultural manifestation of anorexia, while possibly gender neutral, is still galvanized in the cultural position of women.

Bordo (2004) was able to define the cultural stance that has linked the self-starved body with the cultural dilemma of women in particular. She cited Bruch (1978) who wrote about the war between the feminized “fat” self often identified as Woman in the culture, and the imperious and patriarchal male self that provides the rigor for practices of self-starvation. “These two sides are perceived as at constant war. But it is clear that the male side—with its associated values of greater spirituality… strength and will—is being expressed …in the anorexic system” (p.155).
Like the cultural body, the patriarchal aspects of the social world appear within the very psychic splits of the eating disordered individual. Her existential experience is one of alienation and control. The anorexic position, its symptomology, behavioral, and emotional aspects, are in the service of an ideal that she hopes will empower her.

This current study focuses on social constructivist theory because I believe that the recovery from eating disorders involves many facets and processes that individuals must discover and integrate in new ways before they can be successful. Susan Bordo’s (2004) description of the cultural and social forces that shape the psyches of anorexics is an important step toward helping them understand their lifeworld. The lived meaning of the illness is expressed in, and shaped by, cultural meaning. Bordo’s work is a powerful and sensitive attempt to approach anorexia in a non-reductive way, and it parallels a phenomenology of the disease. Conversely, a phenomenology of the recovery process from anorexia is developed according to these themes, and the ways in which these forces may be altered, ameliorated, and/or transformed.

**Bulimia Nervosa**

A review of the relevant literature for bulimia has many parallels with that for anorexia because it was considered a subcategory of anorexia until very recently. The same social processes that may construct anorexia can be extrapolated for bulimic individuals. However, the lived experience of the bulimic and the diagnostic criteria differ from those for anorexia. Thus, I argue that the various manifestations and distinctions in the diseases beg for a phenomenology. I first present the history diagnostic criteria for bulimia nervosa and then discuss some of the constructivist factors applied to anorexia the prior sections. The differences and similarities
between anorexia and bulimia are also be reviewed in order to look at some general distinctions that can be important in the lived experience of the individual.

As with anorexia, incidents of purging appear throughout history. According to Russell (1997), these incidents have little to do with the modern condition of bulimia nervosa. Russell (1979) coined the term *bulimia nervosa* to describe the cluster of symptoms that professionals observed, which did not seem to fit a classic anorexic taxonomy. In 1987, the DSM-III revised its categories to include bulimia as a distinct diagnostic category (Russell, 1979, 1997; Vandereycken, 2002). Major subtypes of bulimia include purging and non-purging types. The non-purging types dissolve excess caloric intake by laxative or diuretic use, or by other means such as compulsive over-exercising (Beumont, 2002; Stiegel-Moore, 1986).

The DSM-5 lists several criteria for bulimia nervosa. The primary definition is recurrent episodes of binge-eating defined as eating portions of food that are much larger than normal intake, with a feeling of loss of control. Purging behaviors are then employed to prevent the resultant weight gain by induced vomiting or misuse of laxatives, diuretics, or other drugs. Excessive exercise and fasting are also used as purging behaviors. In fact, the only differences between the bulimic and anorexic sub-type with binge-eating is body weight and, for the anorexic, loss of menses. The purging behavior must occur once a week for three months. Similarly, perceptual disturbances in the self-evaluation of weight that influence behavior are seen in bulimia nervosa as well as in anorexia. The categories of mild, moderate, severe, and extreme, are provided in the DSM-5. Their level is determined by the number of compensatory episodes per week: mild is designated as 1-3 times per week, with the extreme type purging at least twice a day, on average (DSM-5, 2013).
Despite some of bulimia’s distinct characteristics, many of the cultural influences that construct the disorders remain the same. A glance at the DSM-5 criteria shows that the division between bulimic and anorexic is slight. The social constructs and risk factors that are present in anorexia can are also present in bulimia. The chief demographic is young women in modern industrialized society (Striegel-Moore, 1986). In the developmental history of the individual anorexia and bulimia parallel each other. Many of the initial stages of the disorder, as well as the tyrannical feeling of the need for slenderness, are still prominent features in the disorder. Beaumont (2002) stated that

[t]he development…is essentially similar to that of anorexia nervosa, and originates from long-continued attempts to restrain eating. Few patients, however, have actually fulfilled the diagnostic criteria of anorexia nervosa. In particular, the body weight criteria designating anorexia is not present within bulimia nervosa. The persistent dietary restriction is eventually interrupted by episodes of reactive hyperphagia (binge eating, or bulimia) and compensatory behaviors that usually include vomiting and laxative abuse…The behaviors become the focus of intense guilt feelings, but often serve to reduce tension. (p. 167)

Bulimia differs in that the sufferer turns from restrictive eating to an attempt to manipulate food through purging. While the preoccupation with food is the same, its use varies greatly. Whereas the anorexic restricts food intake, the bulimic gorges and then purges her food. The phenomenology of the disorder is interesting because it contains the excessive gorging that is present in BED, but the personality characteristics more resemble those of anorexia. The research often lumps bulimia into one group or the other (Cash, 1997; Fairburn, 2000; Russell, 1987; Virtuosic, 1994).
Many studies have observed that anorexia and bulimia are linked together in etiology, course of treatment, and risk factors (Eisler et al., 2000; Fava et al., 1990, 2000; Pope, 1984; Strober, et al. 2000; Woodside, 1995). Likewise, similarities in basic personality styles of the sufferers of both diagnoses are identified in the literature. Perfectionism and low self-esteem are still present within the diagnostic criteria of both diagnoses. Differences, however, occur in impulsivity and novelty-seeking (stimulus-seeking) behavior within bulimic persons. These features fit the general symptoms of the disease. Therefore, some basic differences in the lived experience of these individuals have been noted within the counseling literature (Beidel, et al. 2010; Bulik, et al. 1995; Fassino, 2004).

Beaumont (2002) claimed that the two disorders differ in their experience, because the bulimic sufferer “seeks slenderness but wants to be healthy and happy” (p.169). While this specific assertion has not been fully explored in the literature, it leads the inquirer to wish to know more about the lifeworld of the disordered person. Thus, his claim endorses the idea that a phenomenology of recovery from the disorder is needed, and such a phenomenology may reveal similarities and differences in greater detail. If there is a difference in the lived meaning of the disorders it can be inferred by the lived meaning in the recovery process of the disorder. Within the lived experience of the person who has an eating disorder, many of the risk factors associated with social constructs remain the same so that such persons, who are often young women, are motivated to engage in bulimic behavior.

The social construction of risk factors for bulimia is related to that for anorexia. Striegel-Moore, Silberstein, and Rodin (1986) defined risk factors that lead to bulimia nervosa. They named the primary factor as the societal values of attractiveness and thinness, the inverse being that obesity is highly stigmatized. The same gender roles that command thinness in anorexia are
present within the bulimic individual. These authors also comment that the developmental process includes dieting as an attempt to achieve maturity or independence in females. Competence and efficacy are associated with one who successfully diets. Whereas the anorexic perceives a loss of control and maintains abstemious food practices, the bulimic purges. The loss of control is more felt and palpable. Within the anorexic’s practices, if contained to the restricting type, the fear of loss of control is more felt than actualized. A phenomenology will attend to the lived experiences of these differences and similarities aside from the DSM-5 criteria.

Stiegel-Moore et al. (1986) pointed out that in adulthood, self-esteem and thinness are more highly correlated in females than in males. In addition, shortcomings in the loss of control in dieting are transferred into other areas of life. Throughout the life cycle this transference takes on different forms according to the life stages. Risk factors and co-morbidity for other mental health issues continue throughout the life-span. The themes of unresolved conflicts and dependence continue through the adult years (Beidel, et al. 2010; Striegel-Moore, et al. 1986).

Family systems are as important in the construction of bulimia as in that of anorexia in the literature. Perfectionism and family alienation are defining features. Other researchers since Minuchin (1978) have observed several distinguishing features in the family of the bulimic patient (Humphrey, 1986, 1989; Le Grange, 2005; Striegel-Moore et al., 1986). The chief difference between a bulimic family and an anorexic one is that conflict and stress are more open, which means that the family environment is more overtly unsupportive overall. Furthermore, in comparative studies “bulimic families reflected a pattern of deregulation and poor modulation of affect and impulse similar to that commonly seen in the bulimic patient” (Le Grange, 2005, p. 163).
Therefore, the family dynamics are consistent with the phenomenology of the disease. Unsupportive and under-structured emotional environments, combined with the overriding cultural ideals that the bulimic integrates into the personality, require a release mechanism. The use of food and purging provide that release. It is likely that these themes are transfigured in some way that allows for the recovery process to begin and continue. Though these quantitative studies describe features from which one may infer the phenomenology of the disease, these studies do not capture its essence as it appears to the sufferer. Thus, the recovery process from the disease is, in essence, thereby underdeveloped.

**Binge Eating Disorder and Obesity**

This section will examine the phenomenon of binge eating as it relates to obesity. Some of the social constructs that surround the obese person will also be related to the possible lived experience of persons who fall into the definition. Because significant portions of those who binge with food are also obese, it is appropriate to examine obesity in this literature review.

The DSM-5 has upgraded BED from a syndrome (as listed in the appendix of the DSM IV–R) to a diagnosis. BED is marked by recurrent episodes of binge-eating over a 3-month time span, which is defined as eating an amount definitively larger than needed over a 2-hour time span. Loss of control over intake must also occur with the binge-eating episode, and the binge eating must be associated with three of five other criteria:

1. Eating much more rapidly than normal.
2. Eating until feeling uncomfortably full.
3. Eating large amounts of food when not feeling physically hungry
4. Eating alone because of feeling embarrassed by how much one is eating.
5. Feeling disgusted with oneself, depressed, and very guilty afterward.
Other psychological features that the DSM-5 lists as criteria are a marked distress over eating and the absence of compensatory behaviors present in bulimia nervosa. Additionally, specifications such as partial and full remission are provided as part of the diagnostic criteria. The diagnosis can also be specified as mild to extreme. Mild is considered, like bulimia nervosa, 1-3 times per week. Extreme types of Binge-Eating Disorder are episodes reported at 14 times or more a week.

There is an evident overlap between binge-eating and overweight/obesity in the general population. As much as 30% of the overweight/obese population who present for weight loss treatment meet the formal criteria for BED. Very high rates of obesity occur in the BED population. According to Mitchell (2008), “most clinics that treat individuals with BED report…varying degrees of obesity and typically have long histories of repeated dieting” (p. 692). Most who suffer from BED are overweight or obese. They are unlikely to have the preferred body type our culture desires.

For the first time in history, the overweight people globally outnumber underweight persons. In other words, too much food intake may have become more pernicious in society than hunger. The extreme end of this situation is obesity. Defining obesity as a socio-cultural phenomenon is complex, but there are definite social consequences to obesity. Brewis (2011) has noted that “our concerns about weight can be personally consuming, and even as more of us get fat, the stigma against fat people endures” (p. 6). Brewis further referred to the idea that obesity remains an acceptable form of social prejudice and creates enormous social and emotional suffering. The fatter members of our society are statistically more likely to be teased, bullied, and depressed. They are paid less, are less likely to advance in their careers, and have a harder time finding a mate. Our basic sense
of self-identity and how we relate to and understand others is increasingly tied to weight. (p. 6)

Despite its seemingly contradictory appearance, there are many commonalities between the experiences of obese persons and those who suffer from eating disorders as well as between anorexics and bulimics. Those who suffer from food or weight issues tend to share the same societal values. The recovery from the disorders, while medically much different, is psychologically similar. The anorexic, who suffers from the fear of meeting the fate of the overeater, responds to societal pressure in a different mode. The bulimic, who shares symptoms with both the binge eater and the anorexic, carries the same fear of societal impairment from being “fat.”

Methods of defining obesity vary, with MRI technology being the most accurate way to identify adipose tissue. However, this is obviously cost prohibitive and still challenges the need to norm the amount of adipose tissue within a population. The most common method for assessing obesity is the Body Mass Index (BMI). It is calculated by dividing body weight by height; then that result is squared to produce the correct BMI. The standard medical definitions of norms in body weight are; 18.5 to 24.9 = normal range, ≥ 25.0 to 29.9 = overweight, > 30 = obese. However, this statistical method is an inexact method for measuring adipose tissue. The cutoff points for the BMI are based upon risk factors for mortality because increased BMI is positively correlated with increased risk of premature death. Likewise, it does not measure the adipose tissue distribution. The distribution of adipose tissue is often more important when assessing for health concerns than the BMI. Visceral obesity, carried in the abdomen, is associated with pernicious medical conditions, while peripheral obesity, distributed in other areas
of the body, are not as closely associated with lethal forms of cardiovascular health (Bjorntrp, 2002; Rosmond, 1998; Wellen, 1984).

While the BMI is a good statistical measure, there are problems in its application to individual assessment. A person with a higher body weight could be denser in muscle, or other factors may confound the measurement. Therefore, athletic builds or those in cultures with sound nutritional diets register higher BMI’s, yet clearly those individuals are not obese. Arnold Schwarzenegger and Olympic medal winners, for example, would be classified as obese according to their BMI. In addition, age, gender, and “population history” are not reflected in the BMI (Brewis, 2011, p. 15). Additionally, cultural norms vary in ethnic groups, leading researchers to adjust the BMI for different cultural groups (Brewis, 2011).

The epidemiology of the obesity epidemic is even more complex than defining obesity. Note that no method of assessing obesity in a population, or on an individual level, can disallow the fact that it is an epidemic in the modern, industrialized nations. Understating the causation of the obesity epidemic reaches into every domain of public and individual health models. An imagined hierarchy branches upward from an individual forming the global, national, state, community, and family systems. Within the individual and working downward in a public health model are the behavioral/psychological, organ, cellular, molecular, and genomic/heredity levels. Each of these levels contains interactions that change across time. While it may be true that there are genetic weaknesses that precipitate obesity, explanations on the macro-level reference the global food supply that has changed in its nature over the last fifty years. The levels between these two systems are dense in themselves. Linking these various levels into one overall epidemiological model is not possible (Brewis, 2011, Caterson, 2002).

As Brewis (2011) explained,
One of the challenges facing obesity research…is the usefulness of traditional statistics for getting at interconnections between explanations that shape obesity risk…. Current methods in biomedical research cannot account for more than three levels of behavioral or biological influences at the same time, and existing hierarchal models find it difficult to nest the study of individuals in any context beyond families and schools. Likewise, little consideration has been given to the multiple levels of biological data and integration of these into environmental factors. (p. 81)

For Brewis (2011), the various challenges that define obesity are interlaced within a culture. The various models of research cannot be exhaustive, given the complexity of the phenomena. It is clear that culture is related to obesity, and that models for studying its appearance must be diverse. Brewis (2011) stated that “ultimately, our bodies represent cultural facts, just as they do biological ones” (p. 84). The lived experience of those who are overly-concerned or under-concerned about their body-eating disordered individuals—would integrate cultural standards of body image.

The body as a cultural artifact and symbol appears in consciousness as body image. Said another way, the type of body one has often translates into social position and class participation. The way that culture perceives a body defines the individual, and the individual often defines himself by these values. The problem in developing a normative psychology is that body image norms vary from culture to culture. Nevertheless, the cultural standards surrounding one’s body strongly influence emotional, psychological, and social health. Preferred body image in a culture translates into social and economic opportunity. Of one possesses a body that is outside the cultural norm means running the risk being the object of an intense social stigma on all levels of society (Brewis, 2011; Puhl & Heuer, 2008). It is no wonder, then, that obesity is feared by many
and that those who suffer from obesity experience a depression equitable to social death. It is also not surprising that anorexia and bulimia, the attempt to maintain thinness, are adopted by members of a society in modern, western culture. Ironically, in the most vulnerable population for eating disorders, young women in industrialized nations, the inability to identify their own true body type accurately on psychological measures is so common it can be considered normative (Brewis, 2011; Brumberg; Gillman, 2008; Myers & Rosen, 1999; Rosen, 2002).

It is a cruel twist for those who suffer obesity and/or binge eating disorder that at the same time our culture has adopted the ideal of extreme thinness, all the social forces that individuals encounter put them at risk for obesity. It is equally as cruel that even if that ideal is reached, objectively speaking, by the anorexic or bulimic, for reasons we do not understand socially their inability to perceive their bodies accurately will not allow them ever to reach their goal. Ultimately, the goal is for social and emotional efficacy. Definitions of change over time will be presented in this next section to orient the inquiry in the psychological literature.

The lived experience of those who suffer from the disorder and, in this inquiry, of those who have recovered may elucidate the ability to see through this cultural veil. Perhaps it will point to other ways to organize experience.

If the body is seen as a symbol, part of understanding the lived experience of obesity can be understood only in its cultural context. In Western culture, the meaning of obesity is overwhelmingly negative. In many cultures, the body as symbol means social efficacy and acceptability. However, the pernicious connotations of extra adipose tissue are mostly a product of western society. While it is true that morbid obesity is not accepted as ideal in most all cultures, it still does not have the abjectly negative connotations that it does in Western societies. Within modern Western culture, the body, as some have argued, encapsulates the self. Our
society makes very little distinction between the state of one’s body and the state of one’s soul. Those who do not have the preferred body type are stigmatized. Perhaps more important, the stigma is internalized by the individual and becomes an integral part of the self (Bordo, 1993; Brewis, 2011; Gilman, 2008: Puhl & Heuer, 2008).

The reasons for the stigma are not entirely understood. In cultures where lower BMIs are preferred but that are collectivist in their makeup, the obesity stigma is not as powerful. One of the major issues is the individualistic stance in our culture, which perceives obesity as the fault of the sufferer. Individualistic cultures also have more profound social consequences for obesity, and the connection with the body is translated into a moral judgment. If one has the preferred body type one is “good,” and if one does not he is “bad.” As Bordo (2004) has observed, a sense of “control” in modern, industrialized societies are equated with “good.” This presupposition has many socially and historically constructed causes that are too numerous to expound here. Briefly, however, in most of the West, a person with a slim (or an increasingly trim and toned) body is understood as having greater self-sufficiency, autonomy, control, and strength of character. Obesity is the inversion of these core values, a loss of control, and is thus a highly negative reflection on the self in a society where control is central (Brewis, 2011, p. 111).

The point is that if the body is socially translated into a moral and psychological condition of the self, then obesity is judged as unacceptable, and the self is viewed as flawed (Becker, 1995; Brewis, 2011; Martin, 1989). This social stigma runs through all levels of Western, individualistic society from the expected discrimination in employment settings, to the unexpected stigma in health care settings where doctors, nurses, and psychologists practice (Puhl, 2009). It is, therefore, not very surprising that members of society internalize the values concerning obesity.
The values of absolute responsibility are internalized in individuals, public health, and even, Brewis (2011) argued, certain discourses in science. Individual psychological conditions are co-morbid with obesity. The obese person has higher rates of anxiety and depression (Chiadi, 2003; McElroy, 2004). The myth of absolute, individual responsibility is contradicted by recent studies in the relationship between stress and obesity. It is a medical fact that obesity rates are correlated with stress in our Western culture. It points to an ugly cycle.

One may be stressed because of internalized feelings of shame, guilt, and social stigma, and stress is a major factor in obesity. That is, stress, is another medical phenomenon that actually makes the body obese. There is a strong positive correlation to obesity and excess stress hormones in obese individuals. These individuals tend to carry excess and unhealthy adipose tissue around the midsection of the body. Since this is not the preferred body type, one is at risk not merely for health problems, but for social stigmatization. Therefore, a cycle is created wherein the individual is faced with enormous social and psychological pressure, often with very few alternatives for integrating empowered stances into their lives (Chrouros, 2000; Epel, 2000, 2001; Sapolsky, 2004).

The phenomenon of obesity, then, is not merely a medical concern. Obesity is itself a medical, public, and mental health issue, given its relationship to our present culture. When it is paired with a social constructed expectation of having the right body type, it is not surprising that mental health issues arise. The relationship that obesity has with BED intersects in culture as a mental health issue.

**Theoretical Framework**

The following section briefly describes the theoretical frameworks used in this inquiry. Hermeneutic phenomenology will be described first and then two complimentary theories, Terror
Management Theory (TMT)—which will help describe the psychological attitudes of the subjects in the inquiry—and the theory of the stages of change developed by Prochaska and DiClemente, which will specify the criteria of recovery. The use of hermeneutic phenomenology as a research method is further explained in Chapter 3 of this inquiry. The theories provide the lenses by which we can view and understand the lived experience of the eating-disordered person’s world. The theories also provide a context in which to evaluate the data derived for this inquiry. TMT assists with data interpretation by providing insight into an existential dimension of the recovery from eating disorders. The stages of the change model define the criteria for participants in this inquiry.

**Hermeneutic Phenomenology and Van Manen’s Four Existentials**

Phenomenology understood at its most basic level is a philosophical approach to experience (Smith et al., 2009). It is a radical approach that investigates experience without an appeal to pre-conceived categories. Preconceived categories can be religious ideologies, hidden cultural biases, or any other intervening construct that alters our appreciation of experience. Instead, phenomenology seeks to understand experience directly. It does not produce theoretical or empirical data. Rather, Van Manen described phenomenology as the “study of essences” (p. 184). Phenomenology investigates the essential nature of experience as persons live it individually. It is therefore less a codified philosophy and more a practice that inquires into the nature of experience (Moran, 2002; Van Manen, 1997).

The second aspect of the methodology used in this investigation is hermeneutics. “Hermeneutics is the theory and practice of interpretation” (Van Manen, 1997, p.179). Hermeneutics originates from finding the correct interpretation of biblical texts. Various philosophers give the practice nuanced meanings when applied to experience, consciousness, or
text interpretation. Van Manen (1997) explained that, when merged together with a descriptive phenomenology, hermeneutics “is an interpretive methodology ... because it claims there are no such things as uninterpreted phenomena” (p.180).

Therefore, hermeneutic phenomenology is a dynamic study of lived experience. It seeks insight into the nature of the experience free from abstractions (pre-reflective) that would change our understanding of experience. Therefore, Van Manen’s conception of a phenomenology sought out what appears in human consciousness. Humans experience the world and experience significance (meaning) in the lifeworld via conscious awareness. Therefore, phenomenology seeks to understand anything that appears in that lifeworld. Van Manen (1997) believed that through this lifeworld, whether shared or private, meaning is constructed.

According to Van Manen (1997), hermeneutic phenomenological research is a thoughtful reflection on the essential qualities (essences) of a phenomenon. Through thoughtful reflection we can uncover the meaning structures that are the essential nature of the lived experience of a person or group. Van Manen (1997) also asserted that describing the essence of experience is a “poeticizing activity” (p.11) which attempts to grasp the existential meaning of those experiences. He contrasted this sort of poetic activity with research that seeks general knowledge (generalizability) about persons. Phenomenology is a human science precisely because it wishes to understand the particular experiences of human. The “richness and depth” (Van Manen, 1997, p.11) is discovered through thoughtful reflection and the illustration of lived experience. In addition, though it is not a quantitative science, phenomenology’s human science focus is a systematic investigation of lived experience. In that project, we discover what it means to be human (Van Manen, 1997).
As mentioned, hermeneutic phenomenology is an activity rather than a speculative philosophy. Van Manen defined six activities that a phenomenologically oriented study uses to inquire into the lifeworld it seeks to describe: (a) turning to the phenomenon that interests us and attempting to fully understand (commit) it; (b) faithfully attempting to investigate experience as it is lived rather than conceptualized; (c) reflecting on the essence of those themes to grasp the nature of the experience; (d) using a recursive process to write and rewrite a description of the phenomena; (e) maintaining a strong and oriented pedagogical relation to the phenomena; and (g) balancing the parts and the whole. Van Manen (1997) described this as not losing sight of the end of the project as its parts are revealed (p. 30–31).

Van Manen (1997) believed that investigating experience as a human science involves the preceding activities. He did warn however, that the relationship the researcher has to these activities is a dynamic one. As more is revealed, an understanding of the phenomena changes and transforms under the phenomenological gaze. Hence, some authors have described practicing hermeneutic phenomenology as entering a circle wherein a deeper insight can always be acquired (Laverty, 2003; Packer, 1989).

For ordering and understanding lived experience, Van Manen’s (1997) described fundamental existential structures. He explained that people experience meaning through the world that they inhabit. The meaning experienced by a person or group is contained in the thematic structures that constitute a lifeworld. Van Manen (1997) listed four existentials of particular importance that will be used in this study: lived space, lived body, lived time, and lived other. These basic aspects of human existence will be used to understand the lived meaning of the person in the process of recovery. Below is a short description of each existential.
1. *Lived space* can be conceptualized as the way people feel the space around them. “Li-
vved Space (*Spatially*) is felt space” (Van Manen, 1997, p. 102). The way in which
people perceive and respond to their surroundings constitutes lived space. The space
in which humans live and create their lives holds significance that is beyond
geometrical definitions of space. Likewise, persons can inhabit the same space, but
that shared space can hold different meanings for persons or groups while being
geofmetically identical.

2. *Lived body* connotes the fact that we experience the world through the body. Our
perception of the body can change, depending upon its relationship to experience. For
instance, the body as a sexual being is experientially different than the body that is
about to undergo surgery. Hence, in a phenomenology, the experience of the body can
have special significance.

3. *Lived time* is not clock time. Lived time is how we experience time within our
surroundings or situation. Hence, intense physical effort is experienced very
differently than listening to a symphony. “Lived time is our temporal way of being in
the world…the temporal dimension is past, present, and the future constitute the
horizon of a person’s temporal landscape” (Van Manen, 1997, p.104). As such, lived
time is our perception of our place within our culture and histories.

4. Lastly, *lived other* at its most basic is the way we socially experience another. Van
Manen (1997) wrote that it is “the lived relation we maintain with others in the
interpersonal space we share with them” (p.104). However, on a deeper level the
questions of commonality, meaning through relations with others, encompass this
existential. Although we experience meaning individually for the most part, the
dimension in which we live alongside others and our world as meaningfully illuminated by them are understood in the thematic elements of the lived other.

**Terror Management Theory**

TMT is a complementary theory that provides another framework for this inquiry. According to this theory, human behavior (motivation, cognition, and emotion respectively) is constructed from the awareness that existence is finite. It is an existential psychology because the theory explains human behavior from the standpoint of self awareness. The confrontation with fundamental realities of existence describes human interaction in the world. Traditional existential themes and dyads include freedom/unfreedom, isolation/other, meaningfulness/meaning, and being/non-being. According to existential theory, these themes are present in all human experience (Pyszczynski, Greenberg, & Koole, 2004; Yalom, 1980).

TMT in particular, is derived from the works of Ernest Becker (1973), who asserted that the interaction between the person and the environment can be understood through the individual’s awareness of mortality. The individual’s existential quandaries that surround an awareness of mortality are resolved through the person’s interaction with the culture, which surrounds the individual and supplies an outlet for anxiety reduction. It is also a platform wherein different coping behaviors occur. The different worldviews that cultures develop reduce anxiety by providing an assurance that one is secure within the universe one inhabits (Becker, 1973; Greenberg et al., 1997; Pyszczynski et al., 2004).
TMT and Self-esteem

Self-esteem is built by active participation in the worldview of one’s culture, and it is a central concept of TMT. Therefore, culture is a vehicle whereby the individual resolves the problems of meaning, isolation, freedom, and death (Becker, 1973; Greenberg et al., 1997; Pyszczynski et al., 2004). As mentioned previously, TMT asserts that the need for self-esteem is a basic in human existence. It buffers the individual against the terror of death that accompanies being human. This buffer is not a simple façade. It is a worldview that allows individuals to manage the anxiety in life and to live productively in the face of meaninglessness. It also has positive features apart from its function of protection. Becker (1973) asserted that self-esteem is a deep human need that provides meaning and value to existence. Self-esteem is bound up with the contributions that an individual makes to a society, and it can be thought of as a sort of platform that the individual creates in his culture. As such, it is purposeful and meaningful action that connects one to the world. Therefore, it is congruent with notions of self-esteem that describe external and internal aspects of human motivation (Becker, 1973; Deci & Ryan, 2004; Pyszczynski, Greenberg, & Goldenberg, 2003; Pyszczynski et al., 2004).

The TMT literature also distinguishes between authentic and inauthentic pursuits of self-esteem. Moderate self-esteem coincides with factors that are external to the pursuit of self-esteem. Authentic pursuit coincides with autonomous/intrinsic goal-seeking behavior. Conversely, inauthentic behavior is external goal seeking dictated by culture. In contrast, self-determined aims correlate with less need to adopt possibly destructive ideas that cultures may hold (Ryan & Deci, 2004).

In other words, self-esteem is symbiotic with culture. The TMT literature identifies different variations of self-esteem. Individuals with high self-esteem are less likely to bias
themselves towards inauthentic beliefs and value systems. Those with moderate/low self-esteem, however, were more likely to adopt the dominant values of their culture to reduce the anxiety or terror of death and to adopt strategies that decreased the likelihood of social ostracism (Harmon-Jones, Simon, Greenberg, Pyszczynski, Solomon, & McGregor, 1997; Martin, Campbell, & Henry, 2004; McGregor, 2003, 2004; Mikulincer, Florian, & Hirschenberger, 2003).

This study incorporates TMT through an examination of the lived experience of those who are in the maintenance phase of recovery from eating disorders. As outlined in previous sections of this inquiry, eating disorders are inextricable from the culture within which they exist, and they can be viewed as the dysfunctional pursuit of self-esteem. Special attention is paid to self-esteem in the interview schedule. Individuals are existential entities that exist in a system of cultural structures, which shape them. The lived experience of those individuals illustrate some of the existential themes that are common in life, such as freedom/unfreedom, isolation/other, meaninglessness/meaning, and being/non-being.

Together with Van Manen’s (1997) four existentials, a thematic analysis is used to investigate the essence of what it means to be a person in recovery from an eating disorder. The inquiry attempts to discover if existential themes, such as non-being, are prevalent and significant themes in the lifeworld of the recovered individual, and if so, to extract a description of how they fit into that lifeworld.

**The Transtheroretical Model for Stages of Change**

This section describes the criteria for recovery, which conform to Prochaska and DiClemente’s stages of change. In particular, those who participated in the study endorsed the criteria of maintenance described by these theorists. The stages of change model is widely used and for a variety of target populations. The core constructs of this model show a great deal of
validity and reliability across populations (Prochaska et al., 1994). The stages of change model has been a tool for both assessing and tailoring treatment for individuals. These stages are conceptualized as a process occurring over time, and they involve a progression through stages that have distinct tasks that need to be accomplished. The time in each stage may vary; however, there is a temporal dimension to the last two stages (Norcross, Krebs, & Prochaska, 2010). The following is a description of the stages including the maintenance phase used in this inquiry.

1. The first stage in the process is **precontemplation**. In this stage the individual does not acknowledge that there is a problem. Precontemplation is marked by defensiveness and denial of the need for change. The literature notes that others within the individual’s social circle are more aware of the need for change than the individual. The task is to become aware of problem behaviors in this stage (Prochaska & DiClemente, 1983; Norcross et al., 2010).

2. Second, **contemplation** is marked by an awareness that the problem exist. There has been no commitment to changing the behaviors; however, the individual is contemplating the implications of the dysfunctional behavior. The task in this stage is to evaluate the need for change (Norcross et al., 2010).

3. **Preparation** is the third stage of the process. The task in this stage is to prepare a plan of action, and individuals are testing this plan by making small changes. However, there is no substantial change in the behaviors at this time (Norcross et al., 2010).

4. The fourth stage in the model is the **action** stage. This stage is marked by the modifications of behaviors and significant attempts to function differently in the environment. The task in this phase is to implement lasting changes successfully. The time spent in this stage is 1 day to 6 months (Norcross et al., 2010).
Finally, in the *maintenance* phase, individuals have discontinued problem behaviors and implemented behaviors that promote their success. They continue to consolidate the gains made in their recovery. The task is to continue to consolidate those gains and to work to prevent relapse. This stage is marked by 6 or more months of consistent behavioral change (Norcross et al., 2010).

Additionally, indicative of the *maintenance* stage is reinforcement management and stimulus control, two processes of change. Individuals are able to regulate stimulus and to reinforce desired behaviors. In other words, persons in the *maintenance* phase are able to control and maintain their behavior. They do not have to rethink new action in the problem area, and retain all previous improvements in this stage (McConnaughy, Prochaska, & Velicer, 1983; Prochaska & DiClemente, 1983).

Therefore, persons in the maintenance stage are stable, though still dynamically promoting their recovery. They will have maintained and consolidated gains, and will demonstrate an absence of relapse. A relapse is defined as not being able to rid oneself of the problem behaviors for any extended period of time. For example, if a bulimic who compulsively exercised continued to refuse to give up the practice after developing an action plan, such would be defined as a relapse. The literature notes that the stages are cyclical. Persons with 6 months may have begun to consolidate their gains, but relapse is possible in the beginning of the maintenance stage. This inquiry set 3 or more years without relapse and cessation of problem (eating disordered) behaviors as a criterion for its subjects. This criterion ensures a stable population with long-term maintenance in which recycling through the stages has been avoided for a lengthy period (Blake, Turnbull, & Treasure, 1997; Norcross et al., 2010; Prochaska & DiClemente, 1983; Prochaska & Norcross, 2001).
Conclusion

The literature review presented above contains the relevant literature on the phenomenology of recovery from eating disorders. It began with the history of anorexia. The review then presented concepts of social construction so that the lived experience of those who suffer from eating disorders could be better understood. It then moved onto bulimia and binge eating disorder. Present definitions of the disorders were presented. Then, the relevant aspects of the disorders from a social constructivist viewpoint were explained. The theoretical models that guide this inquiry were present. Hermeneutic phenomenology as it is theorized by Van Manen (1997) was explained. Next, Terror Management Theory was elucidated as a complimentary theory that illuminates the lifeworld of recovery from eating disorders. Last, The Stages of Change model was presented. This model gives concrete criteria for the subjects who identify as being recovered from eating disorders. In particular, recovery is considered as parallel to the maintenance stage of change. Therefore, participants were chosen for interviewing who met this criterion to better understand the phenomenology of recovery that they represent.
CHAPTER III: RESEARCH METHODOLOGY

This chapter explains the methodology used to answer the primary research question: “What is the lived experience of those who have engaged in long-term recovery from eating disorders?” The study is an attempt to understand the process of recovery in persons with eating disorders, in particular by examining the transformation during that process.

The qualitative method was chosen for this study because it illumines the essential features of the object or persons under investigation in a way that quantitative methods cannot. Whereas quantitative methods can establish a reasonable expectation of causality or predict probable outcomes, it is not suited to understanding human experience through the eyes of those who are participating in a particular lifeworld. Qualitative research investigates the quality, the distinctive essential characteristics of experience and action as lived by persons… [It] is a reflective, interpretive, descriptive, and usually reflexive effort to describe and to understand actual instances of human action and experience from the perspective of the participants who are living through the particular situation. (Fischer, 2006, p. xvi)

Thus, qualitative methodology can capture voices and experiences in a naturalistic setting that would be overlooked by traditional statistical measures.

In the rest of this chapter, I have described in detail the methodology and theoretical framework used in the study. I also presented information concerning the research design sampling, procedures, and analysis.

**Theoretical Framework**

The inquiry undertaken here was a hermeneutic phenomenological study, with phenomenology being the guiding philosophy chosen to support the methods and procedures that
will be developed to answer the research questions. Van Manen (1997) defined hermeneutic phenomenology as follows:

A descriptive (phenomenological) methodology…attentive to how things appear, it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena… “facts” of lived experience are always meaningfully (hermeneutically) experienced. (pp. 180–181)

The object of this inquiry is the lifeworlds of those who have experienced ongoing recovery from eating disorders. Because hermeneutic phenomenology, according to Van Manen (1997), is used to study lived experiences, essences, and meanings as they present themselves to one’s consciousness, an analysis of the narratives obtained from interviews with the participants will illuminate the lifeworld of the recovering person. The interviews and analysis will provided a way to understand the participants’ experiences “from the inside” (Van Manen, 1997, p. 8).

As Van Manen (1997) asserted, deriving meaning from human activity involves an interpretation by all the participants; thus, putting experience into language always requires an interpretation. A phenomenologically oriented approach to research is consistent with the goals of this inquiry because it seeks out lived meaning through interviews and the interpretations of its participants. As mentioned earlier, exploring causal principles and the establishing scientific paradigms (relying on results that are replicated) are not the primary aims of human science research. Qualitative research design succeeds in grasping a holistic understanding of the human being by establishing a hypothesis from a data set. Van Manen’s (1997) concept of existential categories was used to explore the lived experience of recovery further.
Research Design

The design for this research study was phenomenological. Methods, procedures, and data analysis conventionally used for this type of design were employed. One aim of this study was to describe exhaustively the essence of what it means to maintain ongoing recovery from eating disorders. Van Manen (1997) describes phenomenological research as an approach that attempts to do away with presuppositions, which could distort the essential nature of understanding what is under investigation (p.29). Field interviews were conducted in order to describe the experience of recovery through the eyes of the participants. The themes derived from the interviews revealed a deeper understanding of the process involved in recovery from eating disorders. The following section details sample, sample size, selection, and criteria for participants.

Sample

Qualitative sampling techniques were used for this investigation. Patton (2002) observed that nothing is more illustrative of the difference between quantitative and qualitative research than sampling methods. Quantitative research uses probability sampling techniques to accomplish its goals. Probability sampling is used to represent the larger population through statistical inferences derived from a random sample (Berg, 2007). Qualitative approaches use nonprobability samples. These samples allow the researcher to focus on depth rather than breadth when investigating a subject (Patton, 2002).

Two types of qualitative sampling methods were used. Purposeful sampling was employed in this inquiry to obtain participants who represent the topic under investigation. Merriam (2009) explained that this type of sampling “is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned” (p. 77). The overall purpose of the sample is find
participants who reflect an in-depth picture of the phenomena (Patton, 2002). Additionally, snowball sampling was used to gain access to the population this study aimed to reach. Berg (2007) described this type of sampling as receiving referrals from prior subjects who may know others who may fit the research criteria. Hence, referrals can be obtained within the target population.

**Participant Selection**

Recruitment for this research project involved personal contacts who are leaders affiliated with 12-step groups in Pittsburgh and the surrounding area. The personal contacts distributed the flyer (Appendix C) to 12-step groups for people with eating disorders. In addition, the flyer was sent by postal mail to support groups pertaining to eating disorders and to therapists specializing in eating disorders, requesting they place the flyer in their waiting rooms. The flyer contained a description of the research project as well as of the criteria for voluntary participation. Participants and possible referral sources who responded to the flyer were able to contact the researcher directly by e-mail or telephone. The researcher then screened the applicants to ensure that the criteria listed were met.

The researcher contacted those who met the criteria for the study to inform them of their selection. At that time, possible dates and times for face-to-face interviews were established. Before the semi-structured interview begins, I gave each participant a written consent form, explaining informed consent and the parameters of this study. At that time, I emphasized again that participation throughout the study is voluntary, and that they could terminate at any time. Additionally, the phone interview established the criteria of the interview process continuing.

Those who agreed to the interviews were given full disclosure concerning what the study is for and what was expected of them. The length of the interview and its voluntary nature were
affirmed throughout the process. Confidentiality concerns, questions, and procedures were addressed before the interviews were held. Demographic data was requested, (i.e., age, gender, number of years engaged in recovery, marital status, and the disorder each has managed). Potential risks and benefits were reviewed with each subject. The semi-structured interview began only after each subject was apprised of the aforementioned items and the consent forms had been signed (see Appendix B). After the above-mentioned procedures were established and agreed upon, the semi-structured interviews were conducted. The interviews were video-taped (digitally recorded) for later transcription. The transcriptions were stripped of all their identifying information and were coded in a number system for identification in data analysis. The videotapes will be destroyed (deleted) after a certain length of time.

The goal of the participant selection was to choose a variety of people who have had an extended period of time with non-disordered eating. Though the subjects had had uncommon experiences, they are neither completely typical of people with eating disorders, nor are they entirely extreme. The subjects selected were illustrative of an intensity sample (Patton, 2002). An intensity sample is intended to reflect common experiences among a select group of persons—in this case, those who have survived eating disordered behaviors.

**Sample Size and Selection Criteria**

Merriam (2009) explained that, in a qualitative study, no set number of participants is necessary for a sample size. Patton (2002) suggested that the sample size can be determined by the researcher’s estimation of how many participants he will need to reflect an in-depth picture of the phenomena under study. Because the object of this inquiry was to gain insight into the essence of the recovery process, the sample size in this study comprised eight to 12 people who had established their recovery success by having maintained some years without being
debilitated by the disorder, and who have self-identified as achieving success in the maintenance phase of the change process. For the purposes of this study, subjects who took part had a variety of self-reported criteria related to recovery from eating disorders:

1. The participants had experienced at least 3 to 5 years of non-disordered eating (disordered eating is connoted by binging, purging, or over-restriction of food).
2. As a consequence of their recovery, participants were able to articulate a subjective sense that their overall health had improved.
3. The participants endorsed a positive difference in their overall functioning in social, relationship, and career domains.

Data Collection

In a hermeneutic phenomenology, data collection involves gathering the reflections and experiences of the participants in a study that captures vital aspects of the phenomena under investigation (Smith & Flower, 2009; Van Manen, 1997). In a qualitative inquiry, in-depth interviews (among other methods) take the place of the statistical data used for a quantitative inquiry. The following methods were employed to gather data for this qualitative study.

Semi-Structured Interviews

One method used to collect data for a qualitative study is in-depth interviews of the participants. Merriam (2009) explained that the qualitative interview is simply a shared conversation that has a particular focus. The focus in a hermeneutic phenomenology is to capture the lived experience of the participants. The deeper understanding of the phenomena and the personal meanings that the participants assign to experience can be understood in the analysis of the interviews (Van Manen, 1997).
This inquiry used a semi-structured interview format. According to Berg (2007), “the semi-structured interview has predetermined questions and special topics….but the interviewers are allowed freedom to digress” (p. 95). The structure and types of questions vary according to the type of interview format the researcher is using. I chose the semi-structured interview because the freedom to digress seemed to offer the best tool for gathering information that would be laden with meaning and personal insight. However, I wished to gather data on the specific topic of recovery from eating disorders. Therefore, an unstructured interview seemed too general. It would not focus upon the dimension of recovery that this study wished to investigate.

A semi-structured interview usually contains some specific questions and other open-ended questions that can be followed up with probes (Merriam, 2009). Patton (2002) recommends that the qualitative researcher examine the questions to ensure they are truly open-ended. The opened-ended question “allows the person being interviewed to select from among that person’s full repertoire of possible responses those that are most salient” (p. 354). Likewise, probes or follow-up questions after open-ended questions can be simple, follow-up questions, utterances, and even silences that cannot be planned ahead of time in the interview schedule (Merriam, 2009). The semi-structured format allowed the participants the freedom to elaborate on these complex phenomena in a spontaneous fashion. Having been engaged in the process for a number of years, my participants had a variety of reflections on their lived experiences.

**Interview Schedule and Informant Interviews**

The interview schedule for the semi-structured interviews with each participant may be found in Appendix A. This style of interview allowed for the process to be natural, organic, and reflective of the lived experience of those who participate. Each interview lasted approximately 1.5 hours. The interviews were conducted in a variety of settings that allowed for privacy. The
setting conveyed a sense of safety and confidentiality that allowed the participants to reflect deeply on the subject material. The interviews were videotaped (digitally recorded) for later transcription. The report from the results of the research in this study was devoid of any identifying information: that is, any person reading the reports would not be able to identify the subjects involved. Each subject was given a code that only the researcher could identify. The keys to the codes were locked in a file cabinet and destroyed after the research project was concluded.

The interview schedule was constructed to promote responses that would address the primary and secondary research questions. Patton (2002) recommended that one distinguish among the question types used. For instance, there is an obvious difference between a demographic question and one that attempts to elicit opinions and values. The interview schedule in this study was designed mostly for eliciting opinions, values, and feelings. The questions were constructed to be open-ended for the participants. An open-ended question minimizes the possibility that responses will be predetermined by interviewer bias, and maximizes the possibilities for respondents to communicate their experiences as they have lived them. Additionally, the researcher was generally able to establish a rapport with the interviewees, allowing for an open and honest reflection on the questions. The questions began with general explorations into the recovery process and become more focused as the interviews proceeded (Patton, 2002).

**Instrumentation**

In models of research that employ a qualitative design, the strength and credibility of the study depends upon the researcher. Quantitative studies rely upon standardized procedures to produce reliable results. “The researcher is the instrument” (Patton, 2002, p. 14) when a valid
and credible qualitative design is employed. It is therefore reasonable to detail the qualifications of the researcher in this inquiry.

**Researcher as Instrument**

I have worked in the mental health field since 1997 when I acquired my first Master’s degree in psychology from Duquesne University. My focus at that time and yet today is to employ existential and phenomenological approaches to understanding psychopathology. My experience in direct clinical counseling has covered very diverse populations and diagnoses. While working in a group home outside of Pittsburgh, Pennsylvania, with schizophrenic clients, I began my second master’s degree in counseling at Duquesne University. I acquired more experience at that time working in the family therapy division of a nonprofit mental health agency. I completed my master’s in community counseling from Duquesne University while working there, and attained licensure as a professional counselor. At that time, I began my outpatient work as a therapist for mental health and substance abuse. This brought me in contact again with the persistence of mental illness and individuals’ struggle in recovering from a catastrophic mental disorder. Additionally, I was the head clinician at my agency in working with substance abuse clients, which again reaffirmed my interest in the recovery process for a variety of maladies.

For the last 10 years, one of my primary concerns has been eating disorders. I have attended workshops, conferences, and training programs to better understand the various aspects of eating disorders, which have also been the focus of my doctoral studies at Duquesne University. In private practice as a professional counselor, I have also successfully treated individuals who present with the eating disordered criteria. My own experience with the disorder and my familiarity with the process in others have sharpened my interest as a counselor. From
my experiences, it has seemed to me that the standard definitions in our nomenclature are incomplete. Hence, my doctoral work, culminating in the present investigation, is a continuation of my interest. In particular, eating disorders seem to have many facets and manifestations that people struggle with daily. My personal knowledge and my professional life intersect on this topic to create a deeper understanding of the many ways in which eating disorders can grip the individual.

I was aware that my own experience can create projection or bias as I research this topic. However, strong peer support, my professional consultation at Duquesne, and a rigorous data analysis may serve to ameliorate the possibility of a biased view. In fact, my experiences can aid this investigation as my personal knowledge of the lived-experience of recovery from eating disorders can add richness and depth as themes emerge from the data.

**Ethical Considerations**

In the view of many authors, the ethical *dimension* of a study intertwines with validity and credibility. The researcher has an ethical and professional duty to respect the rights, needs, and personhood of the participants. Credible and valid research depends upon the ethical treatment of persons within the study (Berg, 2004; Glesne, 1992; Merriam, 2009; Patton, 2002). In a research study of this kind, ethical considerations are many, including informed consent, confidentiality, treatment of the participants, data storage and retention, and the reporting of findings, which were addressed and submitted to the Institutional Review Board at Duquesne University for approval. I reviewed my knowledge of the American Counseling Association’s code of ethics (Patton, 2002) and familiarized myself with proper ethical conduct in qualitative research.
Informed Consent

Informed consent means that the clients or participants understand their rights and responsibilities in the process. Paramount is the “freedom to choose whether to enter into or remain in the…relationship” (ACA code of ethics A.2.a). The rights and duties of the participant and the researcher were explained both verbally and in writing. Consent forms were signed and reviewed thoroughly with the participants, and they were informed that questions could be proffered at any time in the research study. Conversely, a written copy of the portion of the findings and data analysis that pertains to the participant was provided to ensure an open process. The purpose of the study and a description of how the data would be collected were also provided to the subjects for further feedback and/or debriefing.

Treatment of Participants

A correlation to informed consent is the ethical treatment of the participants in the study. Every effort was made to respect the rights and sensitivities of the subjects who participated. While the risk was small, recalling and narrating the serious themes concerning eating disorders could be a potential trigger for some of the participants. I am a licensed professional counselor in Pennsylvania and am well-versed in crisis intervention, emergency response, and trauma work. I have had 15 years of experience with diverse populations; thus, I felt able to ameliorate any potential psychological issues that might result from the study at hand. Any risk factors involved were also explained. Follow-up services for all who might desire it, in the event that the study would open a line of personal interest the subject might wish to follow, were addressed. Explanations of those provisions were given. Appendix B provides the consent form that was used.
Confidentiality

Participants in this study were informed about the boundaries concerning confidentiality. The names of the participants were masked by pseudonyms, and the actual identities were available only to me. The standard guidelines surrounding any therapeutic interaction concerning self harm, or harm to others, were also provided in written and verbal communication (Consent Form, Appendix B). All names that appear in other sections of this dissertation were pseudonyms of actual participants’ names. Likewise, and identifying information was altered or removed from this text.

The participants in this study were offered a copy of the findings, if they request them, without cost to them. Subjects were also reassured that any identifying information would be excluded from the final report.

Data Analysis

Merriam (2009) put the case simply when she asserted that “[d]ata analysis is the process of making sense out of data…It involves consolidating, reducing, and interpreting what people have said…it is the process of making meaning” (pp. 175–176). In a qualitative study, the rigor and variety of this sense making is much different than in statistical studies that define an occurrence or phenomenon (Merriam, 2009; Patton, 2002). The entire process, true to the circular and recursive nature of qualitative inquiry, is part and parcel of the data analysis (Levers, 2000; Packer, 1989, 2010; Patton, 2002). Throughout the process, from collection to final analysis, researchers recommend that the primary and ancillary research questions be a guide for interpretation (Merriam, 2009; Patton, 2002).

The narrative analysis and interpretation were accomplished by an attentive regard to themes that relate to the two major theoretical domains: Van Manen’s (1997) existentials and
Van Manen said that “[p]henomenological themes may be understood as structures of experience” (1997, p. 79). That is, they are ways in which human beings can commonly relate to the concrete situations and experience in their lives. It would be a mistake to boil thematic analysis down to some commonly used terms, however. Phenomenological reflection on a narrative pays respect to the contextual nature of the interpretation. Thus, themes open up broader, more universal issues by which individuals experience understanding and meaning.

Van Manen (1997) outlined three approaches to isolating thematic statements in data analysis, which include the following: the holistic, sententious approach; the selective or highlighting approach; and the detailed approach. The one that has the most relevance for this study is the selective highlighting approach. This approach selects thematic phrases that encapsulate the lived experience expressed in the narrative. These themes can then be expanded upon and related to the analytical tools of the four existentials that Van Manen has provided.

Though the qualitative researcher desires rigor in data analysis, many authors have pointed out that within phenomenological reflection upon the data, the flexibility to reinterpret the material is the desired spirit of the analysis (Merriam, 2009; Patton, 2002; Smith et al., 2009; Van Manen, 1997). Nevertheless, Smith et al. (2009) suggest five processes that this inquiry will follow to achieve its goal of answering the research questions.

1. Reading and rereading: Smith et al. (2009) suggested this obvious step as a way of sitting with the material, stating that “the first stage of the process is conducted to ensure the participants’ becomes the focus of analysis” (p. 82). This process, if set aside as a definite stage, ensures that truly engages with the data that begins to reflect the participants’ world. The transcript and audiotape of the interviews are, of course, read, reread, and reviewed during this stage.
2. Initial noting: The analysis proceeds at this stage to the beginning of textual and semantic analyses. Initial notes, core comments, and indicators of important units of meaning are beginning to be established. Giorgi (1985) described meaning units as “manageable units” (p. 11) that lead to a more comprehensive analysis. The initial noting process takes note of these possible thematic elements and begins to break the entire text into a holistic picture.

3. Developing emergent themes: According to Smith et al. (2009), after basic units of meaning are determined within the process of interpretation, the researcher moves onto organizing the data into central and emerging themes. The identification of emerging themes involves a more active interpretive stance by the researcher.

The emergent themes that arise from each interview can be summarized and interpreted. In this inquiry the themes that may emerge through the lenses of Van Manen’s (1997) four existentials are of special interest. The emergent themes then serve as a guide for a further understanding of the lived experience of recovery from eating disorders. Any theoretical constructs also validate and help form the interpretive structure.

4. Searching for connections across emergent themes: This step within the analysis entails describing how the emergent themes from the data fit together in a coherent narrative. The theoretical constructs mentioned previously provide a structure. Smith et al. (2009) advised the researcher that “[e]ffectively…you are looking for a means of drawing together the emergent themes and producing a structure which allows you to point to all the most interesting and important aspects of your participant’s account” (p. 96). The data analysis here is a recursive and non-prescriptive method for grasping what stands out as
important in the narratives. As the researcher understands more about the subject, the process of note taking, interpreting, and gaining a sense of the levels of meaning contained in the themes becomes easier.

5. Moving to the next case and looking for patterns across cases: Finally, this phase marks a move to a more theoretical level. Flowers et al. (2009) said that the researcher defines a general pattern within the lived experience of the participants. The smaller meaning units can be reordered into a psychological language. From this organization a general structure can be seen. Identifying the themes allows us to distinguish which are the most potent themes in the analysis. This level of phenomenological analysis still pays respect to the uniqueness of individual experience. However, since our world is a shared one, commonalities in the lived experience of the participants will be identified as well. The themes at this stage can point to a “sense of the whole” that deepens our understanding of the lived experience (Giorgi, 1985).

*Figure 1.* The five processes in a phenomenological inquiry (Smith et al., 2009).
The Trustworthiness and Credibility of Data Interpretation

In a naturalistic inquiry, the accuracy of the data is not verified by statistical measures. Lincoln and Guba (1985) have asserted the concept of trustworthiness in qualitative research. Some subjective viewpoints are expected in terms of understanding a qualitative inquiry. Trustworthiness connotes “an emphasis on being balanced, fair, and conscientious in taking account of multiple perspectives, multiple interests, and multiple realities” (Patton, 2002, p. 575). The results of a trustworthy study are transferable to different contexts. This study relied on three methods for strengthening the interpretation of the data. The first method used was theory triangulation in order to produce credible results. This method employs multiple perspectives to understanding the meaning of data. The theories triangulated in this study included Van Manen’s (1997) lifeworld existentials; TMT as described previously in this study; and social constructivist thought and other concepts of recovery, including Prochaska and DiClemente’s (1986) criteria, also mentioned earlier.

As noted above, the credibility of the study was enhanced by the researcher as an instrument. Along with theory triangulation, a strong and robust peer review was employed to ensure a credible study. A qualitative study design is not expected to be free of researcher bias. However, limiting researcher bias aids in the credibility of a study. A peer review thus was used to lessen the possibility for researcher bias as the data was analyzed.

Finally, the researcher sought out colleagues that perform research and practice for consultation concerning the data interpretation. These colleagues were asked to comment upon the coded analysis as it was completed for revision, and a record of these consultations was kept. The record, like the field notes, was destroyed when the analysis was complete. Therefore, data,
theory, and researcher triangulation are present throughout the data analysis. I believe that the aforementioned measures have ensured a trustworthy and credible study.

**Limitations**

Conducting a phenomenologically oriented study presented some limitations. One of these is the lack of precision instruments that quantitative/statistical research enjoys. Personal observations, interpretations, and judgments concerning meaning-making risk the bias of the researcher; in fact, it is expected. Other researchers might interpret the data in a very different way, or from different theoretical tools. Another limitation was the data set for this inquiry. It was confined to persons who met the criteria already defined, whereas persons who had been struggling with an eating disorder for an extended period of time, but who have suffered many relapses, were not highly represented. Hence, the results may not be generalizable throughout the entire population in terms of being extended to those who have suffered long term from the illness. By selecting those persons with a degree of competence despite their illness, I attempted to derive the essential features of the lived experience of recovery. Because data is dependent upon a small number of participants, however, bias may have occurred.

Another limitation was, for the most part, the demographic of the sample was confined to older adults. Because the participants who met the criteria were required to have gone a certain time without a relapse, as previously mentioned, and because the recovery process is often marked by relapse, older adults were the ones who participated, even though anorexia and bulimia are prevalent in younger adults.

The last concern is one that applies to qualitative studies in general. The capacity of the inquiry to be generalized throughout an entire population was absent in this inquiry because it was not meant to be a representative sample of an entire population. Rather, it was an inquiry
into a specific phenomenon that may be encountered in the lived experience of other human beings. The strength of the qualitative approach is that it offers insights that cannot necessarily be generalized. It can respond to paradoxes, confounding, and aspects of phenomena that positivism may miss because it cannot be reduced to a certain paradigm. Therefore, while results may not be assumed to be generalizable across a population, I believe that the final data provided insights and knowledge for further quantitative and qualitative inquiry (Merriam, 2009; Patton, 2002; Van Manen, 1999).

Summary

The experiences and voices of those who have recovered from eating disorders is mostly ignored by the counseling literature. This inquiry presented a hermeneutic phenomenology of the lived experience of that recovery and gives voice to that recovery. The theoretical concepts that underpin the inquiry are Van Manen’s outline of the four existentials—lived time, lived space, lived body, and lived relation—and the existential paradigm known as TMT. Another theory that guided the interpretation of the data was Social Constructivism. Through the techniques aforementioned, it attempted to answer the primary and guiding question: that is; what is the lived experience of those who have engaged in long-term recovery from eating disorders? The ancillary questions concerning transformation and change investigated the nature of the change process, and its relationship to the psychological, emotional, and social world the eating disordered person inhabits.

Participants were selected and individual interviews conducted for this qualitative study, from which the data were collected. The interviews used a set of standardized interview questions, also using probes to accrue more data concerning the phenomena. Gathering and organizing the data and elucidating the themes followed a rigorous interpretative process. The
triangulation method of interpretation ensured trustworthy and valid reflection on the lived experience of the individuals who participated. Likewise, the final data analysis depended upon the validation of those who have participated in the inquiry. A stance that listened for a holistic sense of the utterances and attempts to grasp the unique phenomena in its “essence” was the defining feature of the interviews (Giorgi, 1985; Van Manen, 1999). Throughout the interview process ethical and legal boundaries were observed. The interviewees’ well being was paramount, and confidentiality was rigorously observed.

The data were analyzed through the Interpretative Phenomenological Analysis outlined by Smith et al. (2009). This method involved breaking the data down into thematic meaning units. A holistic sense of the themes as well as those within each individual interview was illustrated, and then cross-thematic elements in the interviews were identified. Methods for ensuring that the researcher grasped the essential meaning in the interviewees’ experiences included triangulation, participant feedback, and peer review.
CHAPTER IV: RESEARCH FINDINGS

The findings of this study illuminate the lived experience of those recovering from eating disorders. This existential-phenomenological examination allowed for an in-depth look at the lifeworld of these individuals. The phenomenologically-oriented interviews allowed participants to reflect on their lifeworld, and explore personal meaning related to their recovery. The data from these interviews provided rich, layered descriptions of their experience in the recovery process. The data were analyzed through the lenses of the theoretical frameworks that drove this inquiry explained in the literature review section of this dissertation.

A model suggested by Smith and Flowers (2009) was used for data analysis, as discussed in the previous chapter. The themes that appear in the narratives of the interviewees were constructed from smaller units of data, and the smaller meaning units were derived from the narrative interviews of the participants. These smaller units were then applied on a cross-case basis to single out the common elements within the narratives. Therefore, the analysis will present an accurate portrayal of the lifeworld of the recovered individuals through the common themes thus derived.

After each of the interview descriptions, the categories derived from the research methodologies are organized into tables. These tables link the statements of significance with their analytical categories, and from them, the relevant themes emerge from across the cases. The chapter will conclude with a cross-case analysis, providing the reader with a deeper understanding of the experiences, thoughts, and feelings of those who have recovered from eating disorders.
Demographic Information

There were eight participants in this study, five females and three males. Each participant identified as having an eating disorder that has been in maintenance (Prochaska & DiClemente, 1985) for at least 3 years. The participants range from ages 32 to 64 years of age. Five patients had bulimia/BED, one anorexia, and two BED without bulimic symptoms.

Table 1.

Summary of Participant Demographic Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Type of disorder</th>
<th>Years recovered/in maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katya</td>
<td>32</td>
<td>Female</td>
<td>Bulimia/binge eating</td>
<td>3.2</td>
</tr>
<tr>
<td>Ruth</td>
<td>64</td>
<td>Female</td>
<td>Anorexia</td>
<td>35.5</td>
</tr>
<tr>
<td>Anne</td>
<td>36</td>
<td>Female</td>
<td>Binge eating disorder</td>
<td>9.75</td>
</tr>
<tr>
<td>Bailey</td>
<td>40</td>
<td>Female</td>
<td>Bulimia/binge eating</td>
<td>24</td>
</tr>
<tr>
<td>Josie</td>
<td>36</td>
<td>Female</td>
<td>Bulimia/binge eating</td>
<td>3</td>
</tr>
<tr>
<td>Arthur</td>
<td>56</td>
<td>Male</td>
<td>Binge eating disorder</td>
<td>27.3</td>
</tr>
<tr>
<td>Aaron</td>
<td>38</td>
<td>Male</td>
<td>Bulimia/binge eating</td>
<td>7</td>
</tr>
<tr>
<td>Ford</td>
<td>52</td>
<td>Male</td>
<td>Binge eating disorder</td>
<td>6.75</td>
</tr>
</tbody>
</table>

Each participant who agreed to participate in the study was interviewed according to the interview schedule provided in Appendix A. Confidentiality forms (see Appendix B) were signed, and because privacy is of the utmost concern in the study, the names presented here are pseudonyms. Likewise, any identifying information that may appear in the transcriptions, such as profession, residence, or any other descriptor, has been changed or deleted.

After the data collection, I transcribed the videotapes so that an accurate recording of the interviews could be analyzed. The process entailed viewing the videotapes and reading the
transcripts over several times to grasp aspects that might have been missed the first time through. I aimed to create an iterative and recursive process whereby deeper aspects of the phenomena could be revealed through the analysis (Van Manen, 1997). The process of reviewing the transcript and audio-tape multiple times allowed me to get a deeper sense of the inflections and emphasis in the respondents’ answers.

**Analysis of the Interviews**

The interviews were conducted at various locations that were convenient to each of the participants. These locations were chosen to ensure privacy and safety so that participants could openly share their experiences. Scheduling began with a phone call and screening to make sure that participants met the criteria. The interviews were scheduled by telephone and email, and were confirmed the day before the meeting, using the same means. Each interview began in the same way, with a review of the informed consent, in which the rights of the participant, confidentiality, coding, purpose of the study, and the transcription/analysis of the study were thoroughly explained. I also carefully explained my role as a professional counselor and doctoral student. Immediately following the informed consent procedure, recording equipment was switched on to capture the rest of the interaction. Each interview began with a demographic question that included age, type of eating disorder, gender, and years recovered from the disorder, after which each participant was asked to “describe your eating disorder.” The remaining questions in the interview schedule focused upon the experience of the individual who had recovered from an eating disorder. Each interview ended with the question, “Is there anything else I have not asked you that you would like to share?” This final question allowed for an opportunity to extract more information-rich narratives. It also provided a sense of closure to the interviews.
Following is an analysis of each interview, along with a description that provides context. These analyses are aggregate summaries of the eight interviews, each of which lasted between 50 and 90 minutes. The video recordings, field notes, and transcriptions of the interviews produced a great deal of information that was analyzed throughout, during, and after the transcription process. When the transcriptions and review were complete, I began to extract the units of meaning (Giorgi, 1985) from each interview. I noted these within the margins and in a separate notebook alongside my field notes. Next, I searched for themes within the cases. I color coded the meaning units as per the analytic categories in each narrative. Van Manen’s (1997) four lived existentials provided a framework by which I could organize the clusters of meaning. I also sought for meaning units relating to Terror Management Theory and garnered categories derived from the social constructivist thought reviewed in Chapter 2 of this inquiry.

Finally, I searched for thematic elements across cases (Smith & Flowers, 2009). These themes are the final result of the inquiry, and they address the research question originally posed. These themes extracted from across the cases are an interpretation of the common elements of the meaning units and themes extracted from the individual interviews. The themes as a summary of these results will be provided in the next chapter.

Within the individual cases, analytical categories were derived from the theories that principally guided this research. Saturation was reached in the eighth and final interview. The narratives are rich with information that pertains to the research questions posed in this study. This analysis serves to provide the reader with a contextual understanding of the lifeworld of the recovered person, and it will act as the basis for the culmination of the work in Chapter 5. The analytical categories are as follows:

1. Existential: Lived relation/other
2. Existential: Lived space
3. Existential: Lived time
4. Existential: Lived body
5. Terror Management: Self esteem
6. Terror Management: Awareness of mortality
7. Social Constructivism: Awareness of social categories/changes

Interview #1 with Katya: Awakened to Life

Katya was my first interviewee. She is a 32-year-old Caucasian female who has experienced an absence of eating disordered behavior for a little more than 3 years. Katya acknowledged that BED and bulimia had been present throughout her life. We met in a private office with no distractions. The office is used for therapeutic purposes and is designed to promote a safe and comfortable environment. Katya was fully aware of the nature of the study and was excited about being able to participate in the study.

Katya said that her excitement about telling her story was built on the achievements she had made in her recovery process. She described the taming of bulimic behavior as “no small feat.” She was proud of this achievement and seemed hopeful that it would continue. She took her time in answering many of the questions, as she seemed to be searching for understandable ways to express herself, and I encouraged her not to hurry and to be reflective. Although Katya indicated that eating disorder had affected her life negatively in many ways (as I found with many of the interviews), there also seemed to be a lot of levity and laughter.

We started with the demographic questions (see Appendix A) by which I elicited her name, age, gender, and years recovered from her disorder, along with the type of eating disorder from which she had suffered. As per the interview structure, Katya described her experience with her eating disorder first. She said that she had recognized the bulimic symptoms around age 14, saying that although she was not an obese child, she could remember having a preoccupation
with food at a young age. She was able to contrast this with the recognition at 10 years of age or so that “others didn’t seem to be very preoccupied with food.” Katya said that her bulimia was quite frequent for a good period of time. Although she had not been hospitalized, she asserted that her case had been moderate to severe in her teenage years. She described the beginning of her bulimic behavior as entailed with the use of mood-altering substances, such as alcohol and cigarettes.

Katya noted that the compulsive behavior with alcohol and cigarettes was another way in which she could be less socially awkward and could feel distracted from her problems. She said that her eating disorder merged with these other habits so that she might feel some relief from negative thoughts and emotions. She did become very reflective about this state, as if she were looking back from a better vantage point on the experience. I inquired about her experience within the eating disorder, to which she offered this description:

So, my eating disorder, just to describe my eating disorder, it was like a continuation of things that had been with me my entire life. Like, um…I always needed something to deal. Like, I was uncomfortable talking to other people… I was uncomfortable socially, or, um, or physically. That description of being uncomfortable in your own skin was me. The food was like my God, the food was my everything! I actually did not know about recovery. You know… like, I am in pain so I need to go to the doctor and get pain medicine on top of my drinking, binging, and purging. It was like constant um...avoidance and um like anesthetization.

The experience of reflecting on it appeared to be very powerful for her emotionally, but it did not seem to distress her. Rather, she seemed excited about what she was conveying to me. She emphasized the word “something” in her narration as if to indicate that the BED was one
thing among many. I suspected that it was powerful for her to talk about now, and I asked her if that was correct. She affirmed my hunch and asked for a moment to get “centered” as she searched for the right way to convey more of the experience. She said she realized that the emotional discomfort she had experienced was also a profound discomfort with her body. “That description of being uncomfortable in your own skin, that was me,” she exclaimed. Explaining further, she said that she had used food as a “release” that became ever more ineffective as time went on. Katya said that the time she experienced relief from the uncomfortable emotions came in shorter and shorter intervals. After her mother’s death, she said that it had gotten to the point where it was her entire focus. She said that “food had become her god.”

Katya paused here, becoming reflective again. It seemed like a good moment to segue into the second question: how has recovery from the disorder changed your life? I wanted to inquire further into the essence of the change in recovery. Katya described a very internal process. She described the process as “developmental layers of awakening” in which she was “in the middle of another intense growth moment.” I inquired deeper into her description of the change in recovery as an “awakening.” She reported that previously, she had felt that others’ experience of emotional stability and functionality was beyond her ability. Now, she seemed to marvel at her newfound ability to tolerate discomfort and to grow personally, even when faced with extreme adversity in life. The awakening, as she described it, had shifted her focus from negative emotions to a more reflective stance about herself. As someone with bulimia, she reported having felt the impulse to manipulate others or to derive satisfaction out of situation. In contrast, she seemed now to feel a more authentic relationship to others in her world.

In further revealing her experience with bulimia, she even described having regarded those who could experience positive personal growth as “fake” or “unreal” because living
without the disorder had been beyond her ability to understand. When she saw others in her social world who seemed unencumbered by a disorder, she doubted their veracity. She said she wanted to “get away from people as fast as possible.” However, as she progressed in her development, she became aware of authentic relationships with others. At first she said the recovery was just about ceasing to binge and purge, but then, she said,

It was like I was growing, and I was being awakened to so many things. It was emotional. I had not been able to cry. Like, I hadn’t cried. I would say things like “I don’t cry,” and it had been like I would not cry in front of my therapist. But I think I spent the majority of my first year in recovery crying in front of others. I had not cried like that nearly ever. I haven’t felt vulnerable, haven’t felt it in years.

I asked Katya if she could describe more about the significance of that change since. She talked about her ability to be vulnerable as an essential ingredient in her relationship with a romantic partner and with other people. Earlier in the interview she had referred to her partners as very troubled. She described her current relationship as a “real relationship.” When I inquired what that meant, she said that it related to her ability to be vulnerable in front of another. She noted that many of her values relating to relationships stemmed from the fact that “I wanted people to like me because I wanted to feel important.” She went on to describe a shift in focus for those values, especially those relating to people other than romantic partners. She said, “Helping other people and live a life that is based in—how do I say it?—moving forward. And like being genuine even though I am going to make mistakes and things are going to look messy sometimes.” This description of her relationships with others was her definition of having a real relationship.
Subsequently, she began to elaborate the ways in which recovery from bulimia and binge eating disorder had changed other aspects of her life. She returned to relationships and honesty, with an obvious emphasis on the latter. She said that she had deliberated a great deal about what was the most honest way to handle relationships while in her recovery process, and she referred to her style of relating while practicing her eating disorder. One of the changes with reference to honesty showed in her desire “to feel important, like the best” when she was suffering from the disorder. By way of contrast, a more honest appraisal of her personal self had been part of her recovery process, and this freedom from self-expectation allowed her to create more honest relationships with others.

She specifically mentioned her relationships with her family of origin as being transformed by her developing honesty, describing a family situation that is now more balanced and relational. When she was suffering from the disorder, she related to her family by “telling everybody what to do and how to be, and what role they should play.” Her previous inability to relate well to family members suggests that her lived experience with her family had a qualitatively different focus.

Katya described being able to have reciprocal relationships with her family members. For example, she said, “Today, I spend time with my dad and share things with him. And he shares things with me. It is like, you know, we have a conversation.” Katya punctuated this statement with a laugh. She further said that the ability to have a conversation with her father provided her with satisfaction she had not had earlier in her life. She generalized her ability to converse and to have more honest relationships to all her interactions with people who are significant to her. Emphasizing honesty as her guide, she said that when she is not honest with herself and others, she becomes very uncomfortable.
When I inquired further concerning the honest aspects of her life in recovery, the conversation moved to her workspace and relationships at her job. In reflecting upon the reason for the change, Katya offered the idea that her former attitude was a result of internal turmoil that she had a hard time controlling. When her world felt out of control, she said she would “lash out at others.” As the recovery process developed, she was better able to restore her workplace relationships. Again, she asserted that her relationships had been transformed as a result of being recovered from the disorder.

I was interested in the connection between Katya’s current experience of her world and her ongoing recovery. Katya noted that what has allowed her to manage many of her adult relationships has been a faith in her ongoing developmental process. A part of the process has been a different relationship to her social world—that is, her motivations for relating to others has changed. The validation she used to feel from many of her social behaviors is no longer important. Rather, she implied that more of a sense of mutual struggle has developed. By this, she explained her new recognition that in relationships, “we are both struggling” and that mutual support is a guiding value.

When I inquired further about this process, she said that her self-esteem was related to her ability to relate better with the people in her world. The development in her recovery has made her “able to engage in estimable acts.” She said she is now able to engage with family, friends, and co-workers “without needing all the praise and reward” she had craved before her recovery process began. She finds this ironic, given that the process was a “deflation of the ego.” The deflation of the ego has allowed her to continue recovery and thereby establish more authentic relationships with others. Katya believed that this attitude was essential to her recovery and even went so far as to say that too much praise was reminiscent of her experience in
suffering from the eating disorder. She preferred the experience of “engaging in life” without excess praise. This attitude comprised a more “honest” relationship with the world.

The interview concluded when I asked Katya if there was anything else she wanted to share. Again, she manifested excitement:

Yeah, you know I think being [pause]… I have come to a totally different understanding. At first coming into recovery, it was really hard for me to grasp that this was life and death for me. And like, no it’s not I am just going to binge and purge on ice cream and cookies, but I am going to, you know. I have been awakened to a life…um… that is I know like going through and being engaged with people and knowing what is happening on a daily basis…and when do it is like I flourish..It is not what you would intuitively think would happen, but it is.

I found her account very moving. She was obviously moved by it herself, as I observed through nonverbal cues and body language. After a pause, Katya noted that she had covered the ways she now understands life differently in the preceding content of this narrative. She explained that feeling she was going to die was a literal event and said that she wanted to express her ability to “flourish” as an event she could not have foreseen without gaining a holistic perspective on the recovery process. We sat for a moment, both of us seeming to be reflecting; then Katya signaled she thought this would be a good time to end. I gave her the opportunity to debrief. She declined but said she actually felt very good, and I thanked her for her participation. She said she had enjoyed the experience, and we concluded the interview. In this first interview, as with all the rest, I sat quietly and reflected on the interview after Katya left. I took notes in my field journal on the proceedings, and began to think about the interview as a whole (Giorgi, 1985).
Summarizing Katya’s Experience

Katya’s experience in reversing bulimia and BED was marked by intense personal growth. She referred to personal shifts in her ability to manage, grow, and even “flourish” in all spheres of her life. She seemed to believe that a holistic approach to her life was possible now as part of the recovery process, and to have a sense of optimism that had been absent throughout much of her life. Rather than being compulsive and derogatory, she appeared to be a reflective woman who appreciated deeply her experiences in life. Katya described her experience of recovery as being “awakened.” In her life now, she is present and active: she described herself as being engaged with all the facets of her life, an engagement she appears to renew with vigor as each facet appears.

Table 2

Summary of the Interview with Katya

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Supporting Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existential: Lived Relation/Other</td>
<td>Today, I spend time with my dad and share things with him. And he shares things with me. It is like, you know, we have a conversation.</td>
</tr>
<tr>
<td></td>
<td>I am trying to help you because we are both struggling, and um, ...engage in life.</td>
</tr>
<tr>
<td>Existential: Lived Space</td>
<td>I can very quickly go into a dark room and never come out.</td>
</tr>
<tr>
<td>Existential: Lived Time</td>
<td>My history, all my life I had been engaged in bulimia.</td>
</tr>
<tr>
<td></td>
<td>That is what basically food because to me. And going from eight hours a day, to four hours a day, to thirty minutes a day, and was quickly narrowing, and took over.</td>
</tr>
<tr>
<td>Existential: Lived Body</td>
<td>That description of being uncomfortable in your own skin, that was me.</td>
</tr>
<tr>
<td></td>
<td>I could see girls my age, but you know they</td>
</tr>
</tbody>
</table>
were like smaller than me.

Terror Management: Self-esteem
I used to think self-esteem meant being better than other people.

Self-esteem means more to me today; like I am able to engage in estimable acts.

Terror Management: Awareness
Food was like my god. It was my everything.

Mortality/personal change
It was really hard at first for me to grasp that this is life and death for me.

I have been awakened to a life that is I know like going through and being engaged with people and knowing what is happening on a daily basis.

Social Constructivism: Change in social relationships/awareness
A lot of change has been in my relations with, like, family.

Pursuing my recovery as being the most important thing in my life. I can’t put my husband before my recovery. I can’t put my job, my family anything in front of it.

### Interview #2 with Ruth: It Connected Me to a Core Part of Me

Ruth was a 64-year-old female who had been in recovery from anorexia for approximately 35.5 years. The interview with Ruth was held in her private office, a comfortable and familiar place where Ruth could speak reflectively upon her experiences. She had experienced a minor car accident prior to the interview and had to manage the situation before we started. I gave her all the time she needed to be calm and to clear her head. She said she had been looking forward to the interview and wanted be relaxed. She made it a point to inform me how comfortable she felt speaking about her anorexia, and she invited me to ask her for clarification at any time in the interview. At the beginning, Ruth gave very eloquent and comprehensive descriptions of her disorder and her recovery from the anorexia she had suffered.
With an affable and gentle demeanor, Ruth characterized what she had suffered from anorexia as “pretty significant”:

What I mean by that is the way I thought about things, the way I felt, the way I behaved, and my perceptions were all altered...um, and I decided to—I developed a point of view that the experience of myself in which diminishing weight was...becoming sparer...was the ultimate control, and the most important thing I could do. Being able to diminish my weight, that is get on the scale and see that there were lower numbers than there previously were made me able to reject food. Being able to look at my body and see that it was getting progressively smaller became my reason for being. I affirmed to me that I had some influence in my life. I had some control not only over myself, but with respect to my interactions with others. By refusing, resisting, rejecting their attempts to get me to eat, I was asserting I was an autonomous being, and they could not determine the actions and outcome of my life.

Ruth went on to describe the feelings of “accomplishment” she gained from being severely underweight. She described her weight as being extremely low compared to her height. She gave me the description slowly and with apparent solemnity, often pausing as she spoke, lending veracity to her assertion that the experience of anorexia had deep significance in her life. When she offered to go even deeper into the description if I wanted her to, I eagerly accepted her offer to do so.

She went on to say that her anorexia began later in life than it does for most anorexic women. After graduating from college, she married a man much older than she was, as well as an authority figure. In hindsight, she realized that the marriage and the conditions that surrounded it helped to trigger the anorexia because the stress of entering into another system had a profound
effect upon her. Additionally, the system was not supportive as the stepchildren were hostile to her entering the family. She identified this shifting role in the marriage, and her feelings of being “out of control” in other areas of her life compelled her to develop anorexia. She was thrust not only into the role of wife but also that of step-mother, both requiring a period of significant adjustment. She said “this was a tremendous change in my life, not just adapting to marriage, but adapting to all these people in my life, and in the house, where before it had just been me and Mom.” Moreover, the adjustment was complicated because her role within her new family was contentious:

So I had people in my life who hated me. I had a husband who I now realize was so consumed with guilt for hurting his children and for leaving their mother—he felt the need to make it up to them—and I got lost in the whole dynamic. So part of the anorexia was a way of finding that I mattered, too. I guess I thought nobody cared about understanding me, a sense of literally not mattering at all. And the kind of anger that came out of that that, ok, being treated in ways I did not want to be treated—so ok, in addition, [I was] doing something that would distract me from being hurt, [which] I was all the time. That is, instead of thinking about how hurt I was all the time, I could think about my next food plan, what I was going to do next with food. What I was going to cut out next to bring my weight down more. So it gave me a kind of focus.

She went on to describe how that focus worked to her advantage and that she had often become very “passive aggressive” with her husband and the family. The refusal of food was her way of controlling the interactions with others in her family. She said that practicing anorexia had two functions. It had been a way to distract herself from the pain and a way to feel a sense of power over others that were close to her.
Ruth also recalled two other important aspects of her experience as an anorexic person. First, the disorder was not commonly diagnosed or understood at the time she suffered from it. “Bear in mind it was the 70s, and anorexia was not understood. The uniqueness of it was that, at the time, no one else knew what was going on.” Therefore, when she was suffered from her symptoms, it was a way of feeling special in society at that time. Second, she had a peer who practiced it and who was instrumental in her continued restriction of food. This peer became a role model for her:

She was tall and had this cool kind of attitude. The affect as if nothing could faze her.

And she was also very pretty, and boys flocked around her. That was the one thing I could do. I was in an unhappy life, and I had this one person that I admired that was positive. … I could tell every vertebrae on her spine, and I could count her ribs.

Ruth remembered that her experiences were dominated by “living in a secret private world that no one had access to” alongside another. The private world became the world that she valued. In this part of the interview, she seemed to wish to express the entire world of the anorexic, as she often paused and chose her words carefully. She appears to have thought through the experience a great deal over the years. She expressed concern to me that she was being incoherent because of all the “facets” of the experience. I assured her truthfully that I understood her narrative.

Ruth also linked this sense of uniqueness to her relationship with her family. Because her family did not have a concept of anorexia, there was a sense of power in her close personal relationships. As I probed, she also asked for clarifications on my questions. I assured her that she could answer in any way that felt natural and reflective of her experience. Once she understood that I was not looking for a “correct” answer, her demeanor changed somewhat,
which I interpreted as a good sign. She had shown no signs of being uncomfortable, but she had appeared to be very reflective. As we began to talk about recovery from the disorder, Ruth seemed to become more open, and she began to laugh as she talked.

Ruth reflected extensively on how her values had changed through the recovery process. She was careful to refer to herself as an “anorexic,” and not somebody “with anorexia.” She explained her rationale for adopting this label: “Being an anorexic speaks to every dimension of the experience of oneself.” She spoke of a clinic to which she had been exposed that insisted the residents say they had anorexia rather than naming themselves anorexics. “I disagree. I would say existentially you are. Your identity is very specific. You are an anorexic on every level of your being.”

Furthermore, she thought that the normal roles one might fulfill in society are co-opted by anorexia. For her, the recovery process was partially rebuilding these roles: “what it means to be you in relation to being a wife, a mother, a friend, a member of a community.” What she described happening in hindsight was that the internal locus she had perceived was false:

You know how they talk about internal locus and external locus of control? So!

Everything is external locus of control. To not even say but just to experience existentially the question, “Who am I?” when you are anorexic—forget about even trying to answer the question. You cannot think about the question. If you are an anorexic and you are experiencing that question, you are doing it solely in terms of what it means to be perceived by others.

Ruth perceived her recovery from anorexia as achieving a more “internal locus of control.” When I inquired how she achieved that, she described a moment wherein she had a sudden awareness of a profound change in her perception related to anorexia. She seemed quite
excited as she described this experience to me, choosing her words carefully in order to express its significance.

There was moment for me when there was a shift. And that moment occurred after I left my husband. Maybe six months later, eight months later, and there was a book. I am a bookworm. There was this book called *Working* by Studs Terkel. And in it he interviewed all kinds of people in different jobs…umm and…so I was reading this book…one of the chapters…and I was fascinated. I remember … suddenly realizing that I was reading a particular expression of that person’s life. Of what it was like to be that person or what it is like to be that person in that particular job, or whatever. And that person moved me. I connected to it in this core part of me. This empathetic connection I had to the person…I wasn’t thinking what they would think of me or, in other words, feeling myself from the inside out in the gaze of someone else. At this moment I was responding to it with my intelligence, my feeling, my imagination, my sensibility. I was giving it meaning that originated in me, and was unique to me, and therefore belonged to me.

Ruth thought that this moment she had experienced some 30 years ago had illustrated a part of her recovery from anorexia. She described this experience, which seemed very meaningful to her, as a sudden moment of realization that led her into a deeper level of self-awareness. After this time she had been able to establish more meaningful relationships. The “shift” was a burgeoning ability to be empathetic with others. She discussed the fact that the process of maturing had begun after her anorexia had been ameliorated. She shifted the interview, explaining that she had experienced her anorexia also as hiding vulnerability “behind a pretty tough shell.” Through the recovery process, she had become more empathetic and
vulnerable with others: “It has certainly made me more aware of the complexity of humans, to the degree in which we are all struggling to be ok.”

Ruth digressed back into her behavior as an anorexic to explain the contrast of her behavior when recovered from the disorder. She noted that as an anorexic, she was belligerent with others, which she attributed to being fearful and having an inability to admit her vulnerabilities. She thought that anorexia was marked by a “tremendous vulnerability” that was not acknowledged in her own thought processes. She was “this person who had really dug herself into this hole, and created walls around her.” The recovery from the disorder was developing the capacity to be vulnerable in front of other people. In fact, she said that underneath her belligerence was

a person who felt like all it would take would be for somebody to blink their eyes and she would disappear. So just connecting to the tenderness behind the toughness is inherent in the way I experience everything—people, animals, everything.

Ruth noted that this change was dramatic because of her newfound ability to connect with herself and others; it made her aware of choices she could make that supported her self-esteem. Those choices for her were “messages we send to ourselves” that, when positive, promote self-esteem. When I inquired further about the differences, she said that she could freely participate in a growth process. She said,

I am acutely aware now [that] to choose this instead of that will be to teach me a particular thing about me, and that is a message that to some degree I will internalize. So it is important to choose things that teach me I have the capacity to do these things and be psychologically ok. That I am strong and resilient enough, and that ultimately the
decisions I make are not in reaction to other people—the way it was when I was anorexic—but as an expression of the kind of person that I want to be, and can be.

I asked Ruth for any final thoughts. She wanted to return to the anorexic experience once more. She described feeling “ugly on the inside,” reporting that feelings of fear, hopelessness, and helplessness are very powerful in that state. “You can’t reach in and scrub off the interior,” though as an anorexic she wished she could. Therefore, she said that the wish to become smaller was equated with the wish to become “cleaner.” She went on to say,

A real sign of recovery, psychologically speaking, is when you can experience yourself as a body of substance. Your body is a substantial thing. That is, a reflection not just metaphorically, but also physically, of a substantial inner being of thought and feeling.

Here Ruth seemed to bring her thought full circle. She had begun with her anorexic experience of the body, and had ended with the experience of the body as a recovered anorexic. She further described the transformation as feeling like a person that had some “relevance” and “positive meaning” in existence. She even referred to a moral dimension of “goodness” and “decency” that were, for her, essential for accepting the body she has and not the “small and impaired” body she had sought.

The interview seemed to draw naturally to a close. I thanked Ruth for her time, and explained she could contact me for any reason throughout the study. After I left the private office, I reflected on the interview, wrote down immediate impressions, and tried to acquire a gestalt impression from the experience (Giorgi, 1985).

**Summarizing Ruth’s Experience**

Ruth’s description of her recovery process spanned many different facets and aspects of her life. She began by focusing extensively on the experience of herself as an active anorexic.
She was able, eloquently and sometimes passionately, to describe how her climb out of disorder had given her a personal sense of power and self—the worth that she had desired as an anorexic. Furthermore, she described how the process of recovery was finding a “core” part of herself of which she had been previously unaware. Being connected to this core transformed many of her values and relationships with others. She had gained a sense of the ways in which everyone struggles with life and had found a new empathy and respect for persons in her world.

The connection she felt to a more inwardly directed expression of her efforts empowered her, and the choices she made in her empowered position prompted growth. Ruth’s experience of recovery from anorexia consisted of a deeper grasp of her existential self. This self, which is aware and which chooses and reflects on the world in which it lives, was essential in her recovery. It seemed to me that she made a great effort to explain this to me in a comprehensive manner. What struck me after the interview, looking at it as a whole, was that Ruth had recovered some 35 years ago. Despite this long stretch of time, the disorders and processes of recovery were still alive in her memory. In fact, they seemed to be an important part of her everyday life. The inner connection she had made transformed her.

Table 3

*Summary of the Interview with Ruth*

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<tr>
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</tr>
<tr>
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<td>What it means to be you in relation to being a wife, a mother, a friend, a member of a community.</td>
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Interview #3 with Anne: A Greater Source of Well-Being

Anne, the third person to participate in this study, is a 36-year-old Caucasian female who identified as having suffered from BED at an early age. She has been in recovery from the disorder for 9.75 years. She was able to identify the date of her last binge episode. We held the interview in a private office of her choosing.

In describing her eating disorder, Anne said that she remembers its being present in childhood. She said that she was always obese as a child and that she could remember having a “pretty significant weight issue” in fifth grade when she weighed 150 pounds. In seventh grade, she weighed at least 250 pounds; she might have weighed more, as she has recently realized that the school’s scale that produced that number may not have gone over 250 pounds. It is worth noting that today Anne is small, almost slight. She recounted being shocked as a child when she saw a peer buy pants in a single digit size because she “did not know that pant sizes came in single digits” as a child. As an adult, she grew into a 22 pant size.

Anne then explained some of the underlying thoughts in her childhood. She mentioned that “weight and food was very, very central and shame inducing.” Furthermore, as a result of her weight she always experienced an “expectation” or awareness that she must somehow “fix” something. I inquired what she meant by fixing something. She said,

Fix my weight. Fix my relationship with food. That I just needed to do it differently. I did have a period in high school in my sophomore year of high school until my freshman year in college where I was a normal size, but it was without question the most emotionally miserable period of my life. I had dieted down to a normal size. And I was very normal looking and was wearing single digit clothes sizes. And I was dating a boy on the football team. And I was passively suicidal. And I remember a teacher pulling me
aside and said, “Are you ok?” …He must have mentioned it because I was wearing nothing but black for six weeks, which is not typical for junior high unless you are part of some Goth subculture. I was just really, really depressed, and it wasn’t getting better.

Anne explained that she had thought if she lost enough weight that her life would be “perfect.” She said her focus was to attempt to be healthy by attaining an ideal weight. However, the desire to be “perfect” had made her very emotionally unstable. A turning point in her adolescence happened when she sought therapy and medications for her depression. However, her therapy at that time did not address the binge eating. Because she was a normal weight, it was not identified as an issue. After a period of stability in her freshman year of college, she said that in her sophomore year she “put on weight with an incredible determination.” She continued to binge eat and gain weight after college and on into her professional career.

While pursuing her professional career she had heard about recovery groups in the community for eating disorders. She said it was one of many important experiences for her because “I realized I am not the only one. I thought I was alone. I thought it was my fault—it was my issue. But I realized I am not by myself.” Because she began to connect with others who had suffered from the disorder, she therefore felt as though she had lost much of the shame about not being able to control her binge episodes. She relayed this to me in a very open and unguarded manner, which I interpreted as a sign that she had lost much of the “shame” and “isolation” surrounding her disorder. In fact, Anne noted that all relationships had improved in her life.

And another thing that had become clear in my recovery is my relationship issues, and my relationships with men. Having a hard time with men and knowing how to have a healthy sense of intimacy—knowing what that might mean, or knowing how to choose an appropriate partner for myself. My relationship with myself and others had been quite
fucked up over the course of my adult life, but that’s changing. And I know it is changing because of the work I have done to maintain my recovery from my eating disorder.

After discussing the change in her ability to establish and support positive relationships, Anne shifted her narrative. She reflected for moment and then explained,

“Truly the moment came that my whole trajectory of life—I don’t even know how to describe it, but my life was very definitely trucking along on a certain path. And there was a parallel opportunity—a parallel life I could have—and, um, I had no idea how to get there. A parallel life had to do with professional success, emotional health, intimate relationships, not hating myself, and that was what that other life was really earmarked by.

As her recovery deepened, she believed that the life she was living, and this “parallel life” she had caught sight had become more “interlinked and more integrated than they ever were.”

Since I was interested in transformation in recovery, I inquired more about this “shift” that seemed to allow Anne to alter many other dimensions of her life. She said that the change was “really not about food, and it never was.” She went on to list such areas as relationships, family dynamics, and a biological predisposition to addiction and obesity. The reasons behind why a disorder related to food for her were not as important as living a positive life. For Anne, a transformation in her life occurred when she stopped trying to live an ideal life and started living a “real life.”

My course of recovery had helped me to do that, to really live life, not in an ideal way—that way of dreaming about the way life should be, but then nothing actually happens. I did that for a long time. But I don’t live like that anymore. The life that I really have is
the life that I always wanted. I really feel that way. That is truly my life. I am—it is my recovery from eating disorders. I don’t know why. It isn’t about because I am not trying to weigh 350 pounds, or am I trying to exercise three hours a day. I get to live the life I have; the life I have always dreamt of wanting—and was always too afraid to admit it to myself. The life that I have is because of my recovery. I do not know why that gets to happen, but that is what happens.

Anne let out a very loud and infectious laugh at this point in the interview. I continued by asking her more about the ability to live a real life. She connected it to values in her family. Anne reported that through the recovery process she had been able to discover what her personal values truly are. She said that prior to her recovery her value system was “enmeshed” with that of her family. However, she described her family as having addictions and mental health concerns. She said that this situation had dictated many of her values and ways of experiencing the world outside her family. She stated, “My mother is absolutely eating disordered. She is the daughter of two alcoholics. She is a hate-filled, blame-filled person.” Anne said this energetically, but without anger. She said that her position in the family as the oldest female also contributed to her own problematic values system.

When I probed further, she elaborated on her family system, saying that she had adopted a “fixer” role in the family. Anne attributed her lost sense of personal autonomy in part to playing this role in her family. In her recovery process she had changed her priorities.

I realized that my priority cannot be fixing somebody else. The most I can hope for in this life is to make some improvement on myself. And that was something that was never realistic because I was so filled with self-loathing. Nor a real sense of who I am let alone a relationship to my body and that has all changed. And now I can only see it in
retrospect. I don’t know exactly how it happened. But in retrospect, I can see it is a completely different world than what it would have been without my recovery.

This retrospective vantage point gave Anne a chance to talk about a new relationship to her body, which she believed was another important value shift. As she explained it, “I feel like the weight of my body changing has almost been ancillary to my recovery.” However, something would have been missing if she had not talked about her new relationship with her body in the interview because this new relationship allowed her to continue the process of personal growth.

She said:

“I never really thought I would have access to the kind of familiarity with my body I have now. These kinds of foods make me feel good. These kinds of food make me feel bad. Previous to my recovery I never had awareness of my body. I was never tuned into my body. My body was something over “there.”

She described how “like in the Teenage Mutant Ninja Turtles, I was just a big brain and a holder.” It was a striking metaphor, and we both laughed. Anne continued by saying that her body’s changing allowed her to adopt new values. These new values had not existed when she was a child in her family system. She described them as very commonplace preferences for things like “hiking and biking” and a general love for the outdoors. The newly discovered health that she had acquired led her into a trust of her body. Once, she feared the activities in which she now regularly engages. She said the trust in her body “led to a deeper trust in myself.” This deeper trust in herself, she said, allowed her to master other challenging situations, whether they are interpersonal, professional, or some other sort of challenge. In those situations Anne said,
I can trust myself to get through this the right way. It does not need to be intellectual. It does not need to be all safe and controlled. I can trust my inner self, my emotional self, my spiritual self to get through this. I do not have to know it all ahead of time.

When the interview moved to how self-esteem and recovery are related, Anne thought about her family of origin. She talked about developing this rich sense of self-esteem that is not based on external achievements. She cited an author in our conversation that uses the phrase “other esteem” to describe a false sense of esteem. Anne resonated with this term, which she said was intimately related to her eating disorder. She said that when she was disordered, her self-esteem was based upon the opinions of others. If others judged her appearance, or achievements as worthy, then she felt a sense of self-esteem. However, in the recovery process, she thought that had changed.

And I realized there was something valuable as a self no matter what. Now, of course this all works in gradations. If the day came and I lost something valuable like a professional credential that would be tough. But I don’t think it would completely decimate me. I really don’t, but I have worked with people who have been in that situation. They lost a really, really important job. That would be hard, obviously, but that would not decimate me. There was a point in my life where I knew that was suicide for me, no question. But not today.

Anne directly attributed her new found strength to a personal program of therapy (for her it was a 12-step program). I inquired more deeply into what she thought the nature of the change was. She said that the recovery process “gave her access to something larger than herself”:

I mean, I don’t want to get all “religiousy” in my language because it is not meaningful to me. But I do have this idea I can’t scoot along on my own batteries. I did not have a lot of
gas to begin with. Staying focused on that fact that I am not the only one, and that other things in the universe will help me along as I go through this process.

Anne went on to say that this deeper understating of “something larger” was another essential part of the recovery. “Even if theory is something like bad faith in the process, to be honest with you, I don’t care. I don’t care, practically speaking. I want a happy healthy life.” Anne defined this as a more holistic approach to the eating disorder that she needed. A life wherein she “simply managed symptoms” was not going to allow her to recover from her disordered eating. Rather, she said that it was essential for her to “discover her significance in the universe that the 12-step program offered me” before she could recover.

Because of the recovery process I have access to a life that I would not have [had] access to before. And the only thing that threatens that, that ongoing process, is the degree to which I withdraw from this greater source of well-being. If I choose to withdraw from actions that keep me close to a spiritual source that is when my life would get difficult. Other than that, there is no reason to believe that my life will continue to get better. I don’t have any reason to believe that it is going to stop.

The optimism that Anne expressed was based on her spiritual practices. Perhaps more might have been said, but our allotted time had expired. She ended the interview with a pleased laugh. I got the sense that she continued to feel the optimism she had found as a recovered person. We ended the interview. I thanked Anne for her participation. When alone, I followed my standard procedure of taking notes and reflecting upon the experience.

**Summarizing Anne’s Experience**

Anne had begun her interview with a description of her life-long eating disorder, which had dominated much of her childhood. In retrospect, she could see how her perceptions of
normality and social interaction were dictated by her disordered eating. She began with childhood and moved onto her adulthood, and spoke of the resolution of the disorder through the present. Furthermore, as an adult she could identify the family dynamics that had fed her symptomology. However, as she recovered from the disorder, other aspects of her life came into focus.

A dynamic aspect of the recovery from her disorder was her relationships with others who had suffered the same malady. She was able to realize she was not alone and isolated. The huge sense of personal responsibility she had put on herself and the isolation she felt were lifted by interactions with those who had the same problems. From these interactions she gained clarity on other types of relationships. She regarded her success in other relationships as a direct result of her recovery process.

Beyond the social aspects of healing, Anne reported that she was able develop a deeper sense of spirituality, which she named as another essential to her recovery. This social and spiritual shift allowed her to discover a new relationship with her family, others, and herself. She seemed to have a very clear vision of herself as a disordered and non-disordered eater. She described her recovery as being in touch with a greater source of well being. This vision granted her access to other aspects of a life well lived.

Table 4

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Interview #4 with Bailey: The Grief Process, a Line on a Chalkboard

Bailey, my fourth interviewee, was a 46-year-old Caucasian female who had recovered from binge eating disorder and bulimia for 24 years. She reported that binge eating has been her main issue. However, she was also hospitalized in her twenties for being bulimic. Bailey and I met in a private space of her choosing.

When asked to describe her eating disorder, Bailey began with her childhood experiences. She was always an athletic kid, but she could remember feeling overweight throughout her preadolescence. She discovered dieting in her early high school years. She could lose a great deal of weight quickly, but she would rapidly gain the weight back by binge eating. She often experienced eating “huge amounts” of food, and being perplexed about how to stop the binges. She had experienced a reprieve in the summer before college, and had hit a goal weight that made her happy. She remembered saying to herself; “Whew, now I am ok.” However, this was short lived. As she entered college the binge eating returned, and she struggled deeply with BED as a college student.

So I go off to college, and I gain ten pounds the first year. Everybody said, “The Freshman Ten.” But I knew something was wrong. And then I gained another ten pounds. I had a cake sale and like, would eat a whole cake. I remember going into an ice cream shop, and then going back and the guy saying to me; “Wow! You must be really bored.” Like, I was out of control. And it was also affecting—I couldn’t count on myself. I went from being this honors student in the gifted program—pretty much straight A’s—[to where] I wouldn’t get out of bed. I missed class. I couldn’t count on myself. One semester I got an A, two D’s and F. Like, my whole life—it affected my whole world.
Bailey continued to describe how that she continued to gain weight and to exercise throughout this time, repeatedly referring to the fact that she “could not trust herself.” The binge eating and exercise bulimia had taken over her entire world. She said she “hated herself” and felt helpless despite her best efforts to be empowered. “At one point I could not go out of my house with money in my pocket because…It was insane!”

Bailey spoke energetically, conveying that the “insanity” of her eating disorder was pervasive. These statements led naturally into the topic of how recovery had changed her life. She indicated that the question was “a big one.” Speaking about her recovery, she said,

It helped me physically…it brought me back into a normal sized body. So that is one aspect. Emotionally, I didn't know how much I hated myself. And then I learned not to hate myself. I learned to accept myself—to love and value myself. This does not mean I have my fair share of insecurities. But I do not have the self hatred that I not know I even had. And emotionally, it has made me really deal with a lot. It has led me to family-of-origin issues—to come to terms with things in my childhood. So it has made me much more emotionally healthy. It has given me a way of dealing with situations, whether it is work or personal relationships.

I asked Bailey to tell me more about emotional health through the process of recovery. The self-love and acceptance Bailey referred to rested on her spiritual values. “So it shifted my relationship with God from someone who had a kind of childish view to a more personal relationship.” She went on to say it was one of the reasons that she chose her current profession. It was one in which spirituality was a key element individually and within the community where she practiced. As a child she had never thought of adopting this role in her community. However,
the spiritual values that supported her recovery also “led her down that path” to transmit spiritual values in her community.

The profession she practiced also marked a shift in values. She acknowledged that while eating disordered she had a “fair share” of dishonesty. When I inquired into what she meant, Bailey said she would often lie to others. She named professors she sought favors from to extend papers. She also mentioned honesty to herself, again referring to not being able to “count on herself.” By this, she meant being functional in the academic world and being honest about what she was eating. She named developing honesty with self and with others as the most important change in values.

Through that honesty she was able to meet obligations and “be of service to another,” which was both a part of her job and a deeply held personal value. She recognized that if she were still binging or purging, she would not be able to provide help to others. The value of being of service to others was a powerful idea for Bailey. As mentioned, she had based a career and spiritual lifestyle on that ethic. She added about her recovery process,

It has definitely made my relationships better. It has helped me understand when dealing with other people I have to keep my side of the street clean. It has made me mindful that how when I interact with other people…um…about being respectful, and being honest…about trying to accept them for who they are. And sometimes I think that works against me because, you know, I have a leadership role at work. Having been powerless for so many years, sometimes I think as a leader I should be more assertive. Instead of letting them do what they want, I should say; “Ok! No, we need to do it this way.”

Um…dealing with my parents, you know, with different things that come up…I wonder if
trying to accept people for who they are…um, if trying to be of service becomes a conflict for me as trying to set boundaries as a leader.

Bailey said she was able to resolve these conflicts by looking for a focus that compromise between needs. She said that prior to being recovered, she would not allow herself to compromise because of the fear of her needs remaining unmet. Hence, she was unable to establish productive relationships with others. Her acceptance of her own limitations and those of others allowed her to be more functional in her social and professional relationships. Here she switched her focus slightly in her narrative. She observed that the ability to set boundaries and be assertive while still maintaining her tolerance of others was also true in her family relationships.

I had a lot of anger toward my parents. And I have learned to um…accept them for who they are. And when my mom comes to visit…It can be really trying at times to be around her and um…I say the serenity prayer a lot to say this is who she is. I wish a lot of things about her were different. But it is about having to say “I am the one who has to change. I am the one who has to accept her for who she is.”

Because I was interest in the lived time (history), I asked Bailey to elaborate upon her relationships with her parents. She said that in her past, she has been estranged from her parents. “I was in my 20s and some stuff happened, you know, and things have really come full circle.” Her desire to be “perfect” and “know it all” had led to a conflict with her parents. She called this being “self absorbed.” Another way her life had changed was that she was able to be less self absorbed and less of a perfectionist. This change opened the door to better relationships with her family and with others.
The discussion about perfectionist traits and self acceptance led me to ask about self-esteem. Her concept of self-esteem did change as her recovery process deepened. She regarded high self-esteem as the ability to “respect oneself” and to have “humility.”

Being one among many… I am not better than anybody. And I am not worse than anybody…not being terminally unique and I always felt I was terminally unique.

Um…so I think self-esteem is having a healthy respect for oneself. Being able to have an honest self-appraisal. Being able to say; “You know, I need to work on this…I still need help with this.” Because years ago…I mean I didn’t recognize it until I started getting healthier… but I mean I hated myself. I was so critical of myself. Nothing I ever did was good enough. Everything was just boom, boom, boom. I was constantly pounding myself over the head so to speak. And…um… it doesn’t mean I don’t struggle with feeling inadequate sometimes, because I do. But it is light years away from where it used to be.

I inquired further about what the nature of this change in self-esteem. She said that another important piece to her self-esteem was self-acceptance, which she had been able to gain through various support systems. Aside from the 12-step program for eating disorders she attended, she named her therapist and a spiritual mentor as essential elements in maintaining her self-esteem. Paradoxically, being able to identify the times she needed help from others (i.e., recognizing that she could not do it alone) boosted her self-esteem. She said, “So, being in relationships with other people, being able to share honestly what is going on, and not having to pretend everything is ok when it is not…that is valuable to me.”

Being interested in the changes through the recovery process, I inquired deeper into this relationship between others and self-esteem. She again endorsed the idea that self-esteem began with an “honest self-appraisal”: “from that you have better relationships with others.” Then she
referred to a dynamic between self-esteem and the aforementioned support systems. She contrasted the sense of self-esteem she had now with her years with an eating disorder. She said she was always “in pursuit of the perfect body.” After she had spent 30 days as an inpatient, she remembered having a distorted body image. However, within the recovery process she is able to tolerate weight fluctuations and, for the most part, have an accurate perception of her body image. She stated, “So, today the size of my body is not going to get in the way of living my life.” For her, self-esteem is not built upon her fears of shame or embarrassment over her body size, real or perceived.

Bailey said that at the times the disorder made her feel out of control. She experienced it like an addiction. I asked her about this process. Here she emphasized, “But recovery is possible.” I probed more about the nature of the process, to which she responded, “It reminds me of the grieving process. People think—grieving is linear, and then I have closure. But grieving is really like this…like sqa-shuuu…like drawing on a chalkboard. Like you don’t know when it is going to hit you.” Bailey moved her hands in random patterns to illustrate what she was talking about.

Her recovery was marked with a growing self-acceptance. She agreed that the recovery process was ongoing. Her recovery had helped her grieve the loss of a parent, and she compared that the process of grieving to the process of recovery because they both facilitate a deeper understanding of oneself.

And when I let up on that and think I am cured. Or when I start to think I wear a size 6 but at least I am not a 16…like rationalizing…thank God I never wore a 16…but it is not just about gaining extra weight. It is how my life is going to be unmanageable. And when I feel overwhelmed, stressed, burdened, everything feels like a chore…wanting to
escape…like stop the world I want to get off. That total lack of serenity. That total lack of
sanity…That is the thing I really value today more than my pants size. It is having a life
that is happy, joyous, and free.

Bailey ended by saying that the benefit of her recovery is a newfound gratitude for all the
facets of her life. This new sense, she said, is directly tied to her former feelings of being self-
absorbed when she was practicing binge eating and bulimia. Now she said, “I want to be clear
headed. I want to show up for life. And that comes when I am not in the food.”

Summarizing Bailey’s Experience

Bailey’s experience in recovery was marked by intense psychological and spiritual
growth. She was an adolescent at onset of her eating disorder, which plagued her throughout her
young adulthood. She had been driven toward athleticism and academic success, but the
progression of symptoms finally stunted those pursuits. She was treated in an eating disorder
clinic and sought help from 12-step groups and mental health professionals. She emphasized
honesty: an honest appraisal of her behavior and attributes seemed key to her recovery. Through
this appraisal, she was able to experience relationships in a different and fuller way, as more
competent and nurturing relationships than she had previously experienced.

Furthermore, as she recovered, she found a spiritual focus that led her into her current
profession. She was able to shed much of her self-hatred and to view life as “happy, joyous, and
free.” Her comparison of the recovery process with the grief process was evidence of her belief
that recovery was spiritual in her experience. She asserted the idea that one is never done with
the process. Her recovery entailed acceptance and a deepening sense of gratitude that informs her
recovered life.
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dealing with situations whether it is work, or personal relationships.

I wonder if trying to accept people for who they are…um, if trying to be of service becomes a conflict for me as trying to set boundaries as a leader.

Interview #5 with Josie: The Gift of Recovery and the Clarity of Vulnerability

My fifth interview was with Josie. She is a 36-year-old Caucasian female who identified as suffering from BED and bulimia. She has been recovered for 3 years. We met in a secluded room in her private residence. She was comfortable and it was conducive for reflection and private communication. Josie began by describing how she experienced her eating disorder. She had said that the question was “big and broad” and took time to reflect before she began her narrative. She remembered having a disordered relationship with food as a child, as she would hide it, and it became a focus of her attention through much of her early years. Family conflict over her focus on food was commonplace. However, she maintained a normal body size until college. Nevertheless, she was convinced that she was overweight in middle and high school. In hindsight, she realizes that she was an average size, but at the time, she perceived herself as “fat”: “You couldn’t tell me otherwise…like I knew it. Not that I ever would talk about it.”

Josie said she would not talk about her weight in childhood and adolescence because she doing so would invoke shame. Shame was a powerful emotion in her recovery, dictating many of her actions. Because she also experienced eating as shameful when she was a child, she developed the habit of eating meals alone to avoid shame. Josie remembered this as a guiding force in her early psychological development. The feelings of shame and struggle with food lasted throughout her adolescence.
As she entered college she began to binge eat severely. She reported visiting grocery stores and restaurants several times a day.

I would eat, eat, eat. I would eat to the point where I was almost comatose. I would literally crawl into bed. I would have to crawl, and just pass out. And there was no alternative, because if I did not eat enough to be comatose, then there would be this same spiral of self-hate…and um my head would go round and round.

Josie provided more detail about the “self-hate” and “self-loathing” that she experienced as an eating disordered person. She could not look at herself: she covered all the mirrors in her house so not to catch sight of herself. To counteract the weight gain she experienced through binge eating, she developed bulimic behavior. After she graduated from college, she would stay up late at night to eat and purge. She was obese at her largest, weighing a reported 230 pounds. (It should be noted that Josie now has an athletic build).

Mostly, however, Josie reported that her weight yo-yoed after her college career. She would lose weight by dieting and bulimic practices, only to gain it back with binge eating. She had breast reduction surgery at one point to shed some of her excess weight. She remembers that her goal throughout this time was “to be thin enough to be loved.” She took up exercise in further attempts to reduce her weight to be acceptable to others in an exercise-type bulimia. The exercise and other eating disorder symptoms took a heavy toll on her mental and psychological health. She described all her bulimic practices as “violence.”

It was violence. I look at all my food behaviors and exercise behaviors as violence. It was violence to myself. I intentionally ate with the intention of hurting myself because I didn’t love myself. I intentionally exercised that much because I wanted to hurt myself.
Um…it wasn’t until I got into recovery that I started to see my bulimic behaviors as bulimic…looking back that was fucking crazy. I was fucking bulimic!

Josie observed that she had various methods for purging. “It was not a beautiful process.” She again described it as self-injury to her body. She realized in recovery she “did not have to do that.” She described that the realization she did not want to practice bulimia was a sudden awareness after a particularly bad day of cycling through binging and purging a little more than three years ago. She realized she had to explore the “reality she was bulimic and could not control anything.”

She told me she wanted to talk a little more about control because it had been an important aspect of her eating disorder:

Control, for me, specifically, I can’t control how I feel. I can’t make myself happy. My sister…and I still have conversations on how strange it is for her about being sad constantly. “Why can’t you make yourself happy?” And I thought, thank God you said that. Don’t you think I would if I could…Can’t control what I am feeling. Can’t control what is going on around me. Having all that pressure of not being able to change the world around me, and feeling that I need to… It’s got to come out somehow. I would eat to bury myself…to hold it down or push it out…to not feel anything. But anything under pressure has to pop. And purging was a way for me to let it out, and to feel it all. And the word violent always comes up to me. It was a violent explosion of everything.

Josie gave a rich description of the idea of control in eating disordered behavior. Because the “world” around her seemed chaotic and her own moods and feelings were also as chaotic, eating disorder behavior served as a regulation of her environment. Her attempts at “control” ended in a “violent explosion.” She went on to say that the behavior was also a way to “show”
others in her world that she could be defiant through self-harming behavior. “I can make myself into something worse. I can make myself into the monster I feel like I am on the inside. And that was some form of control.” Furthermore, Josie described her attempts as control “like screaming at the rain. The rain is not going to stop. You have no control over the rain. And thinking you have control is what drove me insane.”

Josie expressed in an ironic tone that the disordered behavior really had control over her. She did not realize this while binging and purging. It was only after recovery that she could grasp the ways in which her efforts at control were ineffective. As we discussed this further, she started to talk about how she had changed in her recovery, but wanted to talk a little more about her disorder and how she “hit rock bottom.” There was an incident in her early 20s wherein her sister caught her gagging herself after they had a fight over a romantic interest. She described the event as very emotionally painful for her. She admitted to her sister her bulimic behaviors at that time. When her family intervened, she “got some psychological help. And that was the start of the healing process.”

A course of therapy began with a psychologist and her family doctor. However, she began compensating for the purging with exercise. Although many habits had changed and she lost weight, she still purged. Despite being at a normal weight, she ended up relapsing—binging and purging, or just binging, regularly. It was then that she realized most of her program of therapy had focused on weight loss, whereas the underlying compulsions needed to be treated. “My mind snapped into awareness” is how she characterized her realization at that time, and she began to address the eating disordered behaviors in their entirety. She engaged her therapist and enrolled in 12-step programs that worked in tandem to help her maintain her recovery. Josie offered another observation recovery:
I noticed right off the bat that people were touching me. I didn’t realize people were avoiding touching me when I was heavy until they just put their hands on my back and I would…shake your hand, grab your shoulder. People were touching me! It’s like they were afraid to catch the fat before. And now…ok…for some reason it makes me want to cry now thinking about that. Yeah…uh…I love my body now in all its aging and changes. I love it.

Josie seemed moved by the memory of being touched physically by others, and her newfound love for her body. It seemed to be a profound change in her relationship with her body, and she began to connect this with other changes in her life owing to recovery. She said that the lack of a “tether” to food was “palpable” in her life. That lack of compulsion allowed her to be social. It also allowed her to leave a relationship that was an “unhealthy.” She stated: “I was healthy. I was smart. I was going to school and had dreams and aspirations that had nothing to do with a man. These are things I could not see outside of recovery.”

Another feature of her life she could see now in recovery was the ability to be vulnerable in relationships. She said that this was a “gift of recovery” and that her vulnerability somehow allowed for clarity. When I queried about what she meant, she said that her life without compulsive behaviors allowed her to establish relationships with a variety of people. She found the ability to connect with others started when she started to ask for help. “In the beginning of recovery, you reach out to anyone who will help you from drowning. And you find you cling to the most amazing people.”

The interview then moved to values within the recovery process. Josie said that a large part of her change in values was a better connection with her family of origin. She connected the new appreciation to her family with the awareness that her eating disorder was life-threatening.
My family is valuable to me. And I was constantly angry at them for loving me…um…I didn’t have any worth. I didn’t have any spirituality. I didn’t expect to live. I heard someone say that compulsive eating is passive suicide. I think that is a perfect explanation of what it is. I want to kill myself. I want to die. I just don’t want to do it right now. And for the record, I have heard people say that they do not know if food issues are a life-threatening issue. I work in the health care industry. Lung issues, blood issues, brain issues, compulsive eating will give you all of them. Don’t tell me it is not passive suicide.

Josie was excited during this part of the interview. I inquired if she was referring to an appreciation of life. She affirmed this as a value she found through being recovered. She said that this appreciation often led her to a spiritual framework. “Being in recovery has given me the opportunity to develop a relationship with a higher power that I refer to as nature. I see beauty in the world that is not there before.” The value of having a spiritual focus also led her to develop an overall sense of honesty.

Josie affirmed that honesty was extremely important to her. From lying about food to lying to others about where she had been, all were part of a more honest relationship with life. Honesty for Josie meant the ability to be “sincere and genuine.” When asked, she affirmed that the aforementioned was also part of her spiritual values. She specifically identified her relationships with family members as being transformed as she recovered from the disorders. Josie named little things in her new value system that seemed make a difference in her relationships: keeping her apartment clean, returning phone calls, being able to apologize to a family member when she was wrong. Through these small acts, she said, “I feel space now where I didn’t before.”
When I inquired more about what she meant by “space,” she said,

The weight of the world on your shoulders, so to speak was always crushing. I felt very crunched or stayed in bed. The things I have done weigh me down. This is very existential energy. Somebody walks into a room, and you know they are all pissed off at you. And you can feel that radiating off them. And really they have no idea you have done something to them. But you can feel it. It is physical. It is pressure in your head and makes you want to turn away. Having the relief of that is comfortable. You can breathe. Whereas before you would put your hand up to say, “Don’t look at me.”

Josie first applied her comments above to relationships to others, but she further applied it to her own body. “I was very disconnected from my body before recovery. Now I feel at home in my skin.” Being comfortable in her body entailed a freedom from obsession over her physical appearance, which she described as a primary focus when eating disordered. Within her disordered thinking she would be “envious or jealous” of others’ physical appearance. As her recovery process deepened, Josie said that the values switched from physical appearance to a state of “clarity”:

I am a good person. I am a strong person. And um... there were days in the throes of my disorder where I had nothing but amazing things to say about myself. I don’t understand why people don’t like me. I am intelligent. I am charming. I am the most beautiful girl out there. No one looks better than me in this, this or this. I can do amazing things with this, this or this. I am awesome. And now neither of those extremes hit. I am able to...I mean...I have clarity enough to see the good and bad of me.

Josie said that the clarity she gained in the recovery process also led her to the value of acceptance. Her acceptance of her body was the beginning the beginning of an attitude change in
accepting other aspects of her life. “Raging against it is what causes turmoil and the feeling like you need control.” She indentified she was also able to maintain acceptance and thereby maintain her recovery because she “had support from every angle.” She gave an example of her family being able to accept her disorder. “In the beginning I would have my family say things like ‘But you’re not a compulsive overeater.’” However, as her family better understood the disorder, they adjusted to her dietary needs. At one point after recognizing her needs when out to dinner her sister said, “Josie, if you were a diabetic, we would be having the same conversation.”

When she gave an account of the ways her family had changed, Josie expressed profound appreciation for their small adjustments, which seems to have meant a lot to her. Here Josie compared her disorder with an addictive disorder. Her family was able to adjust to her eating disorder as if it were a medical condition or an addictive disorder. She expressed a wish that others would not see a bad person, indicating that the disorder is “like alcoholism,” like a disease. However, it is not recognized as such by the general public. Josie ended the interview on this note.

**Summarizing Josie’s Experience**

Though the onset of Josie’s disorder occurred in her college years, she traced its real beginnings to childhood. She reported shame as her dominant emotion while she was disordered, and it guided many of her actions. She talked at length about her experience with binge eating and bulimia, both of which appeared at different times in her life. The recovery process in which she had engaged had many facets, as shame, self-loathing, and self-hate were pieces of her experience she had to overcome during recovery. Her personal growth process granted her what she called the clarity to act freely and authentically in her world. She found a new ability to be
vulnerable and to surrender the control that she had desired while disordered over emotions and events.

Josie’s narrative was very moving. She was able to establish a relationship with her family of origin that was positive and intimate, as well as with herself, and she had begun to establish herself in a career she enjoyed. She talked about transforming self-hatred into self-love through her newfound spirituality. These changes were slow at first. Her recovery process began with therapy and physical conditioning, during which she was still denying that her bulimic practices were harmful. However, as recovery progressed, her harmful actions ameliorated. In that clarity she gained the vulnerability to reach out for help and thereafter to build a better life.

Table 6

Summary of the Interview with Josie

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Existential: Lived Body

Yeah...uh...I love my body now in all its aging and changes. I love it.

I was very disconnected from my body before recovery. Now I feel at home in my skin.

Terror Management: Self-esteem

I was healthy. I was smart. I was going to school and had dreams and aspirations that had nothing to do with a man. These are things I could not see outside of recovery.

Terror Management: Awareness Mortality/personal change

I didn’t expect to live. I heard someone say that compulsive eating is passive suicide. I think that is a perfect explanation of what it is. I want to kill myself. I want to die.

Social Constructivism: Change in social relationships/ awareness

My family is valuable to me. And I was constantly angry at them for loving me...um...I didn’t have any worth.

Interview #6 with Arthur: I Really am Who I Say...Really

My sixth interview was conducted with Arthur, a 56-year-old Caucasian male who had suffered from BED earlier in his life. He had been recovered from the disorder for 26 years. We met in an office within a private residence; the room was free from distraction. After the usual information was obtained, we moved into a description of Arthur’s eating disorder. Arthur reported having a problem with food at an early age. He said he knew he was the “fat kid” in pre-adolescence. (It should be noted that Arthur’s body type now appears slim and lean.) Although he knows he was the “fat kid,” he reports being less aware that he had a problem with food and binging. In retrospect, however, he knows that the eating habits of his family were poor. He described hiding food, being given bigger portions than he needed at family meals, and constantly eating throughout the day in his childhood. Specifically, in his adulthood he and his mother were “binge buddies.” Arthur said his experience of the relationship with his mother included eating large amounts of food. Furthermore, in the recovery process he realized that his mother, obese herself, probably suffered from BED.
He struggled with BED through his teens and early 20s. He recalls dieting successfully in high school, but he also had a great deal of depression. He reflected for a moment and said that when he was a teenager, a psychologist intervened because he had suicidal ideation. He said that one of the results of his recovery from his eating disorder was that “the feeling I wanted to die stopped. I can’t remember how or when. But I know suicide is no longer an option.” He linked a growing spirituality with the cessation of his suicidal thoughts. He said;

My spirituality has definitely changed. I couldn’t do wrong to you without acknowledging it and feeling it. I could no longer call you an idiot…whatever…without thinking, “that wasn’t really good.” I was definitely the person who would never make fun of you in person. But behind your back I would with [other people] so I could be popular with them. And easily I would be with you as my friend, and talk about hem…that kind of thing. It was through the recovery process that it was like, “that’s not right.” It did not really feel connected. And so it was really more a spiritual climb over the years that ended up happening.

Arthur characterized his growing spirituality as acting more “moral” with others. After recounting this, he spoke of his first marriage to illustrate his point, saying that he had a “horrible” marriage with his ex-wife, whereas with others he had a growing grasp of moral action. He admitted that this was not a perfect situation and that his recovery from the disorder certainly did not solve his interpersonal problems with this ex-wife. He was able to see that being disconnected from his wife while having positive relationships with others was not ideal.

When I inquired more about the “spiritual climb” Arthur said that his moral sense “started with food.” He said that “honesty” concerning what he was eating was a guide to other moral actions in his life. He described a point before the beginning of his 27 years of non-
disordered eating where he began to binge again. He had to approach the 12-step individual that was sponsoring him and admit his behavior with his food. He said that “having honesty changed many things,” and he recalled that he began to hold himself accountable to others.

Arthur also spoke of other changes through the recovery process, one of them being his marriage to his second wife. He said that in his second marriage he had never insulted his wife or raised his voice. He spoke lovingly about his second wife.

It really is a result of recovery and that connection...um… I have never insulted my wife, ever. I have never once said anything to deliberately hurt her. You know, I never…um… I never made a joke about her that…you know…um, I got a temper that um… I never said anything that would come across as just plain negative, you know… Um… And that was a big change. I was going to say I never raised my voice. Probably the raising of the voice has happened but the all-out yelling matches never happened… uh… and all of a sudden I realized that I was the husband I would have liked to become. And it was all connected. I was the worker I wanted to be. And I was the friend I wanted to be. And it started with myself.

Becoming who he wanted to be seemed a poignant part of Arthur’s experience. As Arthur described the changes in many facets of his life, I inquired further into the way that these changes were “connected” to recovery. He said that recovery had two different levels for him, with the changing of his food habits being the first level. Deeper than the first level, though, he referenced morality again: “Emotionally, I think it was almost like a set of morals. Like, I did not want to hate myself for the action I did anymore.” He again referred to a spiritual dimension to abstaining from eating disordered behavior:
The spiritual experience I believe I had…which you know they talk about spiritual experience versus spiritual awakening. Spiritual awakening happens slowly. Spiritual experience happens immediately. During my spiritual awakening, I had the spiritual experience where things changed. I no longer felt the same way. I don’t feel the same way about food. I didn’t feel the same way about people. I didn’t feel…um…my trust in God was just like…became a very natural part of me. In fact, my wife talks about the difference between the heart and the head. So it was no longer the book learning that says trust in God. It is like…Ok, I trust in God. And that’s where it is all connected for me.

Arthur describes this awareness as a “real spiritual gift” contributing to his intention never to practice disordered eating again. He said he realized that it was always a possibility to return to the disordered eating. He could not describe how the change happened exactly. He simply said that it did happen for him, and he thought it was miraculous. Therefore, he values the way of life that has maintained his recovery and says he has realized that “the food is just not an option.”

Arthur’s recovery was defined purely as a 12-step model. He did not mention therapy or any other treatment model. Therefore, the spiritual component to his recovery process was highlighted in our interview. Arthur said that the ability to refrain from binge eating was a “miracle.” He recounted how, while he was disordered, he continued to make promises to himself that he would stop at some set date in the future. One day, some 27 years ago he realized that he could not stop. As he made these promises, he realized they were empty. He said that the realization he could not stop were “God thoughts that canceled out the others.” The realization that he was lost in an addictive process compelled him to seek out help from a support group. After that time, he was able to reach out for help and address his disordered eating.
Arthur affirmed that this spiritual dimension was not a failsafe method for treating his eating disorder. He compared his trust in his spiritual world view with a child being on the care of an adult. He said:

I have a great granddaughter. That granddaughter will be in my care or whatever, but she can still get hurt. She can turn around and cut herself and all kinds of stuff. But she will remain in my care and I’ll fix her, bandage her. I’ll, you now, do whatever. I’ll make the changes so she stays in my care. And that is how I learned to view God’s care. When I turn my life and my will over to God’s care…it’s under his control right now. I have free will. I can screw up and just say; “That’s it. I don’t hear you.” In fact, that was always my standard joke, and yet serious…which is like nah, nah, nah, I don’t hear what you are saying. Because I just want to do this. I don’t want to think about you right now.

Arthur laughed loudly when he made this last point. Far from distressing, it seemed comforting to him that he recognized he could deviate from his path of recovery if he chose. I went on to ask about his self-esteem in hopes of exploring more the nature of his change in the recovery process. I moved on to the topic of self-esteem, as it seemed to fit the nature of the change process that we were reflecting upon. Arthur answered thoughtfully, “Yes, a huge change. I would actually want me as a friend.” He referred to his behavior with others prior to his recovery, indicating that he believed the quality of his interpersonal relationships was far better through the recovery process.

Arthur switched the narrative to illustrate his own emotional state. He referenced the fact that he had “strong depression and anxiety.” Now,

I would consider myself a happy man who gets depressed…who gets anxious versus a depressed man who can get happy. That’s exactly where…that’s where a shift happened.
At one point I would have described myself as somebody who is depressed but just puts on a happy face and all that...because I always like to make people laugh...and then I started to realize that this is not an act.

Arthur had described earlier how he had been a depressed and anxious child. As Arthur further reflected, he said that he could now see that positive aspects of his childhood. Specifically, he could identify the “parts of his father” he now had that supported his self-esteem. Despite the fact that his father was alcoholic, he said that humor was a gift he received from his father. “My father was always a one-liner joke person,” he said. As well, he was able to see that despite his mother's perceived impairment, “she was a wonderful friend.” He said that those inner qualities he received from his parents aided him through difficult relationships with peers. Although as a child he hated himself and was always on the defensive from being taunted by peers for his weight, the positive traits of his parents he had discovered helped him through recovery.

Arthur also elaborated on the change in how he viewed his body:

Even through the psychical standpoint, it...there are some ironies I just love. I found it incredibly humbling a couple of years back to work out on a regular basis. And the one thing I never had before...I never worked out for any muscle tone. It was always like work out because you are fat. My work out was just to get off weight and that was it. But for the first time I started to notice my physique...I want my arms bigger. I want this. Now I have gotten older...the true health of it...you know now I have to get strong bones. And I now have more physical definition and muscle tone and all than I ever did...So it is that kind of self-esteem thing. Instead of looking at all the wrinkles and the dropped skin and saying “Oh it’s beautiful”—that would be a lie to me. And instead of
looking and saying “God, you look horrible”—which is what I have always said before—it’s that part in the middle.

Here, Arthur appears to be saying that he has a greater acceptance and appreciation of his physical appearance. Before the recovery process, his body image had been very poor, and he had adopted a critical stance. He also avoided adopting an inflated stance, but he is able now to accurately appraise his appearance. Doing so seemed to provide him peace of mind.

Arthur left this subject and talked about his professional career as it relates to his self-esteem. He mentioned that he had only a high school education, and had at one time been diagnosed with attention deficit disorder and dyslexia. These diagnoses had always made him feel inferior when engaged in intellectual discussions. For some inexplicable reason, he does not feel inferior any longer. Something changed in his recovery, and he could appreciate his own intellect. In fact, as his self-esteem improved, he had begun to establish a career with other professionals, and regarding that he said, “You are not putting on airs. You are not trying to be who you are not.”

Furthermore, part of his self-esteem was to be authentic with others. I inquired whether this had to do with the honesty he had mentioned earlier. He affirmed this, and said that it was “an honest evaluation of my pluses and minuses.” He gave an example of his experience after he had been some years recovered when he was applying for a new job. He had presented his resume.

And…um…I remember the one place I was hired early on was like, “Uh, you really have a pretty amazing résumé…you’ve a good résumé or whatever.” And when talking about my self-esteem those were the words that really came out of me and I looked at her and said; “You know it is really interesting but my résumé is true. This really is…it’s like the
facts. This is what I have done…what I really have learned…what I really believe in.”
And that, like again, the whole thing of like I really am who I say…You know that is who I am…and that’s what I really did. So, yeah, it’s about…a very big deal about being honest and being able to evaluate who I am.

Arthur continued to describe this personal growth as the acceptance of himself as eating disordered. He said, “I am one of those people that believes if you have an eating disorder you are always going to have it.” However, he also said that he is an eating-disordered person who has the freedom “not to act like an eating-disordered person.” He was looking for employment at the time of this interview. Additionally, he had new family members he needed to take care of financially. He was under a great deal of stress. Before his recovery Arthur said these stressors would have compelled him toward to binge eat. However, in his recovery process now, “There is no feeling of picking up the food.” His ability to manage his eating-disordered behavior was based upon faith.

Yeah, it is like total blind faith. I don’t know how it is going to be 2 years down the road, 3, and 5. My depression…when I get depressed or anxious, is it going to be like this every day of my life? But when my spirit is open a little bit, and I get into hope…it is like I know it is going to change. The roof didn’t cave in. So, you are ok.

Arthur stated this last sentence with confidence. I believed he really had the hope that he spoke about to me. We concluded the interview as I thanked him for his participation.

Summarizing Arthur’s Experience

Arthur started the interview by telling about how his disorder appeared in childhood. The childhood experience seemed powerful for him. He tied his disorder to the parental figures who raised him. His experience was a layered spiritual awareness, which manifested as he spoke of
the gift or miracle of being relieved of his compulsive behavior. The alleviation of his compulsive behavior came as a sudden awareness that then fostered an ongoing process. The spiritual process transformed how he viewed himself and others, and his relationships with others, even through very stressful times, have been altered. He realizes that he has become more his ideal friend, husband, and family member as his years of recovery have progressed. Arthur seemed comfortable and content in his life despite the fact that he was under economic stress when I spoke with him. This he attributed to the spiritual aspect of his recovery process.

Most of all, Arthur seemed to be a very authentic person. He spoke with a matter-of-fact demeanor about his difficulties with the eating disorder. Although he was aware of them, the disorder also seemed a manageable condition. He also named anxiety and depression as another threat to his health. However, he seemed the opposite during the interview, appearing relaxed and happy. He expressed an appreciation for the new relationship with his second wife and his rich family life, despite the stress. In other words, it seemed evident that he had experienced the emotional and psychological (spiritual) change that he had described in his narrative. Through this change he had transformed a life-threatening disorder into a manageable aspect of his life, one among many that gave him the full life he desired.

Table 7

*Summary of the Interview with Arthur*

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**Existential: Lived Body**

Instead of looking at all the wrinkles and the dropped skin and saying, “Oh, it’s beautiful”—that would be a lie to me. And instead looking and saying, “God, you look horrible”—which is what I have always said before…it’s that part in the middle.

**Terror Management: Self-esteem**

And when talking about my self-esteem those were the words that really came out of me and I looked at her and said, “You know it is really interesting but my résumé is true. This really is…it’s like the facts. This is what I have done…what I really have learned…what I really believe in.” And that, like again, the whole thing of like I really am who I say.

**Terror Management: Awareness Mortality/personal change**

And all of a sudden I realized that I was the husband I would have liked to become. And it was all connected. I was the worker I wanted to be. And I was the friend I wanted to be. And it started with myself.

During my spiritual awakening I had the spiritual experience where things changed. I no longer felt the same way. I don’t feel the same way about food. I didn’t feel the same way about people. I didn’t feel… um… my trust in God was just like… became a very natural part of me.

**Social Constructivism: Change in social relationships/ awareness**

All of a sudden I realized that I was the husband I would have liked to become. And it was all connected. I was the worker I wanted to be. And I was the friend I wanted to be. And it started with myself.

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**Interview #7 with Aaron: A Dozen Different Points Of Gratitude**

Aaron was my seventh interviewee in this inquiry. He is a 38-year-old Caucasian male who reported as having suffered from binge eating and bulimia, the onset of the former
appearing after adolescence, and the latter in his late 20s. He has been recovered from the disorder for 7 years. We met in an office room, free of distractions, in a private residence. Aaron began by describing the features of his eating disorder, specifically binge eating behavior. Common in his experience was eating a large amount in a short period of time and then feeling distressed over the behavior, as well as a loss of control. He had begun to binge eat in his early 20s. He described how it appeared in his life at the time:

Yeah, I would say daily binging...um...and there was also you know could be a couple of times throughout the day...um...definitely eating all day. But also for dinner quite often a large amount of food. Then I also identify with a significant period of time, from about 1998...I think that was through 98...though 2006...I had varying degrees of time where I would binge and purge. I would eat a lot of food with the express purpose of...mostly to throw it up, and I would eat so much I would constantly have nauseous feelings. Even if I ate the amount that was normal and I felt nauseous, and then might sort of just give that extra bit to sort of help me throw up. Um...that was, uh...from 98 to 99...um for about a year and a half period of time during college I was very active throughout the day...would be multiple...would do it multiple times per day.

Aaron said he had stopped binging and purging in 2006. He began with a process of “figuring out how much food” he needed a day, and also doing the same so he would not throw up. Before 2006, he would often be unable to end a meal once he had started to eat. “Learning normalcy” as he called it, was an essential piece of his recovery process. Diets were ineffective tools for his attempts at weight loss. He reported he would often be “stressed” during the day, and refrain from eating. The abstaining from food frequently precipitated a binge episode.
In 2006, he joined a 12-step group for his eating behavior. Aaron had also ended a relationship at that time. The stress triggered fluctuations in his desire to binge eat. He said that the dieting continued to fail him. On a basic level, recovery had two essential features that were different than a diet. One was that the recovery process was “a guide on how to maneuver through the day without compulsively overeating.” The second aspect was that he was able to handle a meal, either alone or in a social situation, without binging or purging. Aaron talked about a specific time when he did not feel “spiritually fit” and was tempted to binge or purge.

Since I was interested in the lifeworld of the recovered person, I asked him what he meant by the term. Aaron gave as an example a specific time in his life.

Uh…You know… I don’t know that I was in a very good place. I was like after the time I finished (a specific sort of graduate schooling)…you’re very involved in it. Your life is like, that’s your life. You graduate, and you have emptiness in time. And I remember that because I was going down to see my parents, and I had free time. And, uh…I would see them and um…it was just a situation at a particular time in my recovery I hadn’t made a lot of changes related to my family…If the opportunity…um…came up to give me more food…I just have parameters that you know, there are certain lines I don’t cross.

Aaron said that crossing these lines was a “moral dilemma” for him. He referenced the idea that overeating involved “shame and guilt” that he no longer wished to experience. Admitting he could no longer tolerate those feelings was another aspect of honesty. He also realized that other compulsive behaviors were associated with the same emotions that binge eating produced. He had, therefore, abandoned alcohol consumption, smoking, and pornography. He said it was a slow process, and he did not remove them all at once. Slowly, he was able to shed himself of compulsive behaviors through 12-step recovery.
We then moved on to the topic of values that may have changed through the recovery process. Aaron said that “honesty was the biggest shift” in his value system, involving his honest relationship with food and binge eating. He was no longer able to rationalize any of his other behaviors. “I got to the point I was not able to be my pure...well, not my pure… my best self while I was doing those other things,” he explained. Therefore, despite the stress he felt in his life, he could not go back to any of the prior compulsive behaviors he had abandoned. The value of honesty that he used to treat his compulsive behaviors, therefore, spread other situations in life such as conflict;

So...um…honesty continues to grow. I guess honesty is the biggest benchmark I can see. So, when I examine my life I am looking at it from an honest point of view. Today did I do the best I could—yes or no? What went wrong, or what could I do different? Which I do quite often, do a daily self-examination. Like when I have conflict with people um…if I raise my voice with a person that is kind of a red flag that there is conflict. If I am having a conversation with somebody, and I am getting defensive...uh...I am in conflict. I have a real honest dilemma here.

Aaron also stated that along with honesty, he had discovered more gratitude for other aspects of his life. He described it as “a deep value of mine.” The stress of daily life would often overwhelm him. He struggled in his disorder to find experiences in his life meaningful. He listed his ability now to buy a car, have a fiancé, and search for a home. At the time of the interview, he was looking for a home to buy. He expressed excitement and appreciation for the process, along with the stress that was involved. Though he had many uncertainties in his life, he was able to tolerate the uncertainly without the aid of compulsive behavior. He said,
Where will I live? Well, I don’t know where it is. But I do have faith I will. So I went into this house and um…it just had this perfect energy that…the energy that is Aaron. Um…and I don’t know if that is necessarily the house. But I do know that either one of two things will happen. Either it will be available when I am ready to buy it, or it won’t. But I know that God will walk me though it.

Aaron described an alternate attitude he feels sure he would adopt faced with the same situation was anger and resentment. This attitude he felt sure would have precipitated binge episodes. He expressed amazement at this change. Whatever stressful life situation he faced, he felt grateful when he assessed his entire life. He referenced how these feelings of gratitude disseminated throughout his life. He said,

Um…you know it is a struggle with my new job. It is very difficult. I could find a dozen different points of gratitude even when feeling stressed out at work. The work itself…it’s usually nuts and bolts issues. But I can find a dozen different points of gratitude where it is like, “Aaron, just be where you are at.” Um…I really didn’t have that form of living before I came to recovery. You know, certain things I have bought…you know, it doesn’t have meaning to it.

Aaron continued in the interview to describe his new way of coping with stressful life events. He was able see that a love interest that had rejected him earlier in life was “heroic” when she ended the relationship. Reflecting back upon the events, he expressed gratitude that this woman was “brave” to leave his life. “I can see now that was very brave what she did. It was a totally different experience than I had before recovery.” I inquired more about the change he had experienced since recovery as per the interest of this inquiry.
Aaron said that since he has recovered, many things are different. He was preparing in the next month to be married. He said that “reflecting backward on that life” he did not have the ability to manage relationships without compulsive behaviors, especially with food. He felt that the ability to change in all other aspects of his life rested upon abstaining from eating disorder behavior. He said,

I did not have the ability to change without addressing this fundamental problem that the way I lived my life with food was a central source of comfort…when I do that I neglect all central aspects of my life; financial, emotional, spiritual. I can’t get to them all on time…I don’t do them all at once. But I can get to them, and have a fighting chance…uh…living a life that…it happens of life’s terms. That could include cancer, a car accident. It can include anything…and I can get through it. I can deal with it somehow. Because I did not have any really good strong fundamental values before that could get me through tough times…You know?

Aaron clearly felt strongly that recovery had allowed him to find a new level of coping through these changes in his value system. He named sickness and injury as events he could tolerate as long as he remained recovered from his eating disorder.

When we moved along to recovery affecting other areas of his life, Aaron said he felt he had explained these areas already. The one aspect he had not covered was the change in his family relationships. While he felt very connected with the recovery community, he was also involved with connections with his own family when he was going through growth. He said, “I think the area that I grow, or seek to grow, is to try and be more interconnected is within my family.” He continued to say that remembering small events in the family such as birthdays had
become important to him. These events, however small, were overlooked while he was eating disordered.

Aaron discussed two other aspects of recovery from eating disorders in our interview. When asked about self-esteem, he said that he thought self-esteem was now derived from the quality of his actions in the world. “That idea that if you want better self-esteem you have to do something estimable. That phrase works for me.” He named points in his day wherein he felt as though he was attempting to be of service to others, including in his job. Aaron is in a helping role at his job. This role gives him a sense of satisfaction, and he again named the value of gratitude as essential in his concept of self-esteem:

Yeah, actions towards others help me feel good about myself. And I would say that gratitude is another form of improving or increasing that self-esteem level. When I reflect back on myself that is like… I am grateful for myself for this reason. You know, I am grateful for, you know, turning lemons into lemonade sort of situations. So the ability to look at some aspect of my life that didn’t turn out as I hoped it would. And instead of…you know, by using gratitude I am more able to steer toward more positive outcomes than the negative.

The other aspect of his recovery he wanted to discuss was the effect on his relationship with his body. He noticed I had asked about other aspects, but did not inquire about this aspect. He said that he had a new relationship with his body that he was excited about. He said that not only had he

physically lost weight and been able to maintain it for a good amount of time, I have also engaged in physical activities that I otherwise would never have done. I actually ran in three different half-marathons. The third one I had to walk it out, but I was able to jog in
two of those three. Um...I can tell you that nobody looked at me before recovery and thought I would participate in a half-marathon. Um...that has happened. I have gotten engaged in so many...you know...I strive for physical involvement in my life in a way I definitely did not before.

Aaron seemed very excited and proud about this new aspect of his life. It should be noted that Aaron is a tall man within a normal weight range. He simply lacked the desire before the recovery process began to engage his body in this manner. “The body is made to be in motion. We are designed to be people in motion,” he exclaimed in reflecting upon his time in affliction with his eating disorder. He simply said to end the interview, “It is a really great change I can tell you. So, yeah, a really great change.”

**Summarizing Aaron’s Experience**

Aaron’s characterized his recovery world as more expansive and vibrant than the disordered one. He started with small details, such as the mechanics of eating without binging. From there, he found a new psychological attitude towards people and events in his life. He stressed the idea that gratitude for all aspects of his life supported him as a guiding idea that defended against the emotional effects of the eating disorder. Every aspect of his life has been transformed through his ability to feel gratitude even in small aspects of his daily life. Stress and struggle had been changed into an appreciation that surrounded his life. He described this new thankfulness as a condition of being spiritually fit. The fitness supported and defined his recovery from eating disorder, and allowed him to do things he would never have done without this fundamental change.
### Table 8

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Interview #8 with Ford: It’s Just Too Much to Keep For One Person

Ford, my eighth and final interviewee, was a 53-year-old Caucasian male who had been recovered from binge eating disorder for 6.75 years. Our interview was held in a private office free of distractions. Ford began by describing his typical day while suffering from his eating disorder. Ford had the classic symptoms of BED: eating very large meals throughout the day and feeling very distressed through lack of control after he binged was an everyday experience. He said, “The meals I would consume at night would easily be twice to three times the size I would eat today.” He traced his eating behaviors to childhood, although his parents did not recognize the disorder. He mentioned the he had been “relatively slender as a child.”

I was the oldest of five kids in a family where food was love. And there are a lot of other issues …not major…but a lot was going on that I needed an escape. I actually slept in the attic. So it was easy to grab food and go to the attic, and no one was around. If anyone was coming you could hear them coming up the first or second steps. So it was easy to just eat and forget about things.

The habit of seeking solace in food followed Ford into adulthood. Though slender as a child, he was more than morbidly obese over 6 years ago. He remembers that he exceeded the weight limit for morbidly obese according to the chart in his doctor’s wall. At the time of the interview, he thought he would still qualify as obese, though I probably would have guessed overweight. Ford did not mention the amount of weight he had lost; however, it was surely a substantial amount despite the desire he expressed to continue to lose weight. He expressed pride in this accomplishment “because I am on the chart now as opposed to…I was that spot on the wall three feet from the chart.”
In explaining his previous condition, he said that his body’s physical changes were one aspect among many:

And when I say I came to recovery because I could not stop eating…I literally could not stop eating. And that was the only change I wanted. That change came relatively quickly, but it evolved slowly. Um…the other changes are that I am a much nicer, a much happier person than I used to be. I am told by people who haven’t seen me for long periods of time…there is obvious physical recovery. But I think more of the mental and spiritual recovery had been more important. I appreciate life. I live life for reasons other than eating. I have learned to have relationships with people…you know...And I learned that there is a reason to get up in the morning other that it being time to eat again.

Ford named many parts of his life that had changed. I asked him if we could explore some of the parts he named. Ford began to describe what he deemed the “spiritual” part of his recovery process. “I kiddingly say I am a recovering Catholic,” he quipped. He went on to say that his experience of a spiritual form of life as a child was not meaningful. He had gone to church at his family’s behest. He said that he had rediscovered his faith through the 12-step program he attended for his eating disorder. He said,

But…um…I can talk to God now. I can pray on a daily basis. And I understand the answers that are coming are not necessarily the ones I want. But they are the answers I need. And I can be ok with that. I can help other people lean on a higher power, on their God. And help them understand that life is going to be ok.

His ability to help others to recover also had transformed his ability to sustain relationships. Ford described himself as previously being unable to sustain friendships for more than a year. Equally as distressing to Ford was that he was selfish in romantic relationships. He
said his desire to have more positive relationships had changed in the recovery process, and as an example, he said that after he recovered, he married. “And some days I get what I want, and some days I don’t. And that is ok. Overall, life is much better. And that is definitely resulting from recovery.” I explored further into why he thought that his recovery process had allowed him to have better relationships. Ford said;

First of all, the kind of person I was before recovery…there is no other way to say this. I don’t think there is any other way to say this…I don’t think I was lovable. I certainly didn’t think I was lovable. Why would anyone else love me? Where now I accept if someone says I am a nice guy, I can take it. There is still kind of a twinge…like I don’t believe it…but I can accept it and move on. And …um… you know I have learned to give and take. I have learned that someone in the world can appreciate me for something.

I asked Ford to expand further on how he thought being recovered from his eating disorder had allowed him to effect these changes. Ford said that what allowed him to continue in positive relationships was his overall ability to accept that could not control others. He identified acceptance with the spiritual aspect of his recovery process. He had been unable to accept that fact that people were different, or he felt threatened by perceived weaknesses in others. He said, with some embarrassment, that he used to fear gay people as an example. He had experienced a shift of values since his recovery process. For Ford, acceptance seemed to mean tolerance of others. Ford gave this change as an example of a dramatic shift in values. Overall, Ford seemed to be describing openness to experience with others. He had a willingness to “learn” from what he did not understand. I should note that my impression of Ford was that he is a gentle man; I believe that he did not start as a bigot but that he was simply describing a deeper level of
awareness about discrimination. I asked Ford to expand on this shift in awareness. He further explained,

Well, if I can accept I am not right…correct…well, right in every situation…someone else had a better idea. Then I can lean towards that better idea, whereas before recovery I don’t want to hear your better idea. I had the better idea. My mind was shut off to things like that. I can accept the values of another person, their experience. The fact that, yes, that’s my boss. What he says, that’s your job—versus he is lucky to have me here. It is kind of the inverse of self-worth. I had an exaggerated sense of self-worth before. Where now I have a more realistic self-worth. I am good at what I do. But I know I am not the best at what I do. But I can always get better.

The personal value shifts lead to openness to others. Ford named this as another key factor in his relationship with intimate relationships. On a slightly different track, he said that he desired change so that his children could see him differently. “When my kids were young…uh...I was an ugly, I mean ugly, person. I pray they don’t remember that.” His recovery from eating disorders had guided him towards a more positive family life. He was able to establish communication with his son that was realistic. “Recovery brought me to a place where I could say to my son that his job was to be a better parent than I was.” Furthermore, Ford went on to say he hoped that his positive changes would ripple down through further generations of his family.

And in seventeen generations [laugh]…And that is just a number I yanked out of mid-air. Um…my hope is that I will positively affect the life of someone I will never meet. That, you know, my great grandchild, or great, great grandchild that of course I will never know will have a life a little better than mine because I came into recovery, and I was
willing to change my life. And hopefully change the lives of others around me…I do, I do…it is just too much to keep for one person.

I was very moved by Ford’s idea that his willingness to change was altruistic as was the maintenance of his self-esteem. Being in contact with others who had struggled as he did helped him grasp his action as meaningful. He said, “It kind of gives me an idea of where I fit in the world.” As he recovered, he pondered his purpose in life. “It makes me feel liked I helped, like I am worth something.” Ford again referenced the idea that he was “self-centered” while suffering from his disorder. His focus was to make sure he had his binge food, and the privacy needed to binge. He said,

I ate to escape what reality was…um…I would pretend to be more than somebody I was…somebody I wasn’t, to also escape the reality of what my life was. It all seemed like a great idea at the time, but the further I go into recovery the more I look back and realized…you know it was unhealthy and was…uh…self destructive in a lot of ways. And I don’t need to live that way today. You know, I have people in my life that accept me as me.

Here, he shifted and expressed disappointment that others could not recover from eating disorders and that they sometimes perish. He expressed gratitude for those people in his life, and that he could see his family mature. He also felt a sense of mystery over why he had been able to continue recovering from the disorder. He felt the alternative was his own demise. He said, “I was not supposed to be here already. I wouldn’t have been here. So everything I do here is kind of a gift.” He mentioned that he had seen death in his family from other addictions such as drugs and alcohol.
This provoked Ford to remember the poignant experience that had compelled him to seek help. He remembered the day before he sought help that he had binge eaten “three times in the span of 5 hours.” He remembered screaming and crying in his car on the way home from various destinations. He said, “I think that as the first time I had to admit I was killing myself.” Ford reflected on the process of rationalization he was in. He kept describing how the size of his clothing would continue to increase regardless of the promises he made to himself to stop binge–eating. When he had reached a size 58 pants waist he “knew 60 was around the corner, and there was no end in sight. I was going to kill myself one way or another. I mean not go out and commit suicide, but literally eat myself to death.”

Ford said this with great passion. He recounted a story wherein he feared dying in his sleep from a heart attack.

There were times where I would go to bed and my heart was just absolutely racing. And um…I had one woman [with whom] I actually maintained a friendship for a very long time. I would go to bed and call her number and hang up the phone. Because my plan was when I woke up with a heart attack, I could hit redial and she would know where I was…and she could get help. As stupid as that sounded, that was my plan. And when I think about that I think how it was absolutely absurd. But in the middle of all that was admitting I was killing myself. But I did not want to let go. I was just afraid to look at my life, and look at who I was.

He expressed amazement at his former attitude that was suggestive or irony. He seemed to be in disbelief that he lived in such a manner. Ford continued his reflection on mortality and reflected on the changes. He said, “I know we are put on this earth to change, and then change, and then change some more. One of the things that keeps me going in recovery is that I am not
ready to die.” He asserted here that part of what maintained his recovery was a realization that his binge eating habits would eventually lead to his death. Even though the subject seemed grave, I thought Ford spoke with an optimistic tone, and I asked him if I was right. He agreed, and commented that what he spoke about his recovery was being “very hopeful.” He told me he was excited about his future life with his family. He was excited to be able to see his grandchildren grow and to have the opportunity to be a better family member.

Ford did not seem to have any more thoughts on the subject. We moved along, and I inquired if Ford had any other thoughts about his recovery. In the last section of the interview, Ford wanted to tell me that he appreciated being part of the inquiry. He said that he hoped it would help contribute to the recovery from eating disorder of others. He wanted others to know that recovery from the disorder required courage. He had found courage through the help of others, and he now wished to be of help. He said of the help, “I think it is literally the greatest gift I have ever been given.” He ended the interview by expressing the hope that others would be willing to receive that gift as he had. “It would change their life, like it changed mine.”

**Summarizing Ford’s Experience**

Ford is a deeply reflective man. He had suffered from BED for many years, and his binge eating behavior had made him morbidly obese. He opened the interview by reflecting on his typical day when he was eating disordered. This reflection prompted him to mention his childhood behavior with food and revealed a pattern he recognized. As he advanced in years, the binge eating behavior increased. He sought help after he realized that his own efforts to stop binge eating had failed. Through this failure, the recovery from the disorder had altered much more than his weight or eating behaviors.
Both his weight and eating were important aspects of his recovery; however, he also found that other changes had happened. He rediscovered his spirituality now that he had the freedom to explore it, and it helped him with refraining from eating disordered behavior. Ford would strike an observer as a very humble man, and it was surprising to hear that he had believed he had possessed an inflated sense of importance or felt closed off to others through fear. He identified one of the aspects of his recovery as dismissing these fears, and gaining a greater tolerance and humility with others. Instead of self importance, he spoke most often of love and acceptance.

Through the recovery process he had reconnected with his family. He was excited that he was likely to live long enough to see his family mature, and he was now able to embrace their love and acceptance. He thought it was a gift to be alive, given the severity of his disorder. That Ford had almost died from obesity is often symptomatic of the disorder. He was hopeful he would lose more weight, and that along with that his spirituality and his relationships would grow as a result. He felt that the efforts he had made to recover would outlast him. While he admitted that some days were a struggle, he also thought that the positive aspects were “just too much to keep for one person,” and his experiences now were often dedicated to passing these positive aspects along to others. With humility, he hoped that he could grow and help others in his world to grow as he had within the process.

Table 9

Summary of the Interview with Ford

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Supporting Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existential: Lived Relation/Other</td>
<td>First of all, the kind of person I was before recovery…there is no other way to say this. I don’t think there is any other way to say this…I don’t think I was lovable. I certainly</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn’t think I was lovable. Why would anyone else love me? Where now I accept if someone says I am a nice guy I can take it.</td>
<td></td>
</tr>
<tr>
<td>Existential: Lived Space</td>
<td>I actually slept in the attic. So it was easy to grab food and go to the attic, and no one was around. If anyone was coming you could hear them coming up the first or second steps. So it was easy to just eat and forget about things.</td>
</tr>
<tr>
<td>Existential: Lived Time</td>
<td>And I learned that there is a reason to get up in the morning other than it being time to eat again. I literally could not stop eating. And that was the only change I wanted. That change came relatively quickly, but it evolved slowly.</td>
</tr>
<tr>
<td>Existential: Lived Body</td>
<td>There were times where I would go to bed and my heart was just absolutely racing. I knew 60 was around the corner, and there was no end in sight.</td>
</tr>
<tr>
<td>Terror Management: Self-esteem</td>
<td>It is kind of the inverse of self-worth. I had an exaggerated sense of self-worth before. Where now I have a more realistic self-worth. And hopefully change the lives of others around me…I do, I do…it is just too much to keep for one person.</td>
</tr>
<tr>
<td>Terror Management: Awareness Mortality/personal change</td>
<td>And when I think about that I think how it was absolutely absurd. But in the middle of all that was admitting I was killing myself. But I did not want to let go. I was just afraid to look at my life, and look at who I was.</td>
</tr>
<tr>
<td>Social Constructivism: Change in social relationships/ awareness</td>
<td>That, you know, my great grandchild, or great, great grandchild, that of course I will never know, will have a life a little better than mine because I came into recovery, and I was willing to change my life.</td>
</tr>
</tbody>
</table>
Cross Case Analysis

Table 10 presents a summary of the cross-case analysis. It illustrates the meaning units garnered from the interviews and demonstrates the commonalities amongst the participants. The participants shared many similar thoughts and perceptions in the interviews. The supporting statements linked with the analytical categories that emerged as common across the cases. Saturation was reached with the last interview.

Table 10

Cross-Case Analysis of the Interviews to Demonstrate Common Themes

<table>
<thead>
<tr>
<th>Participant</th>
<th>Katya</th>
<th>Ruth</th>
<th>Anne</th>
<th>Bailey</th>
<th>Josie</th>
<th>Arthur</th>
<th>Aaron</th>
<th>Ford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived Relation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lived Space</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Lived Time</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lived Body</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>TMT/ Self-esteem</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>TMT/ mortality-change</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Social construction/change in relationships</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Table 10 provides the basis for the development of common themes across cases. These will henceforth be identified as main themes. The main themes emerged from the interview questions, and the resultant analysis. It became clear through the cross case analysis that saturation had occurred with respect to answering the research questions. Narratives examples of the main themes will be given in chapter 5 of this inquiry, and paired with the research question that best answers it. The common themes in each participant’s narratives were striking. All of

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them spoke of their brush with their own mortality, the relationships with their social world, and change in very similar ways. The conceptual framework of Van Manen’s (1997) existentials provided a framework to elucidate this data. The relationship to lived time, body, space, and other took on its own relevant meaning in the recovery process.

The participants’ statements support the idea that a holistic stance must be taken when one hopes to understand their recovery. An awareness of vital emotional and psychological changes was echoed across their interviews and linked to their ongoing recovery process. They perceived changes in the very basic existential categories, such as body, time, space, and other. A shift occurred in their self-esteem structure during the recovery process, which the participants described as positive. Participant also indicated their awareness of the disorder’s being a threat to their own mortality as an important feature of their ongoing recovery. Finally, the participants named changes in their social world that were essential in their ongoing recovery.

In reflecting on my own experiences in the interview process, I found the sentiments moving. The participants described very dramatic moments in their experiences in the form of realizations that illuminated their life worlds as recovered persons. The cessation of the problem behavior was only the beginning of the recovery process. Other vital factors—such as self-esteem, family relationships, and an emphasis on personal/spiritual development—were the lasting factors that allowed them to recover. I thought that these factors validated the fact that individuals who are attempting to recover must embrace holistic approaches in their treatment. These points, the overarching main themes that relate to the research questions and their implications, are summarized here and will be presented in detail in the next chapter.

1. **Change in self-esteem based on honesty toward self and others.** Changes in the self-esteem of the recovered person were to be expected. However, the exact nature
of that change was never explained in the literature. The participants in this study described a different relationship with self-esteem. In fact, one could argue it was defined against dominant cultural values that were negative—for example, physical appearance. Rather, self-esteem rested on the quality of their actions with others, and an integral attitude toward themselves. Closely linked with other themes, self-esteem became the meaningful actions and connections that these persons developed in their lifeworlds.

2. **A new relationship with the body.** All of the participants described a new relationship with the way that they now experienced their bodies. Many positive examples were given, over a variety of contexts. For instance, some talked about athletics, while others spoke on how they saw their own body in the mirror. In each case, they described an altered and new relationship with their body that emerged in the recovery process.

3. **A positive change in family relationships.** Case after case in this study referenced the family. Some spoke on how the entire structure of their family had changed. Others described how they had to change their orientation toward the family—a change that thereby it affected a different relationship in their family systems. The history with the family was also a major aspect of this theme in these cases. Often, the eating disorder history reached deep into childhood memories. During the recovery process, the family system came into focus and was altered.

4. **A new autonomy and competence/spirituality.** The participants in this study described a new ability to make choices and to discover new abilities throughout the recovery process. This aspect of recovery they often saw as related to a spiritual
dimension in their life. They had the faith that their choices would be meaningful and positive. Furthermore, these people felt that their actions and choices in life were competent. This is contrasted often with the utter lack of choice and autonomy people experience while disordered. Along with the coping skills necessary for recovery, the participants reported they discovered psychological and emotional abilities they did not previously have. Their world had more options.

5. **Optimism in the face of adversity/spirituality.** The last main theme was the quality of optimism in the lives of these participants, and this optimism was often present despite any adversity that they could imaginably encounter in the future. This optimism reflected a continued commitment to personal growth as opposed to events’ merely transpiring well. This commitment to growth was connected to a future that augured well. The spiritual dimension is included in this main theme because the participants referred to a change in their worldview as the basis for their newfound optimism.

| Table 11 |
|-----------------|--------------------------------------------------|
| **Main Themes that Appear Across Cases** | |
| **Theme #1** | Change in self esteem based on honesty towards self and others |
| **Theme #2** | A new relationship with the body |
| **Theme #3** | A positive change in family relationships |
| **Theme #4** | A new autonomy and competence/spirituality |
| **Theme #5** | Optimism in the Face of Adversity/Spirituality |
Summary

This chapter has provided data from the interviews in this inquiry in a descriptive narrative form. After each interview, a table is presented with at least one supporting statement that corresponds to the analytical categories when applicable. The chapter concludes with a cross-case analysis that elucidates the analytical categories with the supporting statements. This data was used to construct the main themes that will be elaborated upon in the next chapter, and the analytical categories were derived from the theoretical frameworks that drove this study. The main themes appeared across the case studies. Each individual endorsed an aspect of these themes in his or her narrative. A further explication of the main themes is presented in Chapter 5 of this dissertation along with their implications for the field of counseling.

These five main themes provide a conceptual framework for understanding the features of recovery from eating disorders that individuals share. An understanding of common features aids the mental health professionals in treatment, treatment planning, and aftercare. It provides concepts of treatment for persons in all stages of recovery. An existential-phenomenological examination of eating disorder recovery also contributes to the overall understanding of the recovery process for other mental health diagnoses. The possibilities include, but are not limited to, chemical addiction, trauma, and other process addictions, such as food or gambling. Each theme elucidates significant aspects of the lifeworld of the recovering individual. These main themes describe ways that the participants found previously undiscovered meaning and significance in their lifeworlds. The meanings they assigned were essential to recovery from the disorder.

The interviews in this inquiry revealed that recovery from eating disorders is a holistic process. The responses in the interviews illuminated the breadth and depth of the recovery
process that was embedded within the lives of the participants. Giorgi (2008, 2006) explained that a phenomenological-existential approach to psychology is holistic. The participants found that the recovery process related to existential concerns, their overall relationship with their bodies, and the social world. Each aspect was irreducible from the other.

Furthermore, TMT provided another holistic account for a basis of recovery. Its existential focus eschews psychological approaches that reduce the individual to a set of cognitive processes (Greenberg et al. 1986; Greenberg et al. 1997; Pyszczynski et al. 2004; Solomon et al. 2004). Rather, the existential model of consciousness provides a holistic account of a self-immersed a world of significance and meaning. The main themes presented in this chapter illustrate essential elements of recovery. Chapter 5 will further connect these theoretical outlooks to other counseling approaches and possible research hypothesis generated by the data.
CHAPTER V: DISCUSSION

The preceding chapters constitute an inquiry into the lived experience of those who have recovered from eating disorders, recovery for the purposes of this inquiry being defined as having been free from symptoms for a period of at least 3 years. A presentation of the problem, background, and rationale was provided to enhance understanding of the recovery process. The research question and a literature review were presented and discussed. A methodology for the inquiry was described, and the data was analyzed accordingly. This chapter seeks to explore further the themes that emerged in this qualitative study.

The world of the person suffering from an eating disorder may is bleak. As many of the interviews in this inquiry attest, in this disorder, death is always a threat. However, despite the gravity of eating disorder symptoms, persons can and do recover from the illness. Given this fact, a fuller understanding of their process is a worthy goal. Such information may provide counselors with a better understanding of treatment goals and give them new ideas from the perspective of success. As described in Chapter 2, the literature in the field has heretofore been one-dimensional, none of it fully representing the lifeworld of those whom we might learn from the most: the recovered.

Pursuant to this goal, I sought after existential and non-reductive models of research that might help elucidate the experience of change in those who had recovered (Becker, 1973; Greenberg et al. 1997; Pyszczynski et al., 2004; Yalom, 1931). I suspected that a way of describing experience through quantitative measures would not capture the lived experience, which is rich with meaning. I thought, however, that an existential phenomenology would help in beginning to understand the totality of the phenomena. Most of all, I wanted the study to give a
voice to those who had recovered—to whom, so far, the literature on eating disorders has not given that voice.

To be sure, extant longitudinal studies on eating disorders were useful in pursuing this study. Quantitative measures have pointed out important features of the disorder, describing possible personality features, the amelioration of co-morbidity, and other variations in the pathology (Herzog et al., 1999; Pike, 1998; Sullivan, 2002). They have also often focused on general features, such as eating habits or depression. The more specific experiences in the lifeworld of those who have recovered from an eating disorder, however, have been overlooked.

In a similar fashion, some treatment models so far have seemed to be as reductive as the studies on recovery. This has been especially true for the cognitive behavioral models of treatment, which rely heavily on a positivist view of human behavior (Evans, 2002; Tollman, 1992). These models of treatment are often a preferred method for alleviating the co-morbid symptoms of the disorder (Agres, 1997; Fairburn, 2002; Fairburn et al. 1999). While these methods, too, have been useful for some features of the disorder, they have not addressed the existential factors possibly inherent in the recovery process.

An alternate model of defining how persons construct meaning in their world is Terror Management Theory (Greenberg et al. 1986; Greenberg et al. 1997; Pyszczynski et al. 2004; Solomon et al., 2004). This theory relies on an existential and non-reductive paradigm. It asserts that the awareness of a finite existence creates a great deal of human behavior. Specifically, it ties the individual to the group through the creation of self-esteem, which allows the individual to stave off the fear of death and binds him or her to the culture. Elsewhere, this inquiry has demonstrated that occurrences of eating disorder are intertwined with elements of the prevailing culture. Maintaining self-esteem may be a powerful factor in eating-disordered behavior. If so, it
would follow that the transformative processes would involve self-esteem and culture in this model.

The focus of this study was to explore the lived experience of those who had recovered from eating disorders. These people demonstrated quite dramatic changes in their perceptions, which have both facilitated and maintained their recovery from eating disorders. The individuals in the study had experienced very serious distress within their behavior. Their recovery required them to alter their sense of self-esteem, values, and perceptions. The changes could not be pinpointed to a few discreet behaviors, such as food management or a simple shift in thinking. Whereas the changes unmistakably entailed these aspects, the subjects reported even deeper changes to their ongoing process in maintaining their recovery.

Giorgi (1985) asserted that a phenomenological research project explores the everyday world of its subjects “where people are living through various phenomena” (p. 8). This research study has explored the lifeworld (Van Manen, 1997) of those who have recovered from eating disorders. Eight participants provided narratives that detailed their own personal experience of recovery. Heidegger (1996) elaborated on how individuals are immersed in their everyday world. A phenomenological stance reveals the latent structures that provide a deeper meaning to the phenomena when examined as a whole (Dreyfus, 1996).

The findings in this study illuminated some of the aspects of change in the lifeworld of the subjects. The interviews revealed a shift in their ideas concerning their source of self-esteem. Many could not identify the exact reasons for recovering from their disorder; nonetheless, they realized that factors they had discovered helped to maintain it. They could often identify a moment in which they realized they had grown and changed. They expressed a new sense of altruism and an authenticity in their relationships with others. They also felt that a greater sense
of autonomy and freedom was inherent in their recovery. Their relationship with their bodies had changed as a result of the process of recovery. In their overall approach to life, they had discovered an optimism or sense of competence in the face of adversity. This optimism was often, but not always, linked to a newfound spiritual focus. They had all experienced the presence of a sudden shift in awareness that altered their eating disordered behavior. This shift allowed for continued maintenance and personal growth.

The eight narratives in this study produced a variety of perspectives and experiences from which, when they were analyzed in their entirety, five master themes emerged. The next section discusses these five overarching themes, which are derived from a phenomenological analysis of the data, along with their implications. These master themes are linked to the research questions that this inquiry proposed at the beginning of the research, and they provide replies to these questions. The chapter concludes with the limitations of the study and provides suggestions for future research that might arise from the findings.

**Discussion of the Findings**

The five master themes that emerged from the narratives were derived through semi-structured interviews that were intended to obtain focused replies from the respondents. The questions were originally constructed with the major theoretical models of this inquiry in mind. In this section, the five master themes are presented and discussed as answers to the research questions. The themes presented here along with the research questions are those most closely linked to the research questions. Because, however, we are attempting to elucidate the lifeworld (Van Manen, 1997) of these individuals, the themes can relate to other research questions also. They are delineated to provide a clear picture of the lifeworld of recovery.
Research Question #1

Central to the amelioration of eating disorders is a process of change. Under investigation in this inquiry is the nature of that change according to those who have experienced it. The first research question in this inquiry was as follows: What do people conceptualize as transformation and growth in the recovery process? The interview data described in narrative form is what illuminates the lifeworld existentials of the recovered person (Van Manen, 1997).

Theme #1: Changes in Self-esteem Based on Honesty Toward Self and Others

This theme relates closely to TMT, one of the guiding theoretical models for this inquiry, which focuses on the idea that self-esteem is a crucial psychological construct in an individual (Pyszczynski, et al. 2004), and that it is intimately related to functionality in a culture. As noted in the literature review, eating disorders are profoundly linked to culture. This inquiry sought to explore the nature of self-esteem in recovered persons and to understand how they experienced changes—if those changes did, in fact, occur. The participants in this inquiry related feeling as though they had a new sense of self-esteem, and the nature of that change was based on honesty. The subjects defined honesty, at its most basic level, as refraining from eating disordered behavior.

This basic change compelled them to make other changes. Many of the participants described self-esteem as having an almost altruistic function. All of the subjects had, at one time or another, realized that their self-esteem was linked with relationships to others in their world. They described these relationships as existing within a new attitude of honesty and appreciation. Phrases such as “self-esteem is estimable acts” illustrate the spirit of this change. As another example, one of the participants identified helping others as a central part of his sense of self-
Esteem. The person characterized altruistic action as giving him “a sense of where I fit into the world.” “Actions towards others” thus constituted an essential element in their self-esteem.

These changes also suggest Van Manen’s (1997) existential category of the lived other. The recovery process included changes in which they related to others, and it becomes evident that persons engaged in ongoing recovery experience others in a qualitatively different way. One respondent described her relations with others as “quite fucked up over the years over the course of my life, but I know that is changing.” One of the respondents reported that part of the change in the self-esteem structure was profound, a realization that “all persons were struggling to be ok.” This realization gave her a new focus for her experience with others.

The self-esteem was multi-faceted and not, of course, simply limited to actions geared toward pleasing others. What seemed equally important in the social systems of these people was a change in their relationships to themselves. The participants also spoke of finding a new appreciation for their own ability to trust themselves. They became honest with others as they became honest with themselves. One participant described his definition of honesty as abandoning “a sort of exaggerated sense of self-worth.” This idea was echoed implicitly in many of the participants’ answers. Maintaining healthy self-esteem meant surrendering expectations of self-worth that involved egotism, perfectionism, or control. Maintaining their recovery meant a continued honest self-appraisal.

Another aspect relating to self-esteem and honesty mentioned in these recovered people was a more realistic appraisal of their own value. This accurate appraisal actually strengthened their feelings of esteem, and they found it to be an essential change. A participant summed up this realistic self-appraisal as “humility,” which was engendered by giving up this possibly defensive self-worth, leading to more authentic relations with others. Another respondent defined
self-esteem as “the degree to which you value yourself... experience yourself as mattering.” In this way also, this more honest self-appraisal was related to the ability to transform relationships with others. The appraisal consisted of a realistic outlook on their capabilities that replaced the exaggerated need to maintain an unrealistic idea of self-worth.

Pertaining to the honest appraisal, more than half the participants had a marked sense of awareness of their own psychological processes. In other words, an internal shift had happened, and they seemed to be aware of a new gestalt within themselves. They used such phrases as being “able to trust” and “inner self.” In another example, one of the participants said that she had suddenly become aware of giving her world a “meaning that originated in me.” Others assigned a spiritual meaning to this overall awareness of a shift in themselves. One subject linked it to “gratitude,” while another named it explicitly as a spiritual awakening wherein he “no longer felt the same way,” and that a “trust in God became a very natural part of” him. Each subject expressed some sort of secular or spiritual change that they presented as integral to their recovery process.

Finally, it should be noted that in the discussions of self-esteem, none of the participants mentioned the appearance of the body. Eating disorder theorists have suggested that overestimating the importance of physical appearance in anorexia and bulimia, and the denial of its social presentation in BED are key factors in the pathology (Bruch, 1974; Heatherton & Baumeister, 1993; Williams et al., 1993). It is ironic that the concern for the physical appearance and its control through the manipulation of food was absent when they discussed self-esteem. All of the participants described themselves, while actively disordered, as being very aware of their body’s appearance to others. However, within the recovery process, their concern seemed to fade. Certainly, they expressed awareness of their physical appearance, but it was neither
overvalued nor denied. This observation is even more ironic or remarkable when one factors in a culture that is hyper aware of beauty and often considers it crucial to high self-esteem (Bordo, 2004; Brewis, 2010; Malson, 1997; Wolfe, 1991).

**Implications for Counseling**

Self-esteem is a basic aspect of the individual (Greenberg et al. 1986; Greenberg et al. 1997; Pyszczynski et al. 2004; Solomon et al. 2004). Participants in this study felt their recovery through and through—that is, it reached into the recovery aspect of their existential awareness. Often counselors are tempted to focus on specific behaviors or thoughts, missing the bigger picture in individuals’ lives. Thus, this research supports the idea that lifeworld existentials must be elaborated for a full understanding of the recovery process. By this elaboration a holistic approach to recovery is apparent. The participants in this inquiry did not describe changing in a discreet process that improved self-esteem; rather, they described a dynamic process that they had to live in and through in order to recover. Thus, this research supports models of counseling and psychology that have respect for these dynamic processes.

One such holistic model is an existential approach to counseling. It considers authenticity, self-transcendence, and meaning as a basic precondition of being human (Sharf, 2001). This inquiry has employed TMT as one of its guiding theoretical models by way of supporting the existential nature of the recovery process. It lent support to the notion that self-esteem was transformed. A quantitative approach that simply measured it would have not sufficed. The change these subjects spoke about encompassed the connections between the spiritual and the existential. This research also supports the assertion that more research into existential models of counseling should be conducted for a better understanding of the recovery process.
This study also supports another holistic model that comes from addictions medicine. Addictions counseling often employ concepts of healing based upon the person’s relationship with their world. Cognitive and emotional processes work in reciprocity with other aspects of their experience. There has been a growing interest in how addictive processes can be linked with eating disorders (Kanerek, D’anci, & Jurdak, 2009; Mate, 2008; Wang, Volkow, & Thanos, 2004). One holistic approach to addictions counseling is motivational interviewing (Miller & Rolnick, 1995, 2002). This model, which is client-centered and existential, focuses on removing impediments to change in the addictive process. Some evidence has shown that it is also effective with eating disorders, especially BED (Cassin, Ronson, Heng, & Wojtowicz, 2008; Treasure & Ward, 1997).

This study validates the idea that changes can continue to occur throughout longer term recovery. The participants (either explicitly or implicitly) described their disorder as an addiction, and described psychological and spiritual changes that were part of the recovery process. Thus, the lived experience of those who have recovered seems to provide an essential component when one attempts to understand eating disorders as an addiction. Further research into addictions models and into counseling those who are addicted should continue. After further examination of the master themes, more recommendations for research will be made that link theory to the lived experience of those who have recovered from eating disorders.

**Research Question #2**

The second question for which an answer was sought from the interviews was as follows: “What do people who are in the ongoing process of recovery specify as essential to their recovery?” This question was asked in the hope of finding out which elements of the recovered
persons lent meaning to their lives. A clear theme closely related to this question emerged, as detailed below.

**Theme #2: A New Relationship with the Body (Embodiment)**

As mentioned, the recovery process for these people has been perceived as a dynamic whole. Though the person’s body can be considered a relatively small part of the process, it is an essential element that the participants named as factoring into their recovery. Thompson (2001) commented on the centrality of the body image and of embodiment for the eating-disordered person. A simple interpretation is that the subjects had been able to lose weight and to refocus their attention cognitively towards other aspects of their lives. However, if one tries to grasp a sense of the whole (Giorgi, 1985), the data supports the idea that a new and different relationship existed that could not be reduced to simple explanations. Rather, those participants spoke of various levels of discovery through an awareness of their bodies.

This new relationship should be viewed through the lenses of Van Manen’s (1997) lifeworld existential, the lived body, which is in stark contrast to the cognitive behavioral theories of body image (Cash, 2002). Rather than reducing the body to a person’s cognitive awareness of it, the lived body is defined by how it constitutes part of the lifeworld. This research validates this phenomenological approach to the body. In the interview process, many reflections were spontaneously produced about how the participants felt a new sense was embodied. Most often, there was an excitement over the new relationship with the body. Rather than a concern for the body’s size and shape, they were concerned with how they might begin to use their bodies more positively. Almost all of the participants believed that the size of their body was incidental to their recovery.
For instance, one participant spoke about how he had striven for “physical involvement” in his life. He referred specifically to athletics. However, he contrasted this focus on athletics with his inattention to his body while he was disordered. With a marked sense of wonder, he referred to the idea that others would never have believed he would engage in this sort of activity. Another participant, too, expressed wonder and excitement that she could “trust her body” now to perform for her in all situations. She, too, referred to athletics. These participants endorsed the idea that the motivation for engaging in athletics ought to be healthy and that the meaning for them had shifted from a desire to change their bodies to please someone else to a positive desire to be embodied in a healthy way.

More than a new motility, however, all but two of the participants referred to an appreciation that was deeply integrated into their recovery. One said she knew she had truly recovered when she “experienced [herself] as a body of substance,” and other phrases echoed a shift in the way participants were experiencing the lived body (Van Manen, 1997). One participant described her new sense of embodiment as “a familiarity that she never had before.” Preferences, feelings, and positive emotional states were linked with this newfound sense of embodiment. In other cases the sense of being embodied was expressed as an appreciation for being able to put concerns over body appearance aside. “Today, the size of my body is not going to get in the way of living my life” exemplifies this change. Finally, a participant summed up the notion of embodiment by simply stating, “Now I feel at home in my skin.”

As the data was extracted and analyzed across cases, it became clear that the participants were talking about a new gestalt way of experiencing their body. One could also say that they had become embodied. The data revealed that all the participants held a conviction that an essential part of their recovery was to maintain a new attitude about their body. More than this,
they expressed excitement and gratitude about their bodies’ capabilities and appearance. Taking an approach that examined the lived body of the participants revealed a further need to develop holistic approaches to the body’s role in treatment.

**Implications for Counseling**

One of the common links among all eating disorders is a misapprehension in the awareness of body image and an over-concern with body image. The issue of body image—its appearance, functions, and distortions—appears in all eating disorders (Cash, 2002). This study begins to provide a set of experiences that can be incorporated into the treatment of eating disorders. The participants in this study had replaced many of the negative symptoms with an ethic of self care and acceptance. Thompson (2001) observed that there is a lack of research integrating body image into treatment interventions for anorexia and bulimia. Furthermore, there is relatively little research on body image intervention in BED.

Cash (2002) lamented the “neglect of body image as a fluid and dynamic person-situation interaction (or transaction), and the overemphasis…as [a] static, cross-situational trait” (p. 164). The treatment of body image problems with eating disordered patients is incomplete as a result of this absence. This data provides support that Cash’s concern is valid, and more research on the body as a dynamic process should continue by using both quantitative and qualitative methods of inquiry. Both methods can harvest valuable information about embodiment in eating disordered individuals. This interest would lead to more cohesive models of treatment for eating disorders.

In simpler terms, this research may aid counselors in understanding what kind of relationship with the body an eating disordered person can establish. Participants did not indicate a complete absence of dissatisfaction with their bodies. Rather, through various means, they
experienced themselves as more embodied. The findings support the idea that counseling techniques that explicitly employ body movement are a valid and even vital aspect of long-term care. The participants felt a new sense of ownership of their bodies they had not felt before.

They often described a long journey in coming to terms with their body image. The results of this study suggest that shifting the focus on body image towards embodiment is essential to the recovery process, and it will be accomplished though a new relationship with the body. Those who had recovered saw it as an essential element to maintenance (defined earlier in this inquiry) in the recovery process. After years of denying the body, participants seemed to have established a new way to live in it. This research suggests that counselors should attempt to establish a clearer idea on the concept of embodiment in the recovery process.

Research Question #3

The third research question was “How do those in recovery express their recovery in other spheres of their life?” It was formulated in an attempt to understand how persons who have recovered express these gains in other aspects of their everyday life. The thrust of the question was to uncover the meaning of their recovery process as expressed in the various facets of their existence.

Theme #3: A Positive Change in Family Relationships

A positive change in the family relationships of those who had recovered emerged as another common theme across the cases. It may be considered positive because this was the overwhelming value assigned to it by the participants. The results of this data are logical, given that the family is one system influenced by a network of systems in a culture (Bronfenbrenner, 1979, 1986). Given that the nature of eating disorders is social and historical, as detailed in the literature review for this inquiry, and given that the family relationship is one social system
embedded in others, it is logical to expect a change in it. This inquiry illustrates the lived experience of that change.

The supporting statements yielded many phrases that illustrate the many facets of a positive change in the family. One such facet was the positive shift that occurred in family roles for the recovered person; two participants elaborated on this change of roles. One observed that the significance of the roles of “being a wife and a mother” changed through recovery. This participant found the change striking because she identified her anorexic behavior as interrelated with her family situation in adulthood. Part of her motivation for anorexic behavior was to obtain control of a family situation within which she felt powerless. She had left this family situation and remarried, partially as a result of her recovery. After she left her husband, she began to establish more intimate family connections. Subsequent to her remarriage, she repaired the damaged relationship with her own family of origin.

Another participant spoke of his sudden epiphany that he “was the husband I would have liked to become” after recovering from BED. This participant also had a very contentious marriage, his role as a husband being decidedly negative. At the time of his recovery, he had remarried. He attributed the “constant reflection on himself” at recovery to the positive change in his role as husband. On a similar note, he said that he was able to manage the stress he was currently experiencing in the family. This person believed that his ability to cope with stress within his family was a direct result of the changes he had made in recovering from BED. He had been thrust into the role of caretaker for a granddaughter, and he had embraced this new role more strongly than he might have while binge eating.

One participant said that because of her psychological state, she was “constantly angry” at her family for expressing love and concern. This attitude had been transformed, and her
relationships with her family had become deeply valued in her life. In her case this change was symbiotic with that of other members of her family because they had changed also. Manifesting a deep sense of appreciation for her family, she described their ability to conform to her dietary needs while at a restaurant. Suggestive of Van Manen's (1997) existential of lived space, the everyday experiences of family ritual were altered positively. The family’s world—the space in which they live—was altered as one of its members recovered.

Another facet of changes in the family was the amending of family relationships from childhood. Many of the participants included childhood experiences in their descriptions of being disordered. They felt their recovery reached that deeply into their past. Through the recovery process, they had actively sought to heal the emotional damage within the family that had been precipitated by their behavior as actively disordered individuals. This aspect suggests Van Manen’s (1997) existential of lived time. The existential refers to the everyday sense of time, but it also includes “what [people’s] project is in life” (p. 104).

One participant’s observations stood out as he described this new experience in the family. He said that part of what motivated his recovery process was the healing that might occur in future generations within his family. His project of healing himself involved bettering family members he would never meet, an experience of lived time in the broadest sense of the concept. He stated that he hoped a great, great grandchild, whom he would never know, would “have a better life than mine” because he had recovered from BED. His lived experience included this vision of the future because he had recovered.

Some were more specific. A participant mentioned that the process of recovery “led me to my family-of-origin issues.” She had talked about being estranged from her parents for a time. When she reflected upon her reconnection with her parents she said, “Things have really come
full circle.” At the time of the interview, she was connected with her parents and was sometimes playing a parental role. She said after she had learned to ask for help from health care professionals, community groups, and the family, she was able to begin to help her family. She had been able to complete her process of healing partially through reconnecting with her family. Other participants echoed this desire to find further healing in the family and in other intimate relationships. Another referred to “intimate relationships” in general, or a specific goal of being “more interconnected” within the family. Still another simply portrayed the change as “spending more time with my dad.” In all the cases, they viewed family relations as an important sphere of change in their lived experience of recovery.

**Implications for Counseling**

Vandereycken (2002) asserted the importance of a change in the family system for the treatment of anorexia and bulimia patients. Conversely, little (if any) research has been done on the effectiveness of family therapy for BED. Although there may be some argument over the extent of a dysfunctional family’s contribution to the pathology in anorexia and bulimia, few clinicians have felt that it is irrelevant for treatment (Dare & Eisler, 2002). This study has provided a realistic portrayal of the family of those who have recovered. They described moving from stigma to acceptance by their family members. They also expressed a pro-social desire to help heal the conflicts their disorder had caused.

Family relationships were prominent in participants’ lived experience. It would be giving them short shrift to say that they are now “healthy,” and that they do not now have an eating-disordered family system. Instead, their systems had maintained and supported alterations to further the recovery of one of its members. As a result, more positive (intimate) relationships were established. These participants were not unaware of the stress and dysfunction in their
families. However, they now possess optimism that any conflict present will be overcome by the renewed sense of intimacy to which these people have committed within the family.

The counseling field in general is aware of the importance of the family in the treatment of anorexia and bulimia (Eisler et al., 2000; Minuchin, 1978; Robin et al., 1999). Eating-disordered family systems are notoriously resistant to change. This is especially true in the acute stage before treatment begins (Dare, 1994, 2006; Minuchin, 1978). This inquiry has validated that a positive change in family relationships is one of the principle changes in the lived experience of the recovered. Furthermore, with these participants, the changes had continued well beyond initial interventions, lasting throughout the recovery process. These changes took many forms. For some it was a renewed sense of intimacy with the family. For others, it was leaving one family to establish another. Whatever the case, an ongoing positive change was maintained throughout.

In the case of BED, few models exist for treatment of or through the family systems. However, the BED persons in this study felt that changes in their family were a profound element in their recovery. Some noted that their recovery process began with their abstaining from binging and developed into wanting to fulfill more positive roles in their family and community. Given the importance of the family, the present inquiry should generate more research into the effectiveness of family therapy for BED. Likewise, it endorses the continued refinement of family systems models throughout the process for all the eating disorders.

**Research Question #4**

In seeking to understand an existential dimension to the recovery process, this inquiry hoped to find an answer for the fourth research question: “What are the most important existential factors that are present in the recovery process?” The self-esteem of eating-disordered
persons is constantly assailed by societal expectations. The inverse is the sense of choice and freedom that these people experience in their everyday (existential) life. The analysis is consistent with Van Manen’s (1997) lifeworld existentials of lived space and lived time. Persons experience their autonomy and competence through the aspect of the lifeworld that these two existentials represent.

To answer this fourth question, we can refer again to TMT as the theoretical framework because it proposes that self-esteem is a vital construct for buffering the existential terror of non-being, literally and figuratively. The change in self-esteem discussed in Theme #1 extended to this aspect of their lives. For them, the feeling of relative autonomy and the efficacy to accomplish goals was a result of being connected to their social world in a healthy and vital manner.

Theme #4: A New Autonomy and Competence

The themes of a newly found autonomy and competence were echoed often in the interviews. Autonomy means the freedom to make choices that could not have been made while suffering from the disorder. These choices are usually based on values that shifted during the recovery process, and they are overwhelmingly positive choices. Competence signifies the relative surety that one can accomplish those goals by the intrinsic skills one possesses. Autonomy and competence became major themes of this inquiry and were often connected specifically to the question of self-esteem and a change in values. The participants all described their discovery of choices and abilities unknown to them until they had recovered. By and large, a change meant a new focus for their values. For some, that change meant adjusting their expectations to be more competent with others. For others, it involved more of a psychological or spiritual change that granted them a sense of efficacy.
Autonomy was expressed in various ways by the participants. One person noted a sense of autonomy when she realized that the opinion of others did not threaten her. She reminisced about how, once when she walked down the street, a man did not notice her. She realized that she did not therefore feel inadequate but thought he must have been uninterested for other reasons. At that time, she realized that feelings of inadequacy had been habitual in her experience. In losing this perceived sense of being inadequate, she found “independence.” Furthermore, her new independence allowed her to separate her sense of self-worth from professional goals. She felt free from the expectations she had for herself that were oppressive. Paradoxically, she said this freedom allowed her to continue with her goals. She said that now “I have the life I always dreamed of.”

Another participant expressed an analogous sentiment. He had found a new sense of autonomy by losing his egotistical stance. He described himself as “self-centered” before his recovery. For example, he said, “I used to think I was the best. I used think I was the king.” Now, he is able to surrender his desire be superior. This surrender of his defense ego gave him the ability to give up “negative influences” in his life. He had also gained autonomy from “negative behaviors” that had haunted him throughout his life, replacing them with positive influences such as friends and family. One of the benefits to his openness was that he had the freedom to be himself. “And me is enough” he explained, by which he meant that when he was free from a defensive attitude, he had the freedom to choose more positive relationships.

Freedom of choice was another variation on this theme. One participant thought that much of her self-esteem could be attributed to the freedom she had to make choices. While suffering from anorexia, she had few choices aside from the choice to refuse food. The freedom to choose her own destiny gave her the sense of competence she had sought through anorexia.
She contrasted it with her anorexic state, noting that while anorexic, she could not make choices because she feared conflict and failure. In the interview, she used “having the maturity” and “surviving it” to signify her newfound competence.

Autonomy and choice was also experienced by some in freedom from oppressive moods. One man realized that he is now able to separate himself from lifelong anxiety and depression problems. Thoughts of passive suicide had been common for him. Now, he said he would describe himself as “a man who gets anxious and depressed rather than an anxious and depressed man.” The shift in his perception positively altered the ways in which he was able to function in the world. Finally, a participant said that she now has an overall ability to “flourish.” She attributed this to her ability to see that her recovery was “life and death.” Her pursuit of personal growth though her recovery process granted her a competence she had not possessed while disordered. All of the participants felt freed in some respect or another.

Implications for Counseling

Hilde Bruch (1978) commented upon the remarkable lack of self-efficacy possessed by anorexics. Perhaps the only way they feel effective in their environment is by manipulation of their body. Likewise Minuchin (1978) described the “hopelessness and helplessness” of anorexics’ mind set when they are enmeshed in the system (p. 8). An anorexic’s feeling of autonomy is always actually dependent on others’ opinions. The bulimic can suffer the same lack of competence, which fuels the bulimic behavior. Like the anorexic, the person is driven to perfection while losing self-esteem. A binge eater’s sense of helplessness originates from the compulsive behavior that is beyond an act of the will. In the case of obesity, which is closely associated with binge eating, the social stigma is obvious. In each case, the individual is locked
in a destructive pattern (Brewis, 2010; Puhl, 2003; Vohs, Bardone, Joiner, Thomas, & Abrahamson, 1999).

Beyond asserting that eating-disordered persons need a sense of autonomy and competence, this inquiry demonstrates the lived experience of those who have found their way to this dimension of the disorder. It is not a vague concept; rather it is a concrete component of the everyday life of the recovered. It has pointed to ways that autonomy and competence are experienced in the lives of the recovered. Of course, they did not lose all anxiety or insecurity. It seemed, however, that when we discussed what being recovered had done for them, their autonomy and competence framed realistic progress. This study suggests that the treatment focus for eating disorders should include therapies that empower the individual and support self-efficacy. Feminist and humanistic therapies are two examples that explicitly set these objectives. Modalities of therapy that reach beyond the cessation of symptoms and into the personal growth of the individual are indicated as appropriate.

Research Question #5

The last question this inquiry sought answer is “How has self-esteem or selfhood been changed by recovery?” This question posits that, to some degree, the experience of recovery would be a change in the emotional, cognitive, and spiritual self. Existential theory asserts that these selves cannot be reduced to the sum of their parts. Therefore, a change in the individual is best understood through an examination of a dynamic gestalt, and existential theory and phenomenology may offer this gestalt lens. While change is ever-occurring in any individual, this research represents how persons recovered from an eating disorder relate their change to being recovered. The change largely consisted of optimism owing to a change in the self that made them different from when they were disordered.
Theme #5: Optimism in the Face of Adversity/Spirituality

Optimism emerged as a common theme as each participant expressed optimism for the future, despite any adversity or hardship they might face. Adversity might be manifest as struggles with the disorder that had been alleviated or as the common, everyday struggles that the participants had come to regard as manageable. Many attributed this new optimism to spirituality, whether as an explicit belief in God or a realization of humanistic values in the recovery process. The change in orientation to a more optimistic stance was a sudden realization for some and a slow process of growth for others. Often, the optimism meant a further commitment to personal growth. The optimism in spite of adversity also suggests both Van Manen’s (1997) lived time and lived space. These persons saw the future as optimistic. They had thereby transformed their world, the space in which they live in order to promote this optimism.

Optimism in the narratives of these people was contrasted with the way they described their disorder as having been debilitating and fatal. One participant recalled that she always felt as though she had the “weight of the world upon [her] shoulders.” This image suggests Van Manen’s (1997) lived space, providing an impression of a very small and enclosed world and the suggestion that the space she lived in was always crushing her. However, as she reflected on the recovery process, she realized that the pressure had been lifted. She had been able to gain “clarity” that allowed her to form relationships and be vulnerable. She described a slow growth process in which she was able to see her life and relationships as a “gift” that she wished not to compromise. Furthermore, these relationships gave her “support from every angle.” The support facilitated more personal growth.

Another powerful example was the participant who emphasized that her life could now “flourish.” She described herself as being “awakened to a life,” wherein she was “present” to any
adversity she might face. She saw existential awareness as a prioritizing experience that did not seem negative and seemed realistic. Being present was a hopeful experience in which she could stay focused on personal growth, which was achieved through her recovery process. She contrasted this with the threat of relapse, which she thought was a matter of “life or death.” Perhaps in the same fashion, another participant related part of the recovery process as almost awakening from a dream of “the way life should be, then nothing actually happens.” Now that she had recovered using therapy and community models, her life was meaningful. Furthermore, she saw “no reason why that should not continue.” The statement rang of an optimism that was part of her world.

Yet another female participant expressed the same optimism. She described her experience of being recovered as “coming out of a fog” to realize all the “opportunities” she had. “It has been amazing and crazy,” she said with much excitement. Noting that she had a chronic and debilitating intestinal disease, she nonetheless felt certain that she could manage it now and continue with her life. She could accept her bowel disorder and feel as though her personal goals will still be achieved. She believed that without the recovery process, in her case 12-step and therapy, she would not have had this assurance that she could do well.

Many of the participants expressed on overall optimism based on their spiritual beliefs with phrases such as “God will walk me through it.” One participant found that when took an optimistic stance, he found “a dozen different points of gratitude” for his life regardless of his circumstances. Likewise, other optimistic and hopeful statements were produced. The previously mentioned participant who believed that staying recovered from his eating disorder would aid future generations expressed an optimism rising from his spiritual beliefs. He believed that the
meaning he had found through the recovery process (his was exclusively 12-step) was “just too big for him to keep.”

Others were more specific about life events that they had found challenging. Despite extremely challenging stressors, they believed that the peace they had found in the recovery process was something they would not lose under any conditions. It was too valuable. For instance, one participant mentioned that both he and his spouse had recently lost their jobs. In addition, he had become financially responsible for a grandchild and a wayward family member. He said that previous to his recovery, these events would have caused a clinical level depression. Now, he had the capacity to believe that these anxieties are part of the flux of life. He said, “It will change. I don’t know when, but it will change.” He said now that he had “hope instead of fear.” He expressed an optimistic faith that life would get better as long as he remained recovered.

Optimism was expressed in very human terms as well. One anorexic participant explained the moment that she felt connected with others in a deeper way. She described it as a “shift” in her orientation that occurred by reading a nonfiction book about others’ lives. She had suddenly been moved with all her faculties. For her it seemed to be part of her healing. It revealed to her the meaning of “being a member of a community of humans”—that is, the human race. Therein she felt a sense of responsibility and a sense of connection that she could not feel prior to her recovery. She went on to say how positive this connection was throughout her life. She was aware now of “the complexity of the human, and the degree to which we are struggling to be ok.” This struck me as a beautiful and humble statement. From her realization of these human values, she said she had been able to experience a deeper connection with others.
Implications for Counseling

Counseling and psychology have paid little attention to the holistic approaches that gestalt, existential, and pastoral counseling offer. The above narratives have illustrated that an essential element to the recovery process is a shift in the participants’ worldview. In their place, cognitive therapies based on information-processing models of the mind have dominated (Pyszczynski et al., 1997). This research suggests that treatment approaches to eating disorders should be expanded to include gestalt, existential, and pastoral perspectives on counseling and psychology. This dissertation has identified these approaches, among others, as holistic because they assert reciprocity between experience and the recovery process.

It identifies the needs of a population who have successfully recovered from the disorder but who may still have some need for counseling. The cognitive and behavioral dimension was one of many domains the participants mentioned as responsible for maintaining their recovery. They also spoke of spirituality, a connection with others, and an optimistic faith in their future. The above models, which are all sensitive to those dimensions, provide support psychotherapy for this very specialized but important population. These results also suggest that alternative models to the one chosen for early treatment of the disorders may need to be revised. Certainly, it is important for those who are suffering from eating disorders to stabilize. Bruch (1978, 1979) recognized that the beginning phase of treatment for the eating disordered person was palliative: that is, one has to manage the behaviors before one can move on to a deeper level of change. Cognitive behavioral theory can be effective for the beginnings of treatment. However, it does not address such topics as meaning, value, or spirituality, to which other approaches are sensitive. However, if these changes are present in and important to those who have successfully recovered, it seems reasonable to begin to promote them in the beginning of the treatment phase.
Of particular note is the spiritual approach that these persons adopted to conquer their eating disorder. Cognitive approaches reduce this focus to simple thought processes, but the persons in this inquiry did not describe having a non-eating disordered brain. Rather, they described being transformed through the process of recovery. This research validates the idea that psychotherapies having a spiritual component are powerful interventions. Spiritual approaches are becoming more accepted in treatment of psychological disorders. Little is known about how faith and spirituality might intervene in the eating disordered process. However, there is a call to explore this issue (Miller, 199; Richards et al., 2007), and the preceding research supports this project.

This research validates another link to holistic models: the salutogenic approach to counseling a recovered person (Antonovsky, 1996). This approach assumes that positive features of change are essential in understanding health. Pathogenic approaches, employed in both disease prevention and treatment, assume an inherent flaw in the organism. Salutogenic approaches attempt to grasp the humans in their context and to begin with positive features that promote change. The five main themes suggest that a positive approach to treatment should be employed in understanding how to treat eating disorders.

Limitations

This qualitative study used eight participants who had reported having at least 3 years without engaging in eating disordered behavior. The participants in the study were selected upon the criteria of maintenance established by Prochaska and DiClemente (1983), which is described in the literature review of this section. Another limitation was that the pool of people overwhelmingly reported BED or bulimia, or both, as the primary illness. Thus, anorexia was underrepresented in this inquiry. While the clusters of symptoms they represent have at times
been historically identified with each other, the current DSM 5 presents these three major divisions as distinct. Likewise, no persons who represented subclinical eating disordered behavior were represented in this sample.

The pool of recruits was primarily from various 12-step groups. Though only three identified as having exclusively 12-step involvement for treating their eating disorder, all but one had some affiliation with these groups. This involvement may have enhanced the spiritual aspects that many participants noted as a crucial factor in their recovery process. Another limitation is that the results are not generalizable to all persons with eating disorders because a less homogeneous group might have more varied results. The participants in this study were all Caucasian; two identified as Jewish, and the rest were ethnically white.

Last, I may have been a limitation in the study through my own biases and presuppositions in interviewing and interpreting the data (Patton, 2002). I have prior experience of eating disorders, having treated these individuals in my private practice frequently. Although I attempted to ameliorate this affect upon the study by triangulation of the data and rigor in the phenomenological method though field notes, bias may still exist. In addition, the participants themselves may have felt a need to answer in ways I expected. The participants, as well, spoke about behaviors and thoughts that had been very uncomfortable at one time in their lives, and it is possible that other co-morbid conditions were not revealed owing to the specific nature of the inquiry. Although it was a stable population, the negative features of recovery may not have been adequately portrayed.

**Implications for Future Research**

This inquiry generated possibilities for future research in many areas. The positive features of recovery from eating disorders have been overlooked. Our counseling literature has
focused upon the symptoms without paying enough attention to the recovery. It follows that persons who have indeed recovered—that is, who have, at the very least, had a significant period of time without symptoms as a baseline of criteria—might provide counselors with clues to treating those still suffering. From that baseline we can learn the positive features that started and maintained them in the recovery process.

What was significant in the recovery process for these individuals was that their success was not defined as the management of symptoms, which was a very small part of their perceived lifeworld. Moreover, that lifeworld entailed the realization that they were survivors of the disorder. It shaped their awareness and guided future actions. Far from always being a burden, it framed in a positive light the way in which they constructed meaning and experienced others. To be specific, meaning here connotes the assessment of future goals, as some stated, and the spiritual and philosophical outlooks that these people held as truth. This outlook is linked to addictions models of counseling and recovery.

The most obvious research possibility is that the present population needs to be studied because the needs of this population are not met by our current research. This group of people is maintaining recovery, which is mostly an ongoing process. Research here might disclose stages after the maintenance stage that would further refine our understanding. Furthermore, it is of interest that these people have exhibited resilience despite the cultural tenants that stand in their way. Anorexia and bulimia is implicitly sanctioned by the cultural ideal, which is to be thin at all costs (Bordo, 2004). For BED cultural sanction is given to the abatement of behaviors despite the fact that social stigma depresses and interferes with healthy psychological functioning (Brewis, 2010). The cultural aspects of the disorder are congruent with a study based on ecological theory
(Bronfenbrenner, 1917). The social construction discussed in this inquiry could easily fit into ecological models that support biopsychosocial models.

Other research topics should include the spiritual and existential psychotherapies that promote the development of the entire person throughout the lifespan. (The term spiritual is here used in its broadest sense, being neither religion specific nor denominational.) The participants in this study spoke often about the need for very deep change and for transformations in the meaning of what it means to be connected to others. They also referenced as part of that change the fear of death. Rather than this fear debilitating them, it aided them in recovery. When they no longer denied its power, they were on the road to being recovered. TMT has demonstrated that even a concept as basic as self-esteem is linked to the awareness of mortality. It helped facilitate the fundamental change that is best described as a shift in spiritual realities.

Another research topic lies in the field of social psychology. Many of the participants talked about prosocial behavior as an important facet of their recovery. It boosted self-esteem and made them feel more competent. The link between prosocial behavior and the benefit it might have for maintaining recovery should be explored. Likewise, the participants reported that they had seemed to move from an extrinsic sense of motivation to an intrinsic one. There may be a link between Self Determination Theory and recovery from eating disorders (Ryan & Deci, 2000). These possibilities, among others, have been generated by this study.

Questions Generated by the Research

One of the functions of a qualitative study is to generate questions for further research (Patton, 2002). The following are a list of questions other researchers might answer.

1. Are there other aspects of the self-esteem described in TMT that can help us understand the recovery process?
2. Can stages beyond the maintenance stage be defined that will allow for a better understanding of long-term recovery?

3. Should the cognitive/behavioral model (including DBT) be augmented by more holistic treatment models before the maintenance stage?

4. Do different eating disorders manifest significant differences in the recovery process?

5. Do subclinical and non-specific eating disorders require the same path through the recovery process?

6. How have biopsychosocial and ecological models as applied to psychotherapy been informed by those who have successfully recovered?

7. What is the relationship between addiction models of recovery and actual recovery from eating disorders?

8. If the above relationship is extant, how does it inform the therapeutic treatment of eating disorders?

9. How is prosocial behavior (altruism) and recovery related?

10. How are spirituality and recovery related?

**Conclusion**

The present inquiry has focused on the lived experience of recovery from eating disorders. It has been especially focused on the nature of change for those who had successfully recovered. The inquiry assumed that these persons have something to teach us. The study provided an exhaustive examination of the lifeworld of the recovered persons. Its special focus was the nature of change that the recovered persons have experienced. Their ideas on how they
have changed (and have continued to change) are vital when understanding all of the phenomena of eating disorders.

Therefore, knowledge of this change process was sought through existential and phenomenological theories, which it was hoped, would grasp the essential features of the lifeworld of recovery. These theories hoped to reveal to a powerful transformation that reductive theories would dismiss. This study revealed that these people did attribute their recovery to such transformations. Each participant described moments of clarity in which their disorder faded. They attempted to renew this clarity daily after realizing that the alternative was to perish from the disorder. At no time did they explain exact techniques used to abate symptoms or to build self-esteem. Rather, the transformation happened over many facets of their experience.

This inquiry has also striven to point out the social nature of eating disorders. The persons who have recovered from them have done so despite cultural messages and unspoken tenets that would block their progress to a fuller experience of the world. The change they experienced has occurred throughout their ecological landscape. It affected multiple systems, as well as how they experienced those systems. Concurrently, the inquiry examined existential theories in relation to this transformation. Changes appeared in the values and self-concepts of the participants. Common ways that they had related to the world were changed. Positive changes translated into a new relationship with their world. Implicit in the experience was an awareness of the figurative or literal death that threatens the disordered individual.

The main themes that emerged across the cases illustrate the nature of the changes that have occurred. The changes could not be reduced to a few simple categories. Each main theme related to the ways in which the participants experienced their world. These organic experiences sustained and continued their recovery from eating disorders. The main themes provide a
beginning in the understanding of what counselors might expect when treating an eating-disordered individual. Approaches that respect the holistic nature of the change process are supported by this research. Grasping the nature of this existential transformation provides a deeper and richer understanding of the recovery process.
REFERENCES


APPENDICES

Appendix A. Interview Protocol

The study proposed is an interpretative phenomenology of the lived experience of those who have recovered from eating disorders. The guiding research question is: What is the lived experience of those who have engaged in long-term recovery from eating disorders. The interview will begin with basic demographic information. The participants’ name, age, gender, the disorder each has managed, and number of years engaged in recovery will be recorded. The interviews will be about 90 minutes long. They will be video-taped (digitally recorded) and transcribed at a later date. The video-tapes (digital recordings) will be destroyed after the research project is completed.

Below are the questions that will be asked in the semi-structured interview.

Demographic questions:
1. What is your name?
2. How old are you?
3. What gender do you identify as?
4. What type of eating have you experienced?
5. How long have you been recovered from this disorder?

Essential questions:
1. Could you please describe your eating disorder?
2. Could you describe how recovery from your disorder has changed your life?
3. Do you feel that any of your personal values have changed or shifted as a part of your recovery?
4. Has the recovery process affected other areas of your life other than physical functioning?
5. What does Self-Esteem mean to you, and has your relationship with yourself changed?
6. Is there anything that I have not asked you that you would like to share?

During the semi-structured interview, the interviewer will probe responses, as needed, to acquire more fine-tuned information. Typical probes would be a request to speak more about a major topic or theme that comes up in the interview, and to clarify information.
Consent to Participate in Research Study

Title
Transformation and Change: An Existential-Phenomenological Analysis of the Lived-Experience of Recovery from Eating Disorders

Investigator
Anthony M. Boone MA. MS.Ed, LPC

Advisor
Dr. Lisa Lopez Levers
Professor, School of Education
(412) 396-1871

Source of Support:
This study is being performed as partial fulfillment of the requirements for the doctoral degree in Counselor Education and Supervision (ExCESS) at Duquesne University.

Purpose:
You are being asked to participate in a research project that seeks to investigate the lived experience of individuals who have recovered from eating disorders. This research seeks to answer questions related to how one has been changed due to his or her recovery from the disorder. It seeks to understand if persons who have been through a process of recovery live their lives differently than before, and how they understand this difference.

Research Procedures:
As part of your participation, you will be asked to allow me to interview you. The interview will last approximately 90 minutes. The interviews will be video-taped and transcribed. I may ask you to review the written transcription for accuracy and clarity.

Risk and benefits:
There are no risks associated with this study. Minimal discomfort may arise as you discuss personal issues related to your eating disorder and recovery, but this is not anticipated to be of any greater risk than that associated with daily life.
The benefits of the study include possible insight into your recovery process as well as contributing to an enhanced professional understanding of recovery-related experience.

Compensation

Participants will not be compensated for their participation in this study.

Confidentiality

Your name will never appear on any survey or research instruments. No identity will be made in the data analysis. All written materials and consent forms will be stored in a locked file in the researcher's home. Your response(s) will only appear in data summaries, and you will be assigned a pseudonym that will identify your responses in the study. All materials will be destroyed at the completion of the research.

RIGHT TO WITHDRAW:

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time. You may contact me by phone or e-mail to withdraw. You may terminate before or during the interview. Accordingly, if you decide you wish me to exclude your data from the study, you may contact me by phone or email and withdraw. All data will be destroyed immediately upon withdraw from the study.

SUMMARY OF RESULTS:

A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT:

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Anthony Boone, Doctoral Candidate, at 412-758 9966, Dr. Lisa Lopez Levers, my advisor, at 412-396-1871, or Dr. Linda Goodfellow, Chair of the Duquesne University Institutional Review Board, at 412-396-6326.

________________________ ________________________
Participant's Signature Date

________________________ ________________________
Researcher's Signature Date
An Investigation of the Experiences of Recovery from Eating Disorders is being conducted.

VOLUNTEERS WANTED FOR A RESEARCH STUDY

You are being invited to participate in research that seeks to investigate the lived experience of those who are in an ongoing process of recovery from eating disorders. One video-taped interview lasting approximately 90 minutes will be conducted. The video-tapes will be destroyed after the research is complete. The researcher is a doctoral candidate in Duquesne University’s Counselor Education and Supervision (ExCESS) program.

Your participation requires the following criteria:
1) Must be at least 18 years of age.
2) Must Self-identify as having an Eating Disorder.
3) Must self-identify as the having been stable for at least three to five years.

If you are interested in participating in this study or would like more information, please contact:

Anthony Boone LPC at:
412-758-9966 or email at:
Boone762@duq.edu

All communication is confidential.