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SUBJECTIVE ACCOUNTS OF RECOVERY FROM ANOREXIA NERVOSA

A research report submitted in fulfilment of the requirement for the degree

Master of Arts in Clinical Psychology

in the Faculty of Humanities at the

University of the Witwatersrand, Johannesburg

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Abstract

Literature on recovery from anorexia nervosa indicates that research studies often exclude the experience of recovery from a subjective point of view. As a result there seems to be a lack of understanding as to what the process of recovery entails. The aim of this study is to explore the process of recovery from the participants' perspective. The focus of this study is on the narratives of young women who consider themselves recovered from anorexia nervosa with or without formal treatment. Semi-structured interviews were conducted with nine young women who reported recovery from adolescent-onset anorexia nervosa. The resulting interview transcripts were subsequently analysed qualitatively using a narrative analytic perspective in order to explore the ways in which participants narrated their recovery experiences. Particular attention was paid to the subjective perspective of the perceived causes of anorexia nervosa, how participants narrated what it was like to be anorexic, how treatment was experienced and various aspects of the recovery process.

The narratives of recovery suggest that recovery has diverse meanings, creates different expectations and has different manifestations for different individuals. The narratives suggest that, rather than a dichotomy within recovery, there are shades of recovery through which traces of anorexia emerge. Experiences of treatment too are not clear cut with a tension existing between resistance to treatment and dissatisfaction with treatment.

By presenting these narratives, this study aims to explore the contradictions and difficulties within recovery experiences in order to extend that which is already known about recovery from anorexia nervosa.

Declaration

I declare that this research report is my own, unaided work. It is submitted for the degree of Master of Arts in Clinical Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

Signed this _____ day of _____ 2007.

_____

Samantha Furniss

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"Stories are habitations. We live in and through stories. They conjure worlds. We do not know the world other than as story world. Stories inform life. They hold us together and keep us apart. We inhabit the great stories of our culture. We live through stories. We are lived by the stories of our race and place. It is this enveloping and constituting function of stories that is especially important to sense more fully. We are, each of us, locations where the stories of our place and time become partially tellable."

Mair (in Howard, 1991, p.192)

CHAPTER 1: INTRODUCTION

1.1 RATIONALE

Anorexia nervosa* is a severe psychiatric disorder which is commonly associated with a chronic course and high mortality rates (Zipfel et al, 2000). Studies indicate that on average approximately 50% of patients recover weight within 4 to 12 years after onset, 25% are still emaciated and amenorrhic and the remaining 25% are at various stages of recovery (Hsu, Crisp & Callender, 1992, p. 341). Long term prognosis is often poor and treatment efficacy varies.

Eating disorders have been investigated from a range of perspectives but remain conceptualized, particularly within medical frameworks, as “individual clinical entities” (Malson et al, 2004, p. 474). Although a variety of treatment approaches have been developed as a result of diverse aetiological explanations, Malson et al (2004) argues that the conceptualization of anorexia and other eating disorders as “individual psychopathologies” has largely excluded explorations of the meaning and experience of eating disorders (p. 474). The majority of the research conducted into this disorder has focused on aetiology, clinical features and prognosis rather than exploring the stories and experiences of those diagnosed with these disorders (Malson et al, 2004). Garrett (1997) suggests that it may be more useful to explore the solution to a problem such as anorexia than explore its aetiology, as an investigation into solutions may either shed light on the causes or indicate that in fact the causes are not of central importance.

Statistics do not tell us much about the experience of anorexia. They provide an inadequate depiction of the complexities of the disorder and do little to shed light on the lived experience of suffering from this disorder, what recovery from this disorder demands, the damage that such acute pathology can result in, and the

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*From this point onwards, for the sake of brevity, anorexia nervosa will be referred to as anorexia.

potential benefits and growth resulting from struggling and overcoming such extreme illness (Garrett, 1998). This valuable knowledge can only be acquired by understanding the perspectives of women who have lived through such an experience which can be brought about by attending to their stories (Garrett, 1998; Way, 1993). This study relies on the subjective telling of recovery stories and how having had anorexia and being recovered from it is made sense of. This may result in a deeper understanding of recovery as stories have the power to get at “truths” that cannot be gained from studies relying on statistics.

Popular literature includes many personal accounts of recovery, and “recovery stories” have become a well-established genre in publishing and journalism (Garrett, 1998). In academic writing and research, much attention has been focused on the aetiology, treatment and outcome of eating disorders from the perspective of clinicians and researchers. However, knowledge regarding the process of recovery from eating disorders from the perspective of young women is limited (le Grange & Gelman, 1998). In the past, neither research nor clinical literature has focused on the subjective experience of the process of recovery and few studies have featured the actual voices or narratives of women who have recovered (Reindl, 2001). More recently explorations into recovery from anorexia using qualitative methods has been undertaken in an effort to present more personal accounts of this disorder.

This research aspires to add to this growing body of knowledge regarding recovery from anorexia as there seems to be something missing from the psychological understanding of how young women recover from anorexia that only first person accounts can fill. Through the use of qualitative narrative methods, this study aims to explore young women’s experiences of recovery and fill the gap identified in academic writing, while adding to other available literature on recovery from anorexia. What distinguishes this study from other studies of recovery is that this study explores the tension between whether participants’ are recovered or not despite them saying that they are. As will be shown, the way that recovery is narrated leaves open the possibility for multiple interpretations of

the degree of recovery achieved by these participants. Furthermore, these kind of interpretations can be extended to issues of treatment, in particular the difference between resistance to treatment and dissatisfaction with treatment. It is hoped that a richer understanding of the process and meaning of eating disorder recovery will be discovered by exploring how these kinds of stories are told. This could provide clinicians with valuable insights regarding recovery.

1.2 RESEARCH AIMS

The primary aim of this research began as a simple exploration into the process of recovery from anorexia as literature revealed that little is understood about the subjective process of women's recovery from this disorder (Weaver, Wuest & Ciliska, 2005). The research aim subsequently developed in relation to the interview material as the content of the interviews began to raise questions as to whether participants were in fact recovered or not. This then raised the question of how beneficial this research would be if it claimed to have as its focus the process of recovery when doubt remained as to whether participants were recovered, a question which often remains unaddressed in similar studies. In addition, it became apparent that recovery is difficult to define and although participants may speak about themselves as recovered, at times they demonstrate something different. This tension between recovered versus not recovered was mirrored in issues regarding treatment. Originally, the aims included an exploration of helpful and unhelpful aspects of treatment but once again this was too simplistic as it became clear that there is difficulty in differentiating between treatment that is unhelpful and treatment that is resisted. Therefore, the focus of this study is not only on obtaining a deeper understanding of the process of recovery and related issues but more specifically on the participants particular telling of these recovery stories and some of the difficulties encountered when attempting to tell stories of recovery.

The aim of this study is to explore how recovery is narrated from the perspective of young women who believe that they have recovered from anorexia with or

without formal treatment. The study recognizes the importance of stories and how they are told and foregrounds the voices of the participants in the narratives. The aim of understanding recovery is achieved through an exploration of different aspects of anorexia, from how participants understand the causes of anorexia, to how the stories that they tell about themselves form a narrative identity of themselves as anorexic, and finally to how various aspects of recovery such as turning points, treatment, sustaining change, meaning of recovery and how recovery in the present is narrated. Although all these aspects are explored the emphasis remains on recovery and treatment which is in line with the primary research aim. The aim of listening to these stories with an interpretative slant is because there seems to be a lack of awareness in other studies of the tension between recovery versus non-recovery and the distinction between dissatisfaction with treatment and resistance to treatment. Therefore, this study has the dual aim of giving voice to these participants by allowing their stories to be heard as well as interpreting the stories and what they might mean. Consequently, it is hoped that a more nuanced understanding of young women's personal experiences of this complex disorder will be gained.

1.3 THEORETICAL FRAMEWORK

1.3.1. QUALITATIVE RESEARCH

Research based within a qualitative paradigm is becoming increasingly popular in psychology. Qualitative data is a source of well grounded, rich descriptions of process in local contexts (Miles & Huberman, 1994). Through the use of qualitative data chronological flow is preserved, one can track what events lead to which consequences and valuable explanations can be derived. This method is ideally suited to investigations into stories. Furthermore, Miles and Huberman (1994) argue that qualitative research studies have a "quality of undeniability" in that words, particularly those that are presented as stories, have concrete and meaningful qualities that hold deeper descriptions than a set of numbers (p. 1).

Qualitative methods emphasise subjective experience and multiple realities and include the use of narrative reports of lived experience. A qualitative approach was adopted in this study to provide rich narratives of the experience of recovery in order to come to an understanding of how recovery stories are told. Relying on subjective accounts of recovery will provide insight into the participants' experiences of recovery and how meaning is created from these experiences. Qualitative research aims to understand, and represent the experiences of individuals as they "encounter, engage, and live through different situations" (Elliott, Fischer & Rennie, 1999, p.216). Of importance is that the researcher attempts to come to an understanding of what is being studied based on the perspective of those who are being studied. In this study, participants' perspective of themselves as recovered is emphasised and forms the basis of the analysis.

1.3.2. NARRATIVE RESEARCH

Narrative inquiries allow us to experience the world through the words of others. One of the most effective ways of gaining insight into the inner world of an individual is through the verbal accounts and stories communicated by individuals about their lives (Lieblish, Tuval-Mashiach & Zilber, 1998). Therefore narrative inquiry is a unique means of gaining access to the world of young women who consider themselves recovered from anorexia. Narrative methods are ideally suited to stories of recovery as the creation of meaning of recovery experiences is placed more in the control of the participants. This is relevant to the current study given that the aim is to explore recovery experiences from the perspective of the participants.

Research on recovery from anorexia has largely focused on the efficacy, or lack thereof, of treatment practices using quantitative methods of research. Recently, narrative accounts of recovery have increasingly been focused on in light of the limitations of outcome-based research. Narrative studies exploring recovery from

anorexia are often approached from a sociological or feminist perspective (see for example Way, 1993; Garret, 1998; Weaver, Wuest & Ciliska, 2005). There seems to be a lack of framework which includes the interpretation of narrative material from a clinical psychological perspective although Hollway (1989) has developed a deeply psychoanalytically informed method of data interpretation. These analytic procedures are based on the principle that narrative accounts cannot necessarily be taken at face value and assumes that there is a "life" beyond the narrative account (Hollway, Jefferson, Spears & Wetherell, 2005). The interpretative approach is based on the assumption that the way participants construct their narratives in the context of the interview relationship can provide additional information about the conflicts inherent in the accounts when interpreted. This method also allows for the interpretation of how different layers of "truth" emerge from the narratives. Hollway's method of interpretation has been critiqued by Spears and Wetherell (in Hollway, Jefferson, Spears & Wetherell, 2005) in that both question the evidence for the psychodynamic perspective of the interpretations that Hollway offers. Wetherell further argues that such methods may place the participant in a storyline not of their choosing. Thus while this study follows the principle that narrative accounts cannot necessarily be taken at face value, such a method of analysis was considered to be too interpretive for the aims of this study. Although it is beyond the focus of this study to develop such a clinical framework, it has been important that the stories of these young women are heard as they were spoken but also that they are heard from a clinical point of view. This study then lies between giving voice to the participants' experiences and a critical interpretation of how these experiences are narrated. This approach may bridge the gap between sociological research perspectives and research that can be applied to clinical settings.

1.4 LIMITATIONS AND DELIMITATIONS OF THE RESEARCH

This study explicitly focused on how women who have suffered from anorexia narrate their recovery. This implies a specifically delimited research question which comes with specific limits as well as limitations.

A limitation, and at the same time a strength, of this study is that the focus is on the subjective experiences of the participants. Tozzi et al (2003) states that the limitation lies in the fact that it is common for individuals to create meaning out of their experiences and they may therefore develop plausible stories as a means to do this. This research does not lie within the realm of "fact" or certainty but rather attempts to answer questions about subjective experiences that cannot be thought to reflect the reality of all recovered anorexics and can therefore not be generalised. The strength however, lies in the fact that these stories, created for whatever purpose, provides valuable insights into recovery and gives voice to stories which have not previously been heard.

This study focuses on individuals who define themselves as recovered from anorexia outside of any kind of formal opinion or diagnosis regarding the status of recovery of each participant. Therefore, rather than assuming that participants are recovered because they say that they are recovered, this study focuses on the way that participants talk about recovery and how they narrate recovery. This raises the question whether or not recovery has actually been achieved. In other studies of a similar nature, the issue of to what degree the participants are recovered or how it was determined that the participants were recovered, and how this impacts on insights gained on recovery, does not seem to have been addressed (see for example Garrett, 1997; Woods, 2004; Weaver, Wuest & Ciliska, 2005). In this study, the researcher has attempted to remain transparently aware of the implications of having interviewed participants for a study on recovery, who identify themselves as recovered but who may not be recovered. This facilitates the exploration of the process of recovery without

foreclosing on the possibility of a gap between perception and reported experience, as other studies have done. A more detailed understanding of the process of recovery is therefore possible.

A further limitation is that while this study focuses on recovery in particular, the sample obtained consists of relatively young and recently recovered young women. Since relapse is a common occurrence in recovery from anorexia, it can be argued that there has not been a sufficient period of recovery for reflection. The sample obtained is representative of the stereotypical age of onset of anorexia. Research has indicated that age of onset is typically at 16 years of age and the recovery extends into the early 20s, after being ill for approximately 6 years (Wagner et al, 2006). After this period, the probability of successful recovering “decelerates” (p. 282). Therefore participants fit both age of onset as well as the age at which recovery is most likely to take place. This advantage may offset the disadvantages of researching a young and recently recovered sample.

Lastly, the sample consists of mostly white middle class participants who are not representative of the diversity of South African society. This may provide a somewhat limited perspective of recovery as, had other perspectives been included, the analysis could possibly have been different. Szabo & Holland (1997) conducted a study investigating the existence of eating pathology among secondary school girls in South Africa. The findings showed an overall prevalence figure of abnormal eating attitudes of 21.66% among the participants. Black pupils had a higher prevalence than white pupils (37.5% vs. 20.67%). A subsequent study conducted by le Grange, Telch & Tibbs (1998) in an effort to examine the presence and severity of eating disorder pathology in culturally diverse students, found that 9% of the participants showed anorexic-like behaviours. This was compared with western Caucasian samples which showed a prevalence rate of between 7% and 12%. Of interest was the ethnic diversity of the participants who scored within the clinical range. This indicates that both

black and white South African women experience significant weight concerns and suggests a changing sociocultural pattern of women presenting with eating disorders in this country (Ziervogel, 1995). Sampling procedures attempted to access different populations and age groups. The predominantly white, middle-class sample obtained is not at all representative of the many young women who struggle with this disorder. This was an unanticipated outcome. The sample size and composition limits the degree of generalisability of the study but is however acceptable as the purpose of this research is to capture depth and richness rather than representativeness.

1.5 OUTLINE OF CHAPTERS

The current chapter of the report serves as an introduction to the study and outlines the aims, rationale and structure of the research to be presented. This is followed in Chapter Two by an exploration of the literature on anorexia and recovery. The literature review provides a brief outline of the clinical definitions of anorexia as well as historical and current contributions to the understanding of anorexia. Perceptions on what cause anorexia and what it is like to be anorexic are also discussed. Lastly treatment issues and how recovery has been conceptualized are explored. These discussions provides a context for the study.

Chapter Three outlines the research method. Chapter Four presents the results of the analysis and is divided into stories of becoming anorexic, stories of being anorexic and stories of recovery which look at turning points, the process of recovery, treatment, staying well, the meaning of recovery and lastly how recovery in the present is narrated. The analysis raises the tension of recovery versus non-recovery and dissatisfaction with treatment versus resistance to treatment. It also highlights the tensions within the recovery process and how identification with the status of recovery is maintained by participants despite evidence to the contrary. The final chapter, the discussion, attempts to consolidate the analysis and discusses some of the implications in light of the issues raised.

Chapter 2: Literature Review

This chapter includes a discussion on both the historical and current clinical definitions of anorexia as well as issues regarding contributory factors, causes of anorexia from the perspective of patients, the experience of being anorexic and treatment. This is followed by a review of the literature, including debates regarding how recovery from this disorder is defined and research studies that aid the understanding of recovery from anorexia.

2.1 CLINICAL DEFINITIONS OF ANOREXIA NERVOSA

2.1.1 HISTORICAL CONTRIBUTIONS

Historically, clinical definitions of anorexia have encountered many debates. Current views of what might cause and maintain anorexia follow in this tradition and at present, there is considerable debate over how much of the known causes contributes to the development of anorexia and which should be given preference.

Anorexia is characterized by a profound disturbance of body image and the relentless pursuit of thinness, often resulting in starvation (The Diagnostic and Statistical Manual of Mental Disorders, APA, 1994). Two anorexia patient subgroups have been identified by consummatory behaviour: a restricting type, in which a relatively enduring pattern of dietary restriction is characteristic, and a binge eating type, in which episodes of binge eating and purging coincide with dietary restriction and subnormal body weight (The Diagnostic and Statistical Manual of Mental Disorders, APA, 1994). Self starvation was recognized as a clinical disorder in the 19th century although references to states of self-inflicted emaciation could be found in earlier literature (Bruch, 1973; Williamson, Martin & Stewart, 2004). The earliest report in medical literature called the condition “A Nervous Consumption” and described the patient as a “skeleton clad only with

skin" (Bruch, 1973, p. 211). In the late 19th century, Gull used the term anorexia nervosa to describe such patients, usually young women. The central symptoms of this condition were starvation associated with amenorrhea, constipation, loss of appetite, slow pulse and respiration and the absence of a somatic disorder (Bruch, 1973). At the same time, Lasegue reported on patients suffering from a condition he called "anorexie hysterique" which he believed was as a result of a hysterical disturbance (Ross, 1977, p. 418). At this early stage, controversy regarding the definitions and origins of this disorder flourished with Gull emphasizing a "central origin" while Lasegue emphasised the concept of a "peripheral disturbance" (Bruch, 1973, p. 214).

In the early 20th century, a pathologist, Simmonds, reported finding destructive lesions in the pituitary gland of an emaciated woman. This resulted in confusion as it was generally considered that anorexia was caused by psychological factors. A change in approach occurred and all cases of malnutrition were recognized as relating to an endocrine disturbance (Bruch, 1973). In the 1930's efforts were made to distinguish between a psychological anorexic condition and "Simmonds disease" (p. 214). This resulted in acknowledgement that anorexia was a condition that has a psychological origin (Bruch, 1973).

More recent contributions to the definition of anorexia include those by Selvini, Bruch, Crisp and Russell (Bruch, 1973). Selvini (1963, as cited in Bruch, 1973) argues that central to the condition is an overwhelming need to control the body which is experienced as threatening. What distinguishes anorexia from other forms of malnutrition and weight loss is a determination to starve the self despite an appetite and interest in food. Bruchs' formulations are comparable to the above as she considers that the primary motivator in this disorder is a relentless pursuit of thinness despite the presence of an appetite and desire for food. Crisp (1965, as cited in Bruch 1973) defines anorexia as a "weight phobia" while Russell (1970, as cited in Bruch, 1973) defines it as a "morbid fear of being fat" (p. 224). Various other formulations of anorexia have since been developed and

expanded upon. A range of psychological, family systems and sociological perspectives have been posited and each has put forward a theory regarding what is thought to influence the development of anorexia. In the following section sociological and feminist perspectives as well as family systems, cognitive behavioural and psychodynamic formulations will be briefly discussed.

2.1.2 CURRENT CONTRIBUTIONS

It is important to place the phenomenon of eating disorders within a sociocultural context considering that restrictive eating behaviours are most prevalent among young women in contemporary Western culture, although exposure to Western media is thought to have led to an increase in cases in non-Western societies (Nasser & Katzman, 2003). There are many culturally entrenched prescriptions regarding the female body which include negative attitudes towards being overweight and an idealization of thinness (Malson, 1998). Society's ever-growing obsession with thinness and the media and fashion industry's promotion of the "ideal" and "acceptable" body shape and size has influenced women to strive for these ideals. This obsession with thinness tends to promote the development of eating disorders (Nasser & Katzman, 2003). A concordant idealization of feminine beauty being represented by images of stick thin models and a rise in dieting articles have been noted. At the same time, since changes in attitudes to female body shape and dieting have occurred, so has diagnoses of anorexia increased (Malson, 1998). Research indicates that women diagnosed with anorexia are more likely to have frequent contact with cultural influences that promote weight-loss and slimness (Garner & Garfinkel, 1980).

Feminist views of eating disorders and recovery include recognizing the relationship between eating disorders and cultural trends and multiple role changes for women in Western societies. Writers from a feminist perspective suggest that societal changes have resulted in a greater range of opportunities for woman which have led to complex and contradictory roles that women are

expected to hold in a patriarchal society. There is an increasing demand on women to conform to a multitude of social personas and as a way of conforming to these demands, women may find consolation in disordered eating behaviour. This behaviour is then understood as a symbolic expression of the various ways that women are partitioned (Matoff & Matoff, 2001). The resulting insecurity underlies the anorexic drive for perfection and autonomy (Szmukler & Patton, 1995). The influence of diet and fashion industries cannot be underestimated but present evidence suggests that it is simplistic to consider this as sufficient in itself to cause anorexia.

The family systems account has provided important insights into the dynamics of families of eating disordered individuals (Eisler, 1995). Most theories of this orientation emphasise an overclose, overinvolved family that has high expectations for childrens' acheivements while failing to provide support for individuation and separation during adolescence. Minuchins' psychosomatic family arose out of clinical work with families of eating disordered patients. These families were found to be characterized by enmeshment, overprotectiveness, rigidity and a lack of conflict resolution (Minuchin, Rosman & Baker, 1978). Within such a family, relationhips are very close and intrusive while boundaries between the different subsystems within the family are often blurred. Therefore, a child from such a family is understood as somone who will have difficulty in developing and maintaining a separate and individual identity, who will distrust the legitimacy of their own feelings and rely on parental approval and thus will not be able to cope with the demands of adolescent development (Malson, 1998). According to this theory then, anorexia is seen as a solution to these interpersonal difficulties within the family, with anorexia becoming an effort to gain control over the body as a means of regaining control over the self and personhood (Swartz, Thompson & Johnson, 1985). Consequently, family systems theories locate anorexia within a conflicted and dysfunctional family system.

Another aspect of family dysfunction which has received attention is the issue of childhood sexual abuse. Malson (1998) and Wilson, Hogan & Mintz (1992) cite studies which have reported a high rate of childhood sexual abuse in women who have been diagnosed with eating disorders. Unwanted sexual experiences have also been associated with eating disordered behaviours although it has been suggested that there is a relationship between past sexual abuse and severity of eating disorder rather than type of eating disorder. Malson (1998) cautions that to suggest a causal relationship between eating disorders and childhood sexual abuse is problematic as not all of those individuals who have been abused go on to develop eating disorders and not all those individuals who are diagnosed as eating disordered report a history of childhood sexual abuse.

Cognitive theories of anorexia suggest that biases in thinking and perception contribute to the development and maintenance of abnormal eating behaviour. The role of intense fear of weight gain and body image disturbance which results in behaviours aimed at achieving weight loss and maintaining low levels of weight is emphasised. These behaviours are reinforced when a reduction in anxiety or stress associated with the intense fear of weight gain is achieved through abnormal eating behaviours. Cognitive perspective also takes into account personality characteristics such as perfectionism, interpersonal stress, cultural pressures to be thin and body image disturbances and how these interact with one another (Williamson, Martin & Stewart, 2004).

Rather than placing importance on overvalued ideas about body shape and weight, Fairburn, Shafran & Cooper (1999) propose that the central feature of anorexia is an extreme need for self-control. This is related to a sense of ineffectiveness and perfectionism, which interacts with low self-esteem. Control over eating gains prominence because it is the one area where direct and immediate evidence of self-control can be achieved. They further propose that once attempts to restrict eating begin, they are reinforced through feedback mechanisms and as a result the disorder becomes self-perpetuating. Firstly, control over eating directly increases a sense of being in control and as a result

increases feelings of self-worth. Secondly, feelings of hunger may be perceived as a threat to self-control which further exaggerates the tendency to use control over eating as a sign of self-control and self-worth. Lastly, particularly in Western society, control over eating, shape and weight is used as an indication of overall self-control (Fairburn, Shafran & Cooper, 1999). Therefore the need for self-control forms the basis of anorexic behaviour from this theoretical perspective.

Various psychodynamic models have been formulated to explain the causes of anorexia (Steiger & Israel, 1999). Bruch (1973) postulated that anorexics have failed to learn autonomy and experience difficulty differentiating between their own needs and desires, and those of their mother. This takes place very early on in the mother-child relationship where the mother fails to respond appropriately to her infant's needs and instead projects her own needs onto her infant which results in major ego deficiencies. The result is a child who is not able to trust in the validity of her own self-perceptions and who becomes confused about appetite and satiety (Malson, 1998). This translates to a child who is not able to recognize hunger as an indication of nutritional need (Chassler, 1994).

Wilson, Hogan & Mintz (1992) argue that anorexia is a manifestation of unresolved oral-phase conflicts which result in an ambivalent relationship with the mother. Maternal over-control and overemphasis on food, and eating functions which come to symbolise love, causes fixation in this phase of development. Furthermore, pressure of repressed, unsublimated, aggressive and libidinal drives, conflicts and fantasies play an important role in the aetiology of anorexia. Drive eruptions are feared but intact ego controls result in total impulse control brought on by archaic superego demands. The fear of a loss of control and therefore becoming fat, is the conscious fear of eating while the unconscious fear is one of becoming overwhelmed by impulses. Therefore, a fear of becoming fat masks a terror of cannibalising and fusing with the object. Wilson, Hogan & Mintz (1992) further state that a multitude of feelings are generated when difficulty in relationships are experienced. These include feelings of helplessness,

rage, frustration, the need to be cared for, separation anxiety and the need to be punished. Because of a fear that the conflict cannot be coped with, the individual displaces the conflict onto food. An inability to control relations with people is transformed into attempts to control food.

From an object relations perspective, Lawrence (2001) argues that the anorexic's assertion of control over weight and eating can rather be viewed as an internal situation, between herself and family which she is seeking to control. Anorexic symptoms are seen as an effort to reinforce phantasies of control of the internal parents and their relation to one another, a feature of Klein's view of the manic defence against the pain associsted with the reality of the oedipal situation (Lawrence, 2001). Individuals with anorexia confirm a phantasy of being able to be in control of the formation and maintenance of the internal arrangement of their objects and their relationships to one another in the mind by maintaining particular control of what they take in (Lawrence, 2001). Other authors have focused on the "symbiotic-like attachments" anorexics have with their parents and disruption in the seperation-individuation process (Chassler, 1994, p. 404). Palazzoli (1978, as cited in Chassler, 1994) suggests that attempts to separate from a bad introject which has become fused with the body self results in control of the body and consequently, in self-starvation. Another view is that anorexia is a defence against an abandonment depression which would surface if seperation was attempted. Lastly, Johnson and Conners (1978, as cited in Chassler, 1994) state that anorexics believe that their attempts to separate will result in punishment or retailiation. Therefore, in order to protect themselves from intrusiveness, a paranoid defence is created in which fat becomes the symbolic focus and the distortion of body image results in a particular psychological organization which provides the individual with a sense of autonomy and control.

The most commonly accepted psychodynamic aetiological theory emphasises deficits in autonomy, self-regulation and identity and their role in predisposing an individual to maladaptive eating behaviours. The development of anorexia is seen to be related to a failure in formative relationship experiences which result

in self and relational deficits. Anorexia serves to create an artificial sense of self control and replaces the striving for stable and mutually satisfying relationships with an intense relationship to the body. The body then, becomes the location for an assertion of independence and mastery and restrictive eating behaviours becomes a means of taking control of the body and what goes into it as an effort to achieve autonomy (Lawrence, 2001; Steiger & Israel, 1999). Psychodynamic theories thus see anorexia as a solution to internal disturbances which have their origin in a dysfunctional mother-infant relationship.

All of these definitions and formulations have made important contributions to the understanding of anorexia as a clinical disorder. How anorexia is understood remains a matter of debate and there exists a lack of agreement regarding the causes and maintenance of this disorder (Jansen, 2001). It is clear that no single cause for anorexia exists and that it is much more likely that anorexia stems from a combination of social, psychological and biological factors. Within this substantial body of research regarding how anorexia develops and is understood, it is striking that there is an absence of studies which include stories of the anorexic's perceptions of how they understand anorexia and what particular dynamics they consider important in the development of their symptoms.

2.2 ANOREXIC PERSPECTIVES: CAUSE AND SELF NARRATIONS

Each of the explanatory models discussed above assume that the discovery of the cause of anorexia will suggest the best course of treatment. While it is now widely accepted that anorexia is multi-determined, an emphasis on aetiology remains and evidence from recovery, or understanding the solution, remain largely ignored (Garrett, 1998). Garrett (1997) suggests that a model which seeks causes and evaluates treatment in an effort to determine recovery is problematic. Rather she suggests that it is in the stories of causes that hold the most significance to recovery.

Way (1993) maintains that women turn to weight loss strategies to gain control in the face of overwhelming pressures and demands. She associated triggering factors with the onset of anorexia which her respondents identified as the break-up of relationships, craving attention, job pressures, starting college, a geographical move, loss, marriage and rape or sexual abuse. Woods (2004) conducted a study of recovery from adolescent onset anorexia without formal treatment. In terms of what respondents perceived to be related to the development of their symptoms, they indicated that for them becoming thin to gain attention, to compete and to be admired were important reasons for their initial weight loss. This can be located in a culture which places pressure on adolescents to perform and excel in all spheres of life and can be understood as a means to conform to societal pressures.

Various other studies have been conducted in order to gain insight into anorexics own perceptions of what contributed to them becoming anorexic (for example see Beresin, Gordon & Herzog, 1989; Tozzi et al, 2003). They identified family conflict, intrusive mothers and mothers who were excessively preoccupied with appearances as contributing to the development of anorexia. Fathers, who were perceived as distant, over-involved with work and who abused alcohol were also implicated. Other women linked the onset of their disorder to distressing romantic experiences, although the nature of these experiences were not elaborated on. Other perceived causes include dieting that became out of hand, stress from various sources, inappropriate comments from others, needing to be in control and weight and food issues within the family. Many of the participants in the Beresin study (Beresin, Gordon & Herzog, 1989) indicated that anorexia was a way to “stop time from moving forward” and often became anorexic at times of transition such as moving to college or separation from family (p. 113). They argue that young women who develop anorexia have profound deficits in the cohesiveness of their selves and struggle to negotiate adolescent tasks. Tozzi et al (2003) suggest that it is human nature for individuals to try to make meaning of their experiences. They go on to say that “individuals often try to give meaning to

experiences in their life and may grasp onto stressful experiences for their explanatory power in creating a plausible story for why they developed an eating disorder" (p. 151).

Way (1993) states that anorexic women often define themselves through their anorexia such that anorexia and identity become intrinsically enmeshed. Taken from this viewpoint, anorexia becomes a way for women to differentiate themselves as human beings and find their own unique identity. Way (1993) warns however that the messages that women are communicating through anorexia are very different and cannot be grouped together under one classification as the individuality of the particular person is lost and this perpetuates the problem of unindividuated self-identity. One way to define oneself through anorexia is to equate self-worth with weight loss (Weaver, Wuest & Ciliska, 2005). The more weight that is lost, the more satisfaction is gained from being able to achieve what others cannot, which is starvation. Many individuals see anorexia as an accomplishment rather than an affliction (Vandereycken, 2006). Because anorexia provides a sense of uniqueness, it is very difficult to separate out identity from anorexia. This being the case, the sense of self is threatened by the possibility of losing the anorexia, particularly in the face of forced treatment.

Tan, Hope and Stewart (2003) found that anorexia in relation to identity was narrated by participants in the following ways:

1. Anorexia is considered as something which had become a part of themselves.
2. Anorexia was conceptualised as an entity which resides inside of themselves.
3. Anorexia could be viewed as inhabiting a part of the mind or body.
4. Anorexia was considered a personality style or a behavioural strategy.

5. Anorexia could be experienced both as a distinct entity and as a part of their minds or themselves.

They argue that although the characterisations of anorexia vary, the participants in the study generally described an altered way of functioning which was both related to but often different from the prior personality. These descriptions of anorexia are not just descriptions of typical symptoms and therefore anorexia is not seen only as consisting of difficulties with issues such as weight loss and fear of fatness but also as having unique consequences on the individual's general personality and style of functioning (Tan, Hope & Stewart, 2003). Therefore, these authors state that it is difficult for many young women suffering from anorexia to imagine a future without anorexia as it represents "something quite distinct, with new and additional features such as a strong drive to achieve, preoccupation with food, and control of themselves" (p.10).

In a study conducted by Malson et al (2004) into patient accounts of treatment, although patients often made references to themselves as having an eating disorder, patients frequently referred to themselves as "normal" and "problem free" (p. 479). Such constructions could be interpreted as denial of any illness but could also imply that treatment is thus unnecessary and inappropriate. The authors further state that it was common for participants to provide multiple and conflicting self constructions which incorporated accounts of themselves as normal and healthy as well as anorexic and ill. Attempts to interpret "true" self perceptions could conceal the complexities of these "multiple, shifting and often contradictory self constructions" (p. 479). An explanation of patient resistance to treatment based on the idea of "unitary self perceptions" is therefore problematic because participants adopt multiple self constructions with regards to their diagnosis and their treatment (p. 480).

Individuals with anorexia also often resist being constructed in particular ways by those involved in their treatment. Resistance is particularly strong to being

defined in terms of their illness, at the exclusion of more individualized knowledge and the potential meaning of their particular symptoms (Malson et al, 2004). It is the particular pathologized version of themselves which is rejected and this may suggest that treatment resistance may be an objection to a "depersonalized and unindividuated construction" of a patient as only being anorexic (p. 482). The issue of power relations is also significant because when a patient is viewed as pathologized and behaviour is interpreted merely on the basis of it being a manifestation of the disorder, patients become disempowered participants of treatment as everything they do and say can be attributed to their illness. This self-construction can not only be attributed to those who work with patients but is also at times a self-construction, where patients themselves describe being "one hundred percent anorexic" (p. 483). This self construction then excludes the possibility of recovery.

2.3 TREATMENT OF ANOREXIA NERVOSA

Anorexia remains resistant to a wide range of interventions and most patients either avoid treatment completely or only reluctantly agree to treatment. A variety of eating disorder treatment approaches have been developed in in-patient, out-patient, community-based, specialist and non-specialist settings. These approaches include pharmacological, behavioural and cognitive-behavioural practices, family therapies, individual, group and feminist psychotherapies and multi-dimensional approaches (Malson et al, 2004). These approaches are linked to specific ways in which eating disordered behaviour is understood. Anorexia remains notably resistant to a wide range of interventions with no psychological or pharmacological intervention proving to adequately alter dysfunctional thinking and eating behaviours. The seriousness of anorexia suggests a protracted course of illness which requires the management and treatment of this disorder by a multi-disciplinary team; which is found to be more effective (Matoff & Matoff, 2001; Ziervogel, 1995). In this section various aspects of formal treatment is

briefly discussed with particular emphasis on the patients' perspective of treatment.

Many research studies have attempted to access the efficacy of a range of interventions. The results of these studies vary but suggest that long-term outcome is often poor, with interventions demonstrating limited success of recovery. Relapse of recovering anorexics is also common; some patients go on to develop bulimic symptomatology, continue to struggle with psycho-social difficulties or die from starvation or suicide (Hsu, Crisp & Callender, 1992; Malson et al, 2004). The ability to treat the disorder effectively remains elusive (Tozzi et al, 2003).

Seldom is the patient's experience of treatment considered when evaluations of existing treatment programmes are undertaken. le Grange and Gelman (1998) undertook a study to determine what an eating disordered patient's perspective was of what were helpful as well as unhelpful components of treatment that they completed. Patients in this study completed either cognitive behavioural therapy or family counselling. Changing dysfunctional beliefs, a supportive and understanding environment and psycho-education were identified by patients as helpful elements of treatment. Those patients who received cognitive behavioural therapy specified behavioural strategies as beneficial while those who received family counselling perceived the therapist's firm attitude as valuable. Criticisms common to both treatment practices were that patients felt that they failed to adequately address personal problems and feelings which they believed were perceived by clinicians as secondary to eating behaviour. Although behavioural techniques were identified as helpful, a significant proportion of patients, particularly those who were more severely ill, identified it as unhelpful. The unhelpful components were identified as food monitoring and the prescriptive nature of the interventions. These results show that patients perceive themselves to have unique therapeutic needs that may be overlooked when prescribed treatments are strictly adhered to (le Grange & Gelman, 1998). This relates to the

findings of Maine (1985 as cited in Jarman & Walsh, 1999) and Morgan (1988 as cited in Jarman and Walsh, 1999) who argue that a feeling of control over the process of treatment is especially important in facilitating the recovery process.

Researchers have attempted to identify clinical features of typical patients who present with anorexia in an effort to determine how these features affect treatment outcomes. These studies have indicated that patients overestimate their body size, deny their problem or take pleasure in or feel ambivalent about their anorexic status and often refuse treatment for the disorder (Ballot et al, 1989; Malson et al, 2004). Based on these characteristics, significant discrepancies may exist between the perspectives and goals of patients and clinicians.

Patient dissatisfaction with available treatment approaches has been documented although scant attention has been paid to patients' perceptions of treatment. Eivors, Button, Warner & Turner (2003) argue that treatment practices may result in patients feeling powerless. These feelings of powerlessness may possibly have played a role in the development of eating disordered behaviour in the first place. Treatment may then unintentionally contribute to the maintenance of the behaviour that clinicians want to alter. Anorexic patients are often excluded from negotiations regarding treatment as all resistance or ambivalence is viewed in terms of being symptomatic of the disorder (Malson et al, 2004). This dissatisfaction suggests that attention to patients' perspectives on recovery and treatment is significant to improve services to eating disordered patients (Malson et al, 2004).

Patients with anorexia often reject treatment with the same intensity that they reject food (Malson et al, 2004). Poor treatment outcome is often attributed to patient resistance to treatment, with resistance to treatment commonly being defined as an integral feature of anorexia itself. Anorexic patients are often described as "hostile, oppositional, impervious to treatment, uncooperative,

untrustworthy, untrusting, frustrating and difficult to treat" (Malson et al, 2004, p. 476). This negative characterization of patients means that any conflict between patients and those involved in their treatment is conceptualised in terms of patient characteristics. Patients often provoke negative feelings in those who work with them but research remains focused on treatment outcomes instead of on ways in which eating disorders are experienced.

Fenning, Fenning & Roe (2002) suggest that there is a gap between physical and psychological recovery which is exaggerated by the modern therapeutic models which emphasise the physical aspects of the disorder. Much emphasis is placed on food, eating and body weight which may confirm anorexic pre-occupations and behaviours (Malson et al, 2004). Attention to studies which focus on recovery may then be useful in determining suitable treatment approaches which take into consideration both physical and psychological factors.

2.4 RECOVERY FROM ANOREXIA NERVOSA

Recovery from anorexia is estimated to be between 17 to 77% while mortality rates are estimated to be between 5 and 8% (Garrett, 1996). A further breakdown by Burns and Crisp (1984, as cited in Garrett, 1996) suggest that 44% of anorexics obtain a good outcome, 26% an intermediate outcome and 30% a poor outcome. Furthermore, it is suggested that 30-50% of patients relapse, with 75% of the relapses taking place within the first year of discharge from hospital treatment (Fenning, Fenning & Roe, 2002).

Although it is agreed that there is severe morbidity and mortality of patients with anorexia, very modest efforts have been made into the exploration of recovery from this disorder. Notably absent in literature regarding anorexia are qualitative studies addressing the experience of anorexia and the recovery process from the patient's perspective. Few then offer a comprehensive description or in-depth analysis of how recovery from anorexia actually takes place (Garrett, 1998). This experience and process of eating disorder recovery has the potential to be an

important source of information and insight for professionals who work with these patients in therapeutic settings. Subjective accounts may provide new understandings and lead to the formation of more effective treatment strategies (Matoff & Matoff, 2001).

The diversity of views and opinions within the literature on eating disorders reduces the potential usefulness of these viewpoints when determining what it means to be recovered from an eating disorder (Jarman & Walsh, 1999). While definitions of recovery vary, recovery is mainly evaluated through the presence or absence of symptoms and rarely includes physical, cognitive, emotional and social criteria (Jarman & Walsh, 1999; Bachner-Melman, Zohar & Ebstein, 2006). No holistic theory of recovery exists; the most popular criteria for defining recovery from anorexia for research purposes is the attainment and maintenance of acceptable body weight and the resumption of menstruation (Jarman & Walsh, 1999; Weaver, Wuest & Ciliska, 2005). Notably absent from outcome studies are positive outcome indicators or factors that are most likely to assist in the recovery from anorexia (Garrett, 1998). A focus on only the physical aspects of change is limiting as individuals considered to be recovered from the physical features of anorexia often continue to display and experience distorted attitudes to food, eating and weight and may display residual behavioural and attitudinal characteristics of the disorder (Jarman & Walsh, 1999). Thus, the importance of psychological aspects of recovery needs attention.

Recent psychological definitions of recovery include the absence of any pathological disturbance in body image, reductions in fears of becoming fat and preoccupation with food and appearance in addition to physical recovery. Assessment of recovery can be further defined. Recovery can be extended to include resumption of healthy social contacts, social adjustment, educational adjustment and/or vocational adjustment. The difficulties in evaluating the psychological and social aspects of recovery have meant that they are often

excluded from definitions of recovery that are used in the majority of research studies (Jarman & Walsh, 1999).

Studies have been conducted to examine and explore important elements in the recovery process. There is recognition that the process of recovery may involve particular stages or turning points which can be identified (Matoff & Matoff, 2001). Due to the limited nature of current treatment practices, Tozzi et al (2003) suggest that insights can be gained through investigations of what life experiences patients perceive to have played a substantial role in recovery. Among the Beresin sample, women viewed therapy as useful in assisting them to deal with emotions (Beresin, Herzog & Gordon, 1989). As important as therapy were life events such as separation from the family, work or school and engagement in meaningful relationships. Supportive relationships were also found to play a role in the positive outcome of anorexia in the study conducted by Tozzi et al (2003). The relationship was with either a partner or a therapist. Thus, the role of a therapeutic relationship in the outcome of anorexia cannot be underestimated and may be one of the important factors affecting recovery. Some patients reported that they "matured out of the disorder" while others indicated that becoming pregnant or wanting to start a family initiated the recovery process (p. 151). Woods (2004) conducted a study of untreated recovery from anorexia with adolescent onset. Turning points in the initiation of their recovery included empathetic support from a mother, an emotional plea from a father, partners, dental and gastrointestinal difficulties and constant fatigue leading to loss of performance in academic and physical tasks. Those that reported early parental involvement had the shortest disorder duration and most complete recovery.

Hsu, Crisp & Callender (1992) documented the process of recovery from anorexia using a sample of British women who had previously been diagnosed with anorexia and who were traced after 17 to 44 years from the onset of their illness. They identified factors such as personality strength, a move from a

destructive environment, satisfactory relationships, unconditional acceptance, therapist patience and self readiness as important factors influencing the course of the participant's recovery. Unexpectedly, fear of hospital treatment seemed to have led to lasting change in eating behaviour for three of the participants. Hsu, Crisp & Callender (1992) emphasize that these identified factors are difficult to operationally define as they have different meanings for different patients but none-the-less provide valuable insight into what may facilitate change and help patients recover from this illness.

Of the studies conducted, Hsu, Crisp & Callender (1992) seem to be the only researchers who ask the question "Are these patients truly recovered?" (p. 348). To answer this question they drew on aspects of recovery such as weight and menstrual status, restrictive eating practices and whether there was a diagnosable psychiatric disorder at follow-up. They do not answer this question satisfactorily as the reader is left uncertain as to whether the question of complete recovery can be answered with a clear cut "yes or no" reply. Beresin, Gordon & Herzog (1989) leaves the question of complete recovery in the hands of the participants. Half reported that they believe that full recovery is possible while the remaining half compared anorexia to alcoholism in that it is a life-long illness that can be controlled rather than alleviated. Results from the study also indicated that remnants of anorexia of recovery remain: all participants reported excessive concerns with about weight and food. Other ongoing features included some degree of poor self-esteem, sensitivity to rejection and a tendency to return to old previous ways of thinking when under pressure. Woods (2004) found that respondents who described themselves as recovered reported a persistence of certain cognitive aspects of the disorder. These included feeling "too full" after having consumed a large meal, with corresponding feelings of anxiety and the urge to purge. This could be counteracted by positive self dialogue and an increase in exercise. Furthermore, for most, being a heavier weight and having to wear a larger clothing size was difficult to accept.

It would seem that whether participants are regarded as recovered or not is reliant on the criteria used by the researchers which in many cases is not made explicit. Windauer et al (1993) investigated the recovery status of 16 weight-recovered anorexic patients and found that patients continued to display a host of behavioural and psychological features of anorexia including excessive preoccupations with weight, shape and food. These findings correspond to those found in the other studies and highlight the difficulty in defining recovery comprehensively, a definition which includes persisting difficulties with weight, shape and food and other residual symptoms. Furthermore the lack of transparency with regards to the recovery status of participants indicates that the findings need to be interpreted with caution.

Non-clinical studies and autobiographical accounts of recovery have also attempted to describe turning points, stages and the process of recovery. Many of the authors write from their own experience combined with that of conversations with other recovered anorexics. In this way, the healing process is described in such a way that has not previously been heard in clinical research (Garrett, 1998). Many of these accounts include women who have not relied on therapeutic methods for recovery but rather have developed their own strategies to aid healing. Garrett (1998) states that while these phenomenological studies are sources of rich material to aid in the understanding of recovery, none have yet developed a theory to describe the self-transformations that they describe. Instead of determining criteria for recovery, Garrett (1998) identifies “fundamental elements” of recovery which were agreed on by the participants in her study (p. 67). These factors included:

> “(a) abandoning obsession with weight and food
> (b) strongly believing that they would never go back to starving, bingeing or purging
> (c) developing a critique of social pressure to be thin

(d) having a sense that their lives were meaningful – existentially or spiritually

(e) believing they were worthwhile people and that the different aspects of themselves were part of a whole person

(f) no longer feeling cut off from social interaction" (p. 67).

Besides the above elements, participants indicated that "feeling normal" in terms of eating and living in a way that was comfortable and different from a previous anorexic lifestyle is what recovery meant for them (p. 186). Furthermore, believing that their life had meaning was another important change. Garrett (1998) asserts that the more stories of recovery become available the more likely recovery becomes in reality.

As individuals recover, they engage with themselves and the world in ways that sustains recovery. Some of the respondents in the study conducted by Woods (2004) indicated the importance of sustained support from a significant person in their lives while others suggested that wanting to experience an authentic life as a most helpful aspect in sustaining their recovery. Lastly, the prescription of anti-depressant medication was found to have a positive impact on subsequent recovery. Garrett (1997) found that participants made use of a variety of practices such as meditation or yoga, involvement in artistic pursuits and physical rituals such as gardening and walking. Eating disorder recovery can be seen as a process over time, with turning points and stages, rather than as a measured outcome at one particular moment. For some, turning points often involve a decision that represents a choice between life and death (Garrett, 1997).

Although physical health can be restored and sustained in the short-term with nutritional intervention, some patients may experience an extended struggle to restore social and emotional well-being, positive self esteem and lasting confidence in daily life (Matoff & Matoff, 2001). Rates of relapse in individuals with eating disorders ranges from 22 to 51% and is a significant problem (Keel et

al, 2005). The results of a study conducted by Keel et al (2005) showed that one third of the participants who had recovered from an eating disorder relapsed. Of interest, women who recovered from anorexia often relapsed into bulimic syptomology. The continued presence of cognitive features of anorexia was related to relapse as was poor psychosocial functioning and the severity of Axis II pathology.

Keel et al (2005) states that studies on relapse suggest that relapse is relatively uncommon after a period of sustained recovery. The continued presence of symptoms could therefore imply that individuals are not in fact recovered but it has been demonstrated that in recovered individuals, concerns regarding weight, body shape and food exist even after many years. This continued presense of symptoms may make it difficult to define what it actually means to be recovered and while some anorexics define themselves as recovered, others prefer to think of themselves as in recovery as different aspects of the disorder persist over their lifetime. Just as recovery is difficult to define, so is relapse.

The above studies have shown that a wide range of factors play a role in recovery. However, they do not seem to come to a clear understanding of the process. Greater understanding of the process of recovery, possibly gained from more narrative forms of research, can offer more detailed understandings of the process, rather than isolated elements within recovery (Garrett, 1998). Attention to sources of recovery and the process of recovery when designing treatment interventions for patients with anorexia may be beneficial. Another problem is the definition of recovery; literature shows that recovery is defined differently by different researchers and the definitions used are rarely made explicit. This lack of consistency raises questions as to the validity of findings with regards to the experience of recovery and leaves us with an uncertainty regarding what needs to happen for someone to recover from anorexia and how recovery can be characterized (Weaver, Wuest & Ciliska, 2005). As many complexities exist in terms of aetiology and treatment practices, it would seem that the issue of

recovery offers further challenges to those wanting to understand what it means to be recovered from anorexia.

Chapter 3: Method

"When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they are revealing truths. These truths don't reveal the past "as it actually was", aspiring to a standard of objectivity. They give us instead the truth of our experiences. Unlike the Truth of scientific ideal, the truths of personal narratives are neither open to proof nor self-evident. We come to understand them only through interpretation, paying careful attention to the contexts that shape their creation and to the world views that inform them"

Personal Narratives Group (in Plummer, 1995, p. 167).

3.1 THE RESEARCH QUESTION

The primary research question of this study is the following:

How do young women narrate their journey of recovery from anorexia nervosa?

In order to answer this question the research focused on the following essential narratives:

1. How young women understand the development of anorexia
2. How young women understand themselves as anorexic
3. How young women narrate the process of recovery
4. How young women define recovery
5. How young women narrate their experiences of treatment

The focus on the above allowed for a coherent narrative to emerge of the experience of anorexia and subsequent recovery. Of interest was how the stories developed over the course of the accounts provided in the interviews and how these separate but related narratives became linked together to form a coherent and meaningful story.

3.2 RESEARCH PARADIGM

Due to the exploratory nature of this study this research study is located in a qualitative paradigm. Qualitative inquiry has to do with the study of experience from the perspective of the individual. This approach is based in a paradigm of personal knowledge and subjectivity, and emphasises the importance of personal perspective and interpretation. Therefore, such an approach provides a powerful means to understand subjective experience and gain insights into individuals' motivations, actions and experiences (Lester, 1999).

Qualitative methods are particularly effective at bringing to the fore the experiences and perceptions of individuals from their own perspectives (Lester, 1999). The method of data collection in this study was through the use of semi-structured interviews. The interview guide reflects minimum structure and maximum depth to maintain a balance between a focus on the research aims and avoiding undue influence by the researcher. The qualitative nature of the research did not limit the discussion and allowed for themes to emerge from the participants' accounts.

3.3 RESEARCH PARTICIPANTS

Participants were accessed through posters and advertisements calling for research participants (see Appendix A). Posters were displayed on notice boards throughout the University of the Witwatersrand, adverts was placed in You magazine and student newspapers at the University of Johannesburg and the University of the Witwatersrand. The non-probability sampling procedure of volunteer sampling was used in this study. Strydom & Delport (2002) warn that there is usually no way of finding out how those individuals who volunteered are different from those who didn't and because participants are self selecting, their motivations for participation are often unclear. However, volunteer sampling was considered appropriate as there were ethical constraints to approaching treatment facilities and therapists for referrals.

Out of the twelve the potential participants who contacted the researcher, nine expressed interest in participating after having been given information about the study and were subsequently interviewed. Although a larger sample may have elicited further meanings and assumptions related to the study, the nine interview transcripts were evaluated for richness of data and were considered to provide the necessary depth to meet the research aims. The amount of data obtained from narratives was sufficient for data saturation to occur and for the analysis to be meaningful. Further interviews were therefore deemed unnecessary. The belief is that the experiences of the nine participants are valuable and important in understanding the nature of recovery.

The primary inclusion criteria was that participants considered themselves recovered from anorexia. However due to the prevalence of females with the disorder and the possibility that there would be different issues involved for each gender, the study was limited to female participants. Six of the participants had been diagnosed as “anorexic”, while three participants had self-diagnosed. Three participants had previously been hospitalized for their eating disorder, three others had sought psychological and medical assistance, one had sought medical assistance only while the remaining two participants had not sought any treatment during the course of their illness. One of these participants is currently engaged in psychotherapy. Four of the participants reported binge-eating/purging type anorexia while five reported restricting type anorexia. All of the participants in the sample were female. They ranged between 18 – 27 years in age, although the mean age was 21 years old. Six of the participants were from white middle class backgrounds, one participant was coloured and the other of mixed race. One of the participants lived with a partner, three others were involved in a relationship while the remaining five participants were single. Three of the participants were employed while six were students studying in various fields. All but two of the participants had pursued post-Matric qualifications.

3.4 INTERVIEW PROCEDURE

This research made use of semi-structured interviews for data collection. The semi-structured interview can be described as a guided interview where the researcher uses predetermined questions to direct the conversation (Tutty, Rothery & Grinnel, 1996). The main advantage of this method is that the researcher can approach the world from the subject's perspective by using unscheduled probes that arise from the interview process itself (Berg, 1998). Miller and Glassner (1998) warn that during interviews participants may at times respond with familiar narrative constructs rather than provide meaningful insights into their subjective view.

Based on a review of the literature and previous studies conducted in this area, a qualitative, open-ended interview guide was developed for this study (see Appendix B). The interview guide covers three broad areas; the beginning of the participants' anorexia, their history of previous interventions and thirdly, their views on the process of recovery. These questions are in line with the broader research aims. The questions utilized in this study have not been tested in larger samples for reliability or validity purposes. The semi-structured interview method was chosen to encourage the participants to disclose the meanings they personally attached to their experiences of anorexia and recovery. The interviews were designed to resemble a conversation rather than a set number of questions and answers to facilitate the description of "events, perceptions and experiences in their own words" (Woods, 2004, p. 362). The use of autobiographical accounts and semi-structured conversations was particularly appropriate to the undertaking of understanding narratives of recovery as this type of reflection is a means through which individuals create meaning of their experiences (Garrett, 1996).

Potential participants were required to contact the researcher telephonically if interested in participating in the study. When contacted the researcher provided potential participants with a brief summary of the aims of the research and what

their participation would entail. This verbal description of the study included that the focus of investigation was on recovery from anorexia and that they were requested to consent to an interview where they would be asked questions about their experience of recovery. Potential participants were informed that participation was entirely voluntary and that their confidentiality would be maintained. Participants were then requested to consider if they were interested in participating and for those who indicated that they would, an interview was scheduled at the University of the Witwatersrand. Of those potential participants who declined to participate, justification was not sought in keeping with the right to voluntary participation.

At the time of the interview, participants were provided with the participant information sheet (see Appendix C) which outlined the rationale for the research and the purpose and procedures of the study. Furthermore, an explanation of the guarantees of confidentiality and the voluntary nature of participation was once again provided. Participants were made aware that the interviews would be recorded, that the data they provided would be analysed and subsequently used in the write-up of the research results. Participants were also informed that they could access the research results in the form of a research report in the William Cullen Library at the University of the Witwatersrand. Each participant signed a consent form agreeing to participation in the study as well as a consent form for the audio-taping of the interview (see Appendix D and E). Thereafter, participants were asked basic demographic information before continuing with an interview on their experiences of recovery from anorexia.

Mishler's (1986) work on research interviewing was influential in the way that interviews were approached in this study. Firstly Mishler argues that the interviewer needs to be aware of their role in the production of a story and secondly to recognise that they are the audience to whom the participant is portraying themselves in a specific manner. Therefore the way that the interviewer interacts with the participant plays an integral role in the way that a

story is told. The telling of stories was facilitated by using a semi-structured interview schedule which encouraged participants to “control the introduction and flow of topics” and extend their responses where necessary, without interruptions (Mishler, 1986, p. 69). Minichiello, Aroni, Timewell & Alexander (1990) states that story-telling can be encouraged by showing receptivity to listening to the story. Askham (1982 as cited in Minichiello et al, 1990) states that this can be achieved by “showing a lack of hurry, by engaging in preliminary chatter oneself, and by appearing to enjoy any detailed accounts from the start of the interview” (p.118). The researcher also paid specific attention to the role of listening, encouragement, interruptions, the initiation and termination of topics of conversation during the interviews and as far as possible attempted to reduce the influence of these interactions on the way stories were told.

Interview length varied from one to two hours. At the end of the interview participants were asked if they had any questions and whether they had anything further to add. They were also encouraged to contact the researcher with any questions, suggestions and thoughts they may have had regarding the interview. Furthermore, a list of recovery resources were provided to the participants for their interest.

On completion of the interviews, they were transcribed verbatim into a word processor. Relevant non-verbal communication was added as well as overall impressions of the interview and interactions between myself and participants. The resulting transcripts were analyzed using narrative analysis.

3.5 DATA ANALYSIS

3.5.1 Narrative Analysis

The data was analyzed using a narrative analysis of the transcripts resulting from the interviews. Narrative analysis takes as its target of investigation the story

itself and, because the approach gives prominence to human agency and imagination, it is particularly compatible with studies of subjective experience (Riessman, 1993). An interpretation of a narrative relates the lived experience of the narrator and considers people to use narratives to create versions of themselves or their subjectivity. The analysis of a narrative does not fully reveal what an individual actually thinks or feels because any truth is merely a construction, and narratives are skilfully composed to produce versions of the self that serve specific purposes (Redwood, 1999).

3.5.2 Process of Analysis

On completion of the transcripts, they were read and re-read. After the reading of the entire story, each was summarized so that a “holistic-content picture” could be formed (Lieblish, Tuval-Mashiach & Zilber, 1998, p. 62). The focus at this stage was on tracing the unfolding recovery story from how participants believed they became anorexic to how they came to believe that they are recovered. Similarities and differences between the different stories were noted. Within the stories, contradictions, unfinished descriptions, difficulties in expressing oneself and emotional tone was also noted.

Through this process, topics and themes became apparent which were stimulated by prior theoretical knowledge and fore-structures of interpretation (Riessman, 1993). These themes included becoming anorexic, being anorexic and recovery. Within recovery further sub-themes were identified which include turning points, process of recovery, staying well, meaning of recovery and personal recovery. Once these themes were identified, the analysis turned to exploring how participants narrated these particular stories. The transcriptions were once again read and re-read and the data was then reduced to the core narratives, related to the abovementioned themes, using a qualitative analysis software package. This involved a selection of key aspects of a longer narrative. Lastly, to check for credibility the draft analysis was discussed with the research

supervisor who provided suggestions and alternate perspectives on the interpretations made.

The features of the narrative account that the researcher chose to write about were inexplicitly linked to the research question and my theoretical orientation (Riessman, 1993). Riessman indicates that through a process of “interpretative practice”, which parts of the narratives to include and which parts to omit are selected (p. 13). The researcher is faced with the challenge of achieving a means of working with the narratives so that the “original narrator is not effaced, so she does not lose control over her words” (p. 34). As has been stated elsewhere, a tension exists between giving voice while offering interpretations which articulate the participants’ experiences in different ways. The narrative structure as presented in the analysis chapter follows how the stories were told by participants. The narrative sequence follows a path from stories of “illness”, through turning points and ambivalences to a belief of recovery. Many of these sequences were then followed by further stories of difficulties in the present and possible future transformations.

3.6 PRINCIPLES OF GOOD PRACTICE IN QUALITATIVE RESEARCH

In qualitative research, standards of quality of the methodology applied include issues of trustworthiness of the data and trustworthiness of the interpretations and/or conclusions derived from the data, as described by Stiles (1993, as cited in Elliott, Fischer & Rennie, 1999). The trustworthiness of data in this context is comparable to reliability in quantitative research, while the trustworthiness of the interpretations or conclusions can be compared to addressing standards of validity in quantitative research.

Elliott, Fischer & Rennie (1999) developed a set of seven guidelines specific to qualitative investigations in psychology. These guidelines were developed to serve the following four functions:

1. To contribute to the process of legitimizing qualitative research;

2. To ensure more appropriate and valid scientific reviews of qualitative manuscripts, theses, and dissertations;
3. To encourage better quality control in qualitative research through better self- and other-monitoring;
4. To encourage further developments in approach and method (p. 215).

These guidelines were applied throughout the research process and will be considered in the following section.

1. The concept of owning one's perspective refers to the importance of the recognition of the theoretical orientations of the researcher as well as how one understands the subject of the study and how the researcher's own values, interests and assumptions impact on this understanding. Through this process, readers are assisted in assessing the interpretation of the data and how the data came to be interpreted in this way (Elliott, Fischer & Rennie, 1999). As a clinical psychologist, in this study participants' narratives have been interpreted with a particular clinical stance in mind. This may have resulted in reading the narratives in a particular way, although it did offer the opportunity to produce an analysis that resonates with clinicians who may prescribe to a similar clinical framework. Furthermore, the researcher has had no personal or professional experience with recovery from anorexia which invariably has influenced the way that these stories have been heard and may offer a very different, and possibly limited, perspective than from the point of view of someone who has more experience. A potential advantage to this lack of experience is that the researcher has been able to approach the narratives with no preconceptions.

2. Situating the sample refers to the importance of providing a description of the research participants and their life circumstances. This assists the reader to assess in what contexts the findings of the study may be relevant (Elliott, Fischer & Rennie, 1999). In this study basic descriptive data has been provided as well as a summary of the stories as told by the participants (See Appendix F).

3. Grounding in examples refers to the fact that researchers should present examples of the data in order to demonstrate both the analytic procedures used and the understanding developed as a result (Elliott, Fischer & Rennie, 1999). In the results section of this study, quotations are extensively included in order for the readers to judge how well the data and my understanding of the data correspond. The presentation of the data in this way also allows the readers to consider alternative interpretations and meanings.

4. Researchers should check the credibility of their categories and provide an indication of how this has been achieved. In this study frequent consultation with the research supervisor in order to review the data was undertaken in order to serve this purpose. In this way corrections and elaborations were made to the original analysis. Furthermore, credibility was further ensured by continuously revisiting the original data during the process of analysis.

5. Understanding of the data should be represented in such a way that achieves coherence and integration while retaining nuances in the data (Elliott, Fischer & Rennie, 1999). The results of this study follow the actual narratives as presented by the participants which helps achieve coherence while the presentation of several quotations preserve the nuances of the data. The understanding of the data fits together to form a narrative map of the stories told. As stated by Garrett (1997) “the coherence of the story often makes it possible to transcend the gaps and inconsistencies in experience” (p. 267).

6. Accomplishing general versus specific research tasks refers to distinguishing where a general understanding of the subject under study is intended and where understanding a specific phenomenon is intended (Elliott, Fischer & Rennie, 1999). The focus of this study is on understanding recovery from anorexia; a more general understanding would have required a larger sample. Generalizations beyond this sample of participants cannot be inferred although specific understandings will no doubt be more generally useful. As discussed

elsewhere, limitations to this study include the subjective nature of the accounts provided as well as the relative youthfulness of participants.

7. The final guideline is that the research report resonates with readers. This report makes an effort to promote resonance in readers by bringing the participants experiences to life through the summary of each participant's story as well as the quotations included in the analysis.

3.7 ETHICAL CONSIDERATIONS

Ethics approval for this study was obtained from the University of the Witwatersrand Human Research Ethics Committee (Non-Medical). Ethical considerations included guarantees to confidentiality, informed consent, voluntary participation and consideration of the potential risks and benefits of participation in this research.

Participants were made aware of the limits to anonymity, given the face-to-face interview format, but confidentiality was ensured. All consent forms, questionnaires and transcripts were given a numerical code and access to these documents was limited to the researcher and the research supervisor. In order to further ensure confidentiality, only the researcher has had access to the audiotapes of the interviews. The alteration of names of the participants, other individuals mentioned and place names in the transcripts and quotations used for the purposes of this study further ensures the privacy of the participants. Furthermore, participants were made aware that only sections of the transcripts would be used in the write up of the analysis of this study. Therefore transcripts have not been included in the appendices in order to limit the possibility of recognition.

As described above, participants were required to sign consent forms agreeing to participate in the study. They were also required to sign consent forms agreeing to the audiotaping of the interview. Participants were made aware of the

voluntary nature of participation and were informed that they could withdraw from participation in the study at any time.

Due to the sensitive nature of the research topic, participants were informed that they were not required to answer any questions that they may be uncomfortable with. They were also made aware of the risk of questions potentially eliciting powerful memories and emotions. At the end of each interview, participants were asked how they felt having told their stories and were provided with a list of referrals for eating disorder-related organizations that could offer counselling services should they require them.

In listening to the stories told by the participants it was the researchers' intention to offer interpretations of the narratives, rather than simply report on the stories that had been told. While this research aims to give voices to those who believe that they have recovered from anorexia, their stories are not viewed as absolute truths but rather as subjective self-narrations. During the write up the analysis, specifically when interpreting the narrative content, the researcher became aware of the potential harm that such interpretations could have on participants who were interested in accessing the research report. It became apparent that the nature of this research could result in using participants' words beyond what they would be comfortable with. Long (2005) states that when participants consent to participate in a study, they are consenting both to participation in the study and consenting that their stories will be interpreted. This raises ethical issues in terms of revealing sensitive aspects of individual's lives which may violate privacy and result in harm (Bakan, 1996; Josselson, 1996). The fact that participants were asked for permission to include parts of the transcript in the actual report provides them with a certain measure of control and potentially minimizes "the vulnerability they might feel from exposure of their stories" (Chase, 1996, p. 48). In addition, the final analysis was re-read keeping in mind the sensitive nature of the data and how it could impact on the participants as

readers. This was done to ensure that interpretations and the way that the stories were presented were done responsibly and respectfully (Long, 2005).

Chapter 4: Results

4.1 Introduction

A collated version of the participant's stories can be found in Appendix F. The participants are introduced in this way in order to provide a brief impression of their stories as they were told during the interview with the intention that a more personal sense of the individual and their particular story can be gained. The stories also show how, while they may follow a similar plot, differences in experiences of being anorexic and recovering from this disorder emerge. This said, each of the above stories share many features in common. Stories were told in progressive manner, starting from the recognition, or lack thereof, of a problem to stories of recognition or resistance to the need for help and ultimately for most, stories about how recovery was achieved and is understood. Within these somewhat "typical" stories are other stories which emerge out of each participant's personal journey of recovery.

The results section follows the narrative stream of the stories told during the interviews. Each of the stories followed a pattern of the authoring of stories about how they came to be anorexic, what it was like being anorexic and how they came to be recovered or recovering. The build up of the story to the end point where recovery is narrated relied on this progression. Telling the story in this way also offered a contrast in stories regarding the past and present and this occurred even when there wasn't a complete decrease in symptomology over time but seemed to allow a different story of identity to emerge. The break between past and present, or sick and well, was often marked for participants by a turning point of some sort that involved a conscious decision to recover. These turning points indicate where a change in the narrative occurs and can be viewed as metaphors for changed perceptions within recovery which are in contrast to perceptions and attitudes held while anorexic. The turning points as narrated in the stories of this study are not uniform in nature but rather reflect particular changes in belief, attitude to self or others, ways of interpreting events or gaining

insight into specific difficulties. The presence of a turning point in a story cannot however be taken to mean that recovery automatically follows, as many of the stories in this study will indicate.

Some of the participants recovered without any therapeutic intervention while others sought treatment from doctors, psychiatrists, dieticians, therapists or support groups. Of particular interest in the stories told about treatment is the difficulty in distinguishing between dissatisfaction with treatment and resistance to treatment. These two positions have been well documented but often as separate issues. Studies focusing on treatment outcomes favour resistance as central to treatment failures while studies focusing on subjective accounts of treatment implicate dissatisfaction with treatment as an often overlooked and discounted aspect of the lack of efficacy in treatment practices. The stories told in this study offer a third version, by showing how dissatisfaction and resistance can co-exist and in some cases present in the same manner.

With regards to recovery, all participants told stories of what they believe sustains their recovery and helps them avoid slipping back into more disordered eating behaviours. This relied on stories that validated the claim of recovery, on stories that could clearly differentiate between before and after recovery. For some, the stories of themselves as recovered or recovering was reflected by family members, friends, therapists and others close to them. This reinforced their view of themselves as recovered. For others the belief that they are recovered was at odds with the perceptions of others. This tension is difficult to resolve and for some participants a reframing of symptoms becomes useful to deny the ongoing presence of symptoms. Therefore the different stories about recovery leaves a spectrum of possibility regarding whether they are in fact recovered or not which has become a central tension throughout this study. The following sections therefore follow the above plot and trace the stories from how anorexia started to how participants came to believe that they are recovered and the tensions inherent in their recovery narratives.

4.2 Stories of Becoming Anorexic

Participants had different perceptions of what caused them to become anorexic although the stories of what led them to the initial weight loss had some commonalities. Most common were stories of losing weight for sports purposes, negative comments from friends and family regarding their weight, self comparisons to the perceived "ideal" and conformity to cultural stereotypes. Most easily made were links between the onset of anorexia and family or social pressures and this is often how participants began to speak about how they made sense of the development of their anorexia. Many of their stories are also located within popular psychological theories of causation. For example Carla* describes her family in the following way:

> *…my life and the whole situation where I (.) how I grew up, um, it's just, it's just, um, out of the book you know, it's exactly what, what they say, um, the warning signs for anorexia and bulimia are and, um, you know situations and, and that was all there. You know I come from a super-controlled, um, environment.*

Carla attributes her eating difficulties to a *"super controlled environment"* and suggests that if I were to read a book about anorexia and what causes it I would find her story there and gain an understanding of the particular dynamics that led to her developing anorexia. This implies that she believes that all anorexics arise out of the same set of circumstances which limits the different kinds of stories that potentially could be told. All of the participants mentioned at some point during the interview that they had read widely on issues related to anorexia, whether it be consulting pro-anorexia websites, psychological texts or personal accounts of overcoming anorexia.

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*All names and identifying particulars of the participants and other individuals mentioned have been altered in order to maintain confidentiality. A pause is indicated by (.) while … indicates where sections of the transcript have been omitted.

The question that this raises is how familiarity with popular theories influence, obscure or conceal the type of stories told about causation, or indeed stories told about anorexia and recovery as a whole.

Stories of the development of anorexia soon evolved into explanations of anorexic behaviour as if it was difficult to conceptualize how they got to the point that their behaviour was diagnosable as anorexia. Almost all the participants agree though that anorexia does not start at diagnosis. When looking more closely at the research material, it is evident that, compared to the narratives of the experience of being anorexic and narratives of recovery, there was an obscurity to these particular stories of becoming anorexic, as if they are hard to tell. Stories around causation were very briefly narrated and portrayed as neat packages of information which the participants presented as rather unidimensional accounts of their experiences that were not easily elaborated on. When asked about what Chelsea believes led to the development of her anorexia she begins by speaking about how her friends made negative comments about her weight and then starts speaking about how this directly led to restrictive eating habits and how much weight she lost as a consequence.

> *Chelsea: Um, I think it was like, like negative comments especially like from my friends at (.) that I was fat. So I got very like restrictive about my eating and stuff like that, mm… Like you know, it was just in three months I lost about seventeen kilograms…*

Kelly associates becoming anorexic with comparing herself unfavourably with peers.

> *Kelly: All right, I'll tell you when (.) I never had a problem with food and weight, nothing and I got to high school at about (.) and about at the age of fifteen, I started noticing girls' figures and I thought, okay, my stomach's not flat enough (.) and <u>this</u> is what happened to me.*

For these participants becoming anorexic is easily explained but there is a conspicuous absence of detailed narratives which encompass the complexity of interactions which led to an individual becoming anorexic. There was a lack of reflection of the possible personal responsibility or internal dynamics that, together with family dynamics and social pressures, may have contributed to becoming anorexic. More common were stories that centered around the relationship between eating difficulties and self-image and the behaviour of one parent, whether it was a controlling father, an absent mother or a mother who herself is obsessed with weight and dieting. For Elizabeth, difficulties around eating and weight is closely linked to her mother's eating behaviour; because her mother has always dieted it was therefore inevitable that Elizabeth herself became anorexic.

> *Elizabeth: Well my mom is a real dieter and she's always been like that, so, it was sort of inevitable. It just felt um, like something that I was meant to do eventually, so um, because my mom was doing it.*

She does not question that for her it could be different and expresses that becoming anorexic was in a sense inherited. It is possible that locating her own difficulties within the family has been a useful means for her to narrate her own life story and anorexic behaviours as learned behaviour or inherited traits. In this way she becomes a passive participant in her own behaviour and consequently finds it difficult to take responsibility for her own recovery. Rachel also speaks about anorexia as being passed down from one generation to the next and states that there is nothing that she can do except hope that she doesn't pass it down to her children. This places her in a position of a passive victim and locates the problem of anorexia outside of herself.

> *Rachel: I can't think that I wouldn't have gone anorexic and then I think, like (.) there's nothing that I can really do about it, just hope that you don't pass it on to your children… I mean, my gran's passed it on to my mom*

and kind of passed it on to me and (.) my cousins as well, it's just all, you know it's inside us…

Rachel speaks about anorexia as "it", as something that has a life of its own inside the female generations of her family that is passed magically from one to the other. What "it" is exactly that makes them engage in anorexic behaviours is not elaborated on but is a nameless entity that is an important character in the story of who they are.

While Elizabeth and Rachel understand their anorexia in terms of being inherited, Heather locates the cause of her anorexia in the punitiveness of her parents. She feels this is unique to her story, finding it hard to believe that other anorexics could have as punitive parents as she has.

Heather: When I stopped blaming myself for it, I shifted the blame on to them because it was them who instigated the whole thing, had they just left it I doubt I would have been like this but I couldn't have been worse than I am now. Do you know what I mean? I couldn't have been worse thinking about things if they had just left and let me sort it out for when I, you know, when I – instead of making an issue out of it, a six-year-old, just wait let's see what happens and deal with it in a better way than how they dealt with it… Not all – everyone who becomes anorexic is, you know, thought their parents instigated – I'm quite sure none of the ones you interviewed, hey?... None of their parents contributed towards it, so.

Heather narrates her uniqueness around the fact that she holds her parents completely responsible for her difficulties with weight, self image and destructive eating behaviours although she does suggest that she at first blamed herself. She says that she doubts that she would have been this way had they not made an issue of her weight when she was six years old. To attribute blame seems important to her and the blame that she places on her parents may detract from

the emotional discomfort that may arise if she has to think that this is possibly something that she has done to herself. There is also the sense that it is lonely to be the only person with anorexia whose parents were so influential in the development of her eating difficulties. The above quote is a powerful expression of the pain she still feels when she thinks about her six year old self being criticised by her mother for being overweight. The rejection and ridicule that she experienced as a result of being overweight as a child remains a painful part of her narrative.

At times, speaking about how or why they became anorexic was a painful process for the participants which evoked powerful emotions of anger, resentment and despair.

> *Heather: …I can remember the first remarks. I often, as I say like, even though I'm turning twenty-eight this year I can still think back to the very first remarks from my parents, they started with my parents. I can remember the first remark, I must have been about five or six (.) I can't remember (.) but it was obviously just before I started Grade 1. I can remember getting a Christmas book for full attendance at Sunday School and I had this little dress on like this and I can remember teacher helping me down to give me my award, and I can remember as I sat down, my mom turned around and said, "You know," she said something like, the fat by my arms or something, and I was really (.) <u>that</u> already started it… I remember thinking, you know, it must have been so bad… To be like this that….You can't make those comments, I mean there, there's so many sensitive – my mom telling me, like, if I got any fatter, whatever, she'd be too embarrassed to walk in the shops with me.*

In the above quote Heather speaks powerfully of the effects that these comments made on her and somewhat recognizes that at 28 years old she is still responding to what was said when she was much younger. While Heather could

have told a different kind of story, she chooses to tell one which seems to place the responsibility for her difficulties outside of herself, excluding any need for self-examination and self-knowledge. While Heather blames her parents for drawing attention to her being overweight and making her feel ashamed of herself, Jessica believes that it was her own appraisal of herself that resulted in her feeling insignificant compared to her sisters. Becoming anorexic for Jessica was both a way of expressing how she felt that she could just disappear by losing weight and paradoxically gaining the attention and uniqueness that she felt she never received.

> *Jessica: …I didn't feel I was important in my family base. I'd always felt that, you know, I always used to have this dream that, you know, I could just disappear because I just didn't feel I was there, so, so to speak. I didn't want to commit suicide but I just didn't feel, you know, that I was being recognised at all…*

In contrast to the above stories of anorexia being the result of family dynamics, Christine links anorexia and bulimia to conforming to society's idea of attractiveness although this is against her feminist principles.

> *Christine: …I'd really like to think of myself as not doing what everyone says is right (.) you shouldn't have to be what everyone tells you to be and you shouldn't have to look like what everyone tells you to look like, like it's a brand to look and to be attractive because you're thin (.) and that is another reason why I always feel like I need to punish myself… punish myself by starving but then furthermore I feel like I have to punish myself, punishing myself in this complete, in this way that's completely against my principles which I believe in, I mean, okay I don't believe in….. I believe in a modified kind of feminism but it's completely against women's principles, completely against all these values and then I feel I need to punish myself even more so I don't eat even more. It feels like a kind of cycle.*

Here Christine highlights the conflict between considering herself as an independent woman with a mind of her own and the disgust that she feels with herself when she finds herself conforming to ideals held by the wider society. Conforming thus reinforces her need to punish herself by starving which is then equated with further failure to not live up to her ideals. Throughout the interview Christine dismissed the importance of psychological factors in causing her to become anorexic, instead focusing on social pressures.

> *Christine: I think things are often analysed too much, especially since you're involved in psychology and these kind of things, I mean, there's no doubt that it's got a lot of, er, psychological background but I think you also must underline the way being thin is, being physically thin is what's said to be attractive… .because I mean if there are psychological factors they could play out in many different ways, and this is the way they choose to play out a lot of the time because of the social factors.*

Here Christine suggests that there are underlying psychological factors which manifest in certain ways because of cultural influences but she does not indicate what these might be. Later in the interview Christine briefly mentioned that her mother had passed away when she was 15 years old which was followed by a period of self starvation. The possible emotional turmoil that this created is minimised and it seemed important to her that I knew that she experiences no "*pain or misery or anything*".

> *Christine: …an example is with my mother passing away, like, where you feel like the world has done something wrong to you, (.)and just so you know I'm not talking about death or parents and stuff but I have no kind of pain or misery or anything, so I don't (.) even at the time I don't think it was <u>that</u> big a deal… but there could possibly be a link between that… for a period after she passed away I stopped eating, um, probably for about well, a couple of months.*

Christine is not sure that her mother's death was *"that big a deal"* but she leaves room to reflect on the possibility of a link between her death and the onset her symptoms, but almost as a link that she can't bear to make and rather leaves for others. Thinking of anorexia as culturally produced may therefore be a way of denying how her past and her current anorexic behaviour are linked. Anorexia thus gives her a means of expressing feelings while protecting herself against them at the same time.

Most participants spoke about how their eating behaviours were reinforced by successful weight loss initially and then by both positive and negative feedback from others. Christine admits that she enjoys attention whether it is positive or negative and actively seeks it out. She takes pleasure in being noticed for being thin and is disappointed when her weight is not commented on. Like Jessica, Christine is speaking about a feeling of not being noticed and needing someone to be aware of her.

> *Christine: Oh, firstly I started noticing a lot of positive feedback about the weight loss, um, from family members and in terms of my peers… I mean, like I've always loved attention but I don't know if, I think I even, er, thrived on the negative attention, which I think people do, um, and even now when I do not eat for a long time I, um, I do thrive on the negative attention, and um, and it's painful when people don't notice... you know what I mean? But, ja, maybe that's what I needed (.) for someone to be interested. Maybe that's why I did it, so people <u>would</u> be interested.*

Here Christine offers a different story to the one about losing weight as a result of societal pressure. Reflecting on how she likes to gain the attention of others leads her to tentatively conclude that anorexia may have arisen out of a need for attention. The difficulty in narrating causes of anorexia is reflected in Christine's accounts. She cites cultural influences, the loss of her mother and the need for attention as possible contributions but has not integrated them into an

explanatory model as such, rather relying on cultural influences as her dominant narrative and offering the other two as tentative possibilities. Narrating the genesis of anorexia, for her and others, is a process of sifting through competing narratives that have different implications; conversely, no doubt, hearing them as an audience is also a process of making sense of these competing stories – both overt and hidden.

Participants had a range of narratives from which to draw to make sense of why they became anorexic. As has been described, participants experienced difficulty engaging with this question and provided very brief accounts. While some participants mentioned some sort of distress, many could not connect them directly to the onset of their anorexia, as if a link was missing from the narrative (Garrett, 1998). In the next section, how participants narrated what it was like to be anorexic is considered.

4.3. Stories of Being Anorexic

Central to the telling of stories of recovery were stories of what it was like to be anorexic. Participants spoke about recovery in terms of defining who they were before and after being anorexic. The interview questions did not intentionally aim to explore how these understandings of the self were narrated but how the narratives revealed self understanding became prominent in the stories that were told about recovery. In a way, it seemed that through conversations about recovery they could reflect on this “otherness” of who they had been when anorexic. Some reflected on these aspects of themselves with disbelief, others with dread while for some there seemed to be a longing for something that now in recovery has been lost. It therefore seemed important to comment on how these understandings of the “anorexic self” were narrated and understand what was so important about being anorexic. Being anorexic was narrated in three ways. Firstly, it was narrated as a discrete episode of “alien” behaviour which could be reflected on and contrasted with recovered behaviour. Secondly,

anorexia was narrated as an aspect of themselves which could not easily be separated from how they view themselves as if anorexia had become a part of their personality. Thirdly anorexia was perceived as being an entity that inhabited their mind or body. Within the narratives with regards to what it meant to be anorexic, stories of control seemed to take centre stage. Each one of participants told a story about how anorexia meant to be in control, to feel powerful and how these feelings made up for something which was lacking before the onset of anorexia.

Carla speaks about how she identifies with certain aspects of anorexia.

> *Carla: …But I think, um, I associate more with the anorexic mindset – when you read, the stuff I read… I'd always identify more with the anorexic than with the bulimic person that they describe.*
>
> *Interviewer: And what was that, that you were identifying with?*
>
> *Carla: Um, I think, um, I think with the perfectionism, the driven kind of character I think they, you know, what um, usually they said people are quite intelligent, I think they mean you know analytical as well, and always thinking and, um, and you know I think that, ja, I kind of associate myself with that and you know, and always, almost in every aspect of their life taking things to extreme and I think I'm very much like that… And that's like the ultimate control because if you're bulimic you're not as much in control as when you're an anorexic.*

Carla seems to have taken on these general descriptions of an "anorexic personality" as her own. When asked at the beginning of the interview how she would describe herself, she said that she considers herself to have many contradictory characteristics, for example believing herself to be analytical on the one hand and creative on the other. She also thought that while she considers

herself to be strong willed and independent, she recognizes that she also has a sensitive and dependant side. In the above quote she speaks about control and being able to take things to the extreme as if they are positive characteristics in contrast to the lack of control in bulimia which she would rather not identify with. The centrality of issues of control in the stories of what it was like to be anorexic will be elaborated on towards the end of this section.

Participants spoke about how anorexia became a denial of physical and emotional needs.

> *Jessica: …I mean I'd get bouts of hunger and then I'd get cross with myself and then, then I'd go do jogging or exercise [Laughs] …Ja, I would just basically ignore that…*

Jessica speaks about getting cross with herself for getting hungry as if hunger, or needs, are a weakness that should be overcome. The anorexic body becomes proof of the denial of the body's needs and verifies the mind's control and strength. For Christine the physical feelings of hunger provide an alternative to emotional distress.

> *Christine: It gives you a sense of identity and a sense of belonging to something, um, and a sense of feeling something that's different from the emotional feeling, like hunger is a physical feeling that detracts from the emotional feeling, painfully sometimes and it's, it's, it's comforting in a painful way.*

Starving herself therefore becomes a way to avoid unbearable emotions and gain a temporary sense of relief by substituting one painful sensation with another. Christine also says that being anorexic provides her with a sense of identity and belonging. Kelly also speaks about anorexia becoming her identity.

Kelly: It became my identity. It's like everyone knew Kelly and the anorexic. People at school thought I was going to die. I loved that (.)it was great because people cared about me, you know. It was, um, um, it gave me a specialness, a uniqueness that I, that I was striving for, I don't know.

Kelly seems to be describing two separate entities, herself Kelly and *"the anorexic"*, which exist side by side. It is through the anorexic identity that Kelly can invite care and attention and be seen as unique and special. Heather refers to anorexia as her companion.

Heather: …it is a complete obsession. I wouldn't – I actually consider whatever it is like my companion, I couldn't imagine my life without thinking like this… It's like having a second job…

It is interesting that Heather says that that *"whatever it is"* is like her companion, as if she is not sure what exactly it is that makes her think and behave in the way that she does. Of significance is that by creating a story in which she cannot imagine her life without thinking in the way that she does, she provides an account of herself which excludes the possibility of recovery. These narratives suggest that anorexia can be experienced both as a distinct entity as well as a part of the self and that the distinction is not always clear.

While for some participants becoming anorexic and taking on an "anorexic identity" fitted with their stories of themselves, for others being diagnosed as an anorexic was at first resisted. Participants spoke about how they were reluctant to identify with the medical understandings of anorexia and what that implied. Rachel thought that she was depressed and had difficulty identifying with a diagnosis of anorexia.

Rachel: And pretty much I saw that all my symptoms related exactly to that… at first I thought it was depression. Because I still didn't see myself

as skinny and anorexic and, um, only after a while I realised that you know these were the exact symptoms, that I'm not eating and I'm obsessing and what, what, what. Then I realised you know, this is what it is. And it actually took me a while to, to tell myself, you know, I actually am anorexic. That was hard for me to actually say to myself but… you know I had to.

Rachel seems to be saying that part of the difficulty in accepting that she was anorexic was the denial of how thin she had become and it was other symptoms like restrictive eating and food and weight obsessions that eventually led her to think of herself as an anorexic. In this narrative Rachel expressed that she had to admit this to herself, which may imply that she had to come to a different understanding of herself which later helped her to make sense of her whole experience. Elizabeth initially sought treatment for depression and resisted the diagnosis of anorexia.

Elizabeth: For quite a while I didn't agree with that and, um, I still had that feeling that it wasn't good enough to be anorexia and I still needed to be thinner… And also then once she'd mentioned it then I thought, um, well I'm not really, I'm not really anorexic, she thinks I'm anorexic so let me make myself anorexic so that it's true.

Elizabeth seems to be saying that only when she was diagnosed with anorexia did she start to create a personal narrative of what this meant and then consciously decided to live the story of being anorexic. Her narrative implies that anorexia has particular characteristics of its own and that based on this a person may create a fictional version of who they are which then corresponds to these external expectations. Denial of symptoms may also play a role here: in both Rachel and Elizabeth's accounts of themselves as depressed, anorexic symptoms are minimized and at best, given secondary status to depressive symptoms. Therefore, Elizabeth could continue to believe that she had further

weight to lose before she would be *"good enough"* to be an anorexic. Paradoxically the diagnosis of anorexia encouraged her symptoms rather than alerted her to the fact that something was wrong and that she needed help.

Lisa speaks of how she *"started living being an anorexic"* after her mother told her she was anorexic.

> *Lisa: I was underweight and then when my mom told me I was anorexic that's when I almost became (.) started living being an anorexic. Because I never really stopped eating, like, before then, but then I started to focus more on food, and, I don't know (.) I think being labelled anorexic was not a good thing [Laughs] it was like, how on earth can I be anorexic because I pictured you know these pictures of (.) there was like kind of holocaust people and I was like, I mean that was, I'm not like that.*

Lisa's personal beliefs about herself and what it meant to be anorexic were initially at odds with one another. Like Elizabeth, rather than reject this label of anorexia they seemed to have embraced it and found a way of becoming what others thought them to be. Contrary to the above narratives, Carla speaks of the frustration of being labelled as anorexic and the difficulty she experienced in trying to hold on to some sense of herself that was separate from her illness.

> *Carla: …you know it was just like you're immediately labelled and everybody forgets that (.) that you're still, that's, that's not the only identity, you know, it's like they've made your actual identity, that becomes your identity and people treat you as anorexic, you know, they don't treat you as a person almost, a person with other characteristics just because of this one thing that everybody focuses on.*

Carla's resistance to an anorexic diagnosis centres on the implied loss of any personalized self-narrative, as if being anorexic excludes the possibility of being

anything else. This distancing is interesting in light of how she describes herself in the opening quote of this section where she identifies herself with what she reads about anorexia. While Carla can call herself anorexic and identify with particular characteristics, she implores others to see different aspects of herself and not just a textbook definition. Rachel also dislikes being defined as an anorexic and prefers to describe having had an “anorexic experience”.

> *Rachel: But, but the thing that I try hard not to do is sort of define myself as an anorexic person because once you do that then it’s very easy to fall back into the trap of it... It’s an easy crutch to latch on to if any problems arise, I try very hard not to do that. Because only if you put yourself in that definition then you end up staying like that.*

Her refusal to define herself as anorexic is borne out of fear that she may then always have to be anorexic.

The adoption of what it means to be anorexic is not then a uniform process. Some participants assume the identity of an anorexic on their own accord, others through contact with psychiatrists or therapists, and others resist being labelled yet hold on to their own versions of themselves as anorexic.

Central to these stories of what it was like to be anorexic were stories of control. Anorexia is often considered as an attempt to overcome powerlessness by engaging in an internal struggle for self-control which manifests in the assertion of control over the body by starvation. The following extracts illustrate how the theme of control is common in narratives pertaining to restrictive eating behaviours and weight loss, which result in feelings of power and accomplishment. It is through these narratives that participants seem to draw on broader stories to explain their behaviour to themselves. It is also here that the following question arises: If it weren’t for these particular stories of control that participants use to explain their behaviour, how else would these stories be told.

Christine speaks about control as a means of gaining power and she uses her body and eating as a way of acting this out.

> *Christine: ….that feeling of starving yourself is both the most incredible feeling and the worst feeling in the world (.) like you, you never feel as in control as when you're starving, or as when you're going to bed really hungry. Like, I don't think it's something you can explain, you just feel so empowered when everything else is out of control.*

She also identifies that the need for control arises out of the perception of an environment being chaotic. Jessica also speaks of feeling like she had no control over her environment after her family moved.

> *Jessica: There was the feeling that I had lost control of the environment around me and so the only thing there for me to control was myself.*

What the two quotes above illustrate is that a lack of control over external events has been associated with a corresponding assertion of control of the self. Elizabeth considers the onset of her anorexia with feeling out of control after recovering from cancer and wanting to regain control over a frightening period in her life.

> *Elizabeth: …when I started taking control of my eating, then it was also um, like I wanted to be sick again so that I could be treated specially and ja (.) It was very much like I wanted to take just control of my life because I'd been so out of control and it was um, when I'd had the cancer and I wasn't, like, I wasn't allowed to diet because I had to remain healthy so that um, my immunity was okay and so I just, I wanted to take control so that it was only me in charge of everything and um, I wanted to have very strong control of everything. Like, you know, just to be in control that I*

could do everything my best and that I could control um, every result and every outcome of everything that I did.

Elizabeth struggled to cope with the independence she gained after recovering from cancer. She speaks about how anorexia provided her with a way of regaining attention and concern while allowing her to return to playing the role of a baby who demands all the attention of the family and requires constant concern.

Elizabeth: …I was sort of like a baby (.) Back to being a baby and um, I was getting a lot of attention and ja, it wasn't um, I don't know, I'm not too sure whether my eating was comfort eating. Um, I quite liked it and um, when I became, when I started taking control of my eating, then it was also um, like I wanted to be sick again so that I could be treated specially and ja (.) Because you know, once I was better I thought, it was sort of a feeling that I would be back to normal and almost abandoned…

The way Elizabeth tells this story can be perceived as a manipulation of her environment and exerting control in a more subtle way. While anorexic narratives of the self emphasize the importance of self control, they also seem to emphasise an awareness that control is only temporary; participants spoke about how they were soon confronted with a control paradox (Vandereycken, 2006).

Elizabeth: But um, at the same time I was very, very depressed and um, I did feel sort of out of control um, because (.). you know, um, I don't know I was just um, I don't know how to explain, I was just losing weight, losing, losing very quickly and that was very scary but still you know, nice.

Elizabeth identifies that her weight loss was "scary" and felt dangerous but she discounts this by then saying that at the same time it was "nice". Jessica speaks about two opposing "voices" fighting for control.

> *Jessica: …it almost felt like it was taking control of me and, you know, even if I said, "This is wrong," that voice in the back of my mind was always telling me no, that was right and that's how it should be.*

Carla demonstrates this control paradox when she speaks about how anorexia is both about the assertion of self-control and at the same time a complete loss of control.

> *Carla: …the irony of anorexia is, it's, it's, you think you are controlling, you think it helps you cope, it is your coping mechanism but in reality it's the thing that, that makes you cope less and less and less and be less in control of every other aspect of your life.*

Being in control and being out of control seem to meet in the anorexic. It is interesting that the conviction of being out of control is what leads to an awareness that something is wrong. The above quotes show how participants utilize a widely accepted template of stories regarding issues of control. These stories rely on social and psychological narrations of anorexia and leads to the question of whether these stories are narrated according to popular beliefs at the expense of more personal accounts of participant's experience.

Anorexic characteristics become a large part of a how person narrates their sense of self and as the participants' stories show, it is sometimes difficult to distinguish between where anorexia starts and the person ends. Is it not surprising then that treatment threatens the way that participants have come to understand themselves. Acceptance of treatment implies a loss of this "anorexic identity" as well as the loss of self-control, perfectionism and self-esteem that are inherent in the stories of what is gained by being anorexic (Tan, Hope & Stewart, 2003). A decision to engage in treatment therefore involves a change in the way the self is perceived from the creation of a fictionalized "anorexic identity" to the discovery of a more personalized understanding of the self (Vandereycken,

2006). How then do these stories evolve in a way that allows for the creation of a new way of thinking about the self, a distancing from being anorexic to being recovered or in recovery? It is to these stories that the analysis now turns.

4.4 Recovery Stories

4.4.1. Identifying Turning Points

All participants told stories about an event or a thought process that started them on the road to recovery. This event or experience can be termed an origin of recovery or turning point which is typically reflected by an awareness of the destructive nature of anorexia and subsequent desire to change (Way, 1993). Central to these stories was the assertion that making up one's own mind to recover is crucial and that there is a particularly strong resistance to comply with the wishes of others that they recover.

> *Lisa: You see, that's what so dangerous, you can get as much help, but no matter what it's only that person, that girl that can make the change and, you know, all the help will never make you better, it's only you that can make that change and make yourself better. I mean you can go and spend thousands and thousands of rand on the best psychologists, the best psychiatrists, anything, but that doesn't mean that you're going to get better… It's only <u>you</u> then that's got to like make that connection.*

Lisa speaks of a "connection" that has to be made before a person can be receptive to intervention. All of the participants were asked about what could be done to assist an individual with anorexia to reach this point of awareness that they are ill and need intervention to assist them to recover. Most participants agreed that nothing can be done and it is entirely an internal process that needs to arise out of some sort of crisis. This is illustrated in the following quotations.

Kelly: …I think at first, you need someone to listen to you. I think a person needs to admit that but a psychologist cannot make someone want to be better. You can't like sit there and think, "I'm going to make this person want to get better." They have got to want to get better before they take up, you know, what you say and, and really listen to you… There was nothing that could motivate me…. I know for me, I had to hit rock bottom.

Kelly echoes Lisa's assertion that a person has to want to get better first before intervention can be beneficial but also importantly identifies that "*at first, you need someone to listen to you".* For her, being listened to is important. Jessica also emphasizes that she needed to recognize her illness before she could begin to recover but, unlike Lisa and Kelly, is more hopeful about the role that others can play in helping come to that realization.

Jessica: If you want help, you know, the only person you can really help is yourself. Even an alcoholic, an alcoholic is not going to be (.) unless he wants to stop. …Unfortunately with anorexics, I think, unless you can recognise what's going on, have somebody that, you know, helps you recognise… and just supports you and sort of says, "This is it. Get better!" Then, you know, you can come to terms with yourself.

Jessica also then frames recovery as a coming to terms with herself. While Lisa and Kelly feel strongly about not being influenced by others, for Jessica it is through support and being shown what she has become that she can recognize herself.

Rachel illustrates her own personal sense of agency - "*I decided to get better, which I did".* She identifies wanting to get her life back as a turning point in her recovery.

Rachel: ….my internal drive, if I didn't have that I mean it sounds stupid but a lot of people just don't feel the need to recover and I felt I really needed to get back my life. I, I couldn't handle it any more. Just feeling like you don't exist is well, you're not living, you're just existing. I really felt that I just existed. I didn't feel I was any worth and I know that I'm not that kind of person so (.) I needed to get that back.

Anorexia had become an existence but one that robbed her of living and stripped her of her worth. She speaks of a distancing of herself from the anorexic persona and having a desire to *"get back"* or reclaim her sense of worth, of living rather than just existing. Carla's experience was very similar to Rachel's.

Carla: …that was the choice I made the day that I wanted to recover. I said, "You know what, I'm, I'm sick of standing on the sidelines and I'm sick of not being able to use any of the gifts that I've been given. I'm sick of not making, um, and um, contributing… anything to society and now I want to be there, I want to be part of life, I want to live my life. I don't want to stand on the sidelines and watch it go by.

The statement *"the day that I wanted to recover"* is striking. Rachel and Carla firmly emphasize the importance of desire and locate control over symptoms within themselves. Dominant approaches to recovery portrays anorexics as having little agency and passively taking in social messages about women and attractiveness which ultimately leads to the development of anorexia (Fuller & Hook, 2002). A question that could be asked is what prevented Rachel and Carla from wanting to recover before they made the decision to recover. The initiation of recovery was a desire to become an active participant in life, to reclaim life from anorexia but can also allow us to see how instead of being passive victims they may rather be active agents who have made a choice to use their bodies as a site of resistance (Fuller & Hook, 2002).

For Kelly, recognizing that she had a choice between life and death led to the initiation of her recovery.

> *Kelly: I was lying in hospital and I know this is going to sound like, very "whoa" but I (.) on the, on the Wednesday I was just lying in hospital and I thought to myself like, um, why was I really put on earth? Do you know what, was I put here to die and be unhappy and follow this weight and food issue or was I put here to actually live some kind of life, was I put here to die or live? And I knew that if I was pursuing this anorexia and you know this like perfect whatever, then I just, I would die… that for me is death or otherwise I can choose life.*

Kelly was able to link anorexia with unhappiness and ultimately death and to link recovery with having *"some kind of life"* with recovery.

Heather started thinking about her future and gained perspective on her weight after becoming seriously ill and spending time in ICU, after which she gained a considerable amount of weight. This experience helped her to gain perspective on her weight and through comparison allowed her to challenge previously held appraisals about what it meant to be fat.

> *Heather: So when I did put on all that weight… then I realised I wasn't fat, when I thought I was fat, I wasn't fat. I was fat then at a size 38 but I wasn't fat before, so, and maybe also because the older you get like I said you start to realise your, um, body's got another fifty years to do and I mean I've had everything wrong with me, from – I've got allergies, you know, you always have gynaecological problems, your periods last one to two days, you want kids one day, I mean what else? I've lost my thyroid, I've buggered up my teeth, I've had to chemically peel my face so many times because from the appetite suppressants you get acne. …I think well*

what else? What else am I going to have to – and you know I've got myself to think of.

The process of deciding to live differently also came out of a process of taking inventory of the damage that she had done to her body through her eating disorder. Looking to the future and thinking about having children runs through her narratives and is an important factor in her recovery. Heather claims that she's got herself to think of, as if she has been unable to think of herself before. Her commitment to recovery appeases the guilt and shame that she feels about harming her body.

Unlike the above stories, which illustrate increased awareness and personal choice, Elizabeth believes that her recovery was borne out of a sense of responsibility towards her mother and that she complied with treatment plans to please her.

Elizabeth: …and then my mom and I had a fight and she was just saying, you know, she's spent so much money, um, trying to get me better and I'm just not doing anything, not making any effort, and then, even though that was really hurtful and, you know, it wasn't true because it was just really difficult to make an effort to get better, um, that made something inside me sort of snap and after that I thought, well, maybe I should just try to make my mom happy and then, ja, then I just started going (.) going with the plan.

There is a sense of resignation in Elizabeth's account, her use of the word *"snap"* seems to signify the end of her resistance to intervention although unlike Carla and Rachel there is a lack of personal desire to be different. Chelsea also complied with her mother when she was threatened with being sent to a psychologist if she did not start eating more regularly.

Chelsea: … my mom said that if I didn't like start eating, that I um, that she'd take me to a psychologist [Laughs] I didn't want to go, so um, like I started eating more and more [Laughs]

In Chelsea's account there is again a lack of personal desire but rather a desire to avoid a perceived negative consequence of ongoing starvation. For both Elizabeth and Chelsea they could only begin to identify anorexia as a problem when they realized the effects that their behaviour was having on their mothers. Jessica's recovery was also influenced by a parent.

Jessica: …my dad had a fight with me, he said I was losing weight and at one point he said why don't I just kill myself, he'll run me over if, if I want because it's suicide. (.) I think one day that really scared me was that he burst into tears and that was also one of the turning points because, you know, I'd seen my mom cry but I'd never seen my dad cry and that was, for me, a real shock. Because, you know, I always used to get the feeling that he didn't care…

This extract communicates how important it was for Jessica to have confirmation that her father did care for her and was not only someone who in a seemingly ruthless manner offered to kill but was also someone who felt deeply for her. This *"shock"* of recognizing his care played a crucial role in her recovery.

Lisa's insight was facilitated by a strategy taught to her while in a treatment centre which forced her to separate her "realistic voice" from her "anorexic voice".

Lisa: I just had this "click"… trying to put perspective you know like, reality versus what my anorexic kind of "evil alien" is telling me inside. I found that by doing that, I started to see, see more Lisa, find more Lisa and this slowly made me realise that, you know, there's a problem here and I mean, I'm (.) nothing and that you know, …my life actually was falling to

pieces because everything I wanted to do and everything I wanted to go on, like everything was just being taken away from me and I just realised that this is not what I want, I want my freedom again, you know.

Like some of the other participants, Lisa was able to author a different version of herself in contrast to the story of herself as anorexic. In this story she could recognize the reality of her situation and want something different from what the version of herself as anorexic wanted. From these stories of turning points, stories of how anorexia is no longer viewed as solution but rather as a problem develop.

While each of the participants experienced a turning point which they interpreted as the start of the recovery process and therefore allowed them to differentiate between the past and the present they are not necessarily sufficient causes of change (Garret, 1998). It may be argued then that although participants have reached a point of desiring recovery, turning this desire into action is not always a linear and simple process. As will be elaborated on in the next section, making a decision to recover, whether through a process initiated through force, crises or increased insight, is a difficult one to maintain. At this stage, many participants were still dissatisfied with their external appearance and continued to some degree to secretly practice weight loss measures and hide their behaviour from others.

4.4.2. Process of Recovery

After making a decision to recover, participants spoke about periods of resistance and longings to return to the safety of anorexia which was familiar and offered refuge from the fear of gaining weight. Recovery was not narrated as a linear process involving sudden change but rather as an ongoing and cyclical process. Stories of recovery included stories of resistance, of relapse, of

overcoming immense fear, of integration, of transition, of changing perceptions, of honesty rather than denial (and sometimes denial rather than honesty), of arduous self reflection and emotional expression and of learning to live in the world and relate to it in a different way.

Elizabeth experiences an extended struggle with whether she in fact wants to recover or is simply going through the motions of appearing to recover for the benefits of others. At her family's insistence, Elizabeth consulted a psychologist and a psychiatrist and, despite herself, gained weight.

> *Elizabeth: …then things started getting better even though I didn't want them to at all.*

Although Elizabeth had made a decision to recover she did not take an active role in her recovery and although she considers herself recovered the stories that she tells about her recovery are fraught with the ambivalence of holding on to the idea that she is recovered while many of her behaviours and beliefs about herself suggest otherwise.

Some of the participants spoke about how devastating a return to restrictive eating behaviours were when they thought that they were recovering. Christine holds the conviction that anorexia is a coping mechanism and can be compared to alcoholism or other addictions. She finds it useful to think about a return to anorexic behaviours as a relapse in her recovery from which she can move forward and use as an opportunity to learn about what triggers her behaviour and how that can be overcome in the future.

> *Christine: …it's like having an addiction, just because you go into relapse it doesn't mean that you must just say okay, well, I've stuffed it up, stuffed everything up, you should take it as a starting point to say why have I got into that relapse and how can I, how can that help me the next time, you know?*

Christine's struggle with relapse is not an uncommon story among the participants. Many identified gaining weight as the most difficult aspect of recovery and considered the fear associated with this as the most important to overcome. Carla still struggles with this aspect of recovery.

> *Carla: Obviously gaining weight is very difficult. It still is for me and I, um, I, I'm hardly ever comfortable in my clothes still now today and the other thing is, you know, I don't have money to buy new clothes so the clothes that I have at the moment is my anorexic clothes, you know, so I have to squeeze into a number five or a number six, you know, or maybe a number eight. I've no idea how much I weigh or how big I am now but you know, it's, I'm constantly uncomfortable. Um, so that's, that's a challenge for me, it's, it's really a challenge for me.*

Carla finds her new body shape uncomfortable and, in saying that she does not fit in her anorexic clothes, may be resisting her changing identity. Although she attributes the need to wear her "anorexic" clothing to financial difficulties it does indicate a desire to hold onto something of her identity as an anorexic.

For Jessica the most difficult aspect of recovery was overcoming her "anorexic" voice which acted in resistance to those aspects of herself which wanted to become healthy.

> *Jessica: …if I keep on listening to this inner voice of mine, you know, that's it, "I'm tickets, I'm gone!" And so, and so it was basically a struggle of trying to get rid of that voice and when I started eating food again and so forth, you know eventually it did go away… those first months were daunting and then I'd get over it… in the back of my mind I was going, "But I'm doing this because I want to get better," and that would then drive me forward to, to get better because even if I didn't want to do it, it was like, I still l wanted to do it because I wanted to live, I didn't want to die!*

Jessica offers a contradiction of both wanting to get better and not wanting to get better. It seems that in order to persevere with recovery efforts she framed recovery as a choice between life and death. Lisa too struggled to integrate two aspects of herself and for her making the distinction between an *"evil alien"* aspect of herself and reality became central to her recovery and allowed her to discover more of who she is without anorexia.

> *Lisa: …reality versus what my anorexic kind of "evil alien" is telling me inside. And that's, I found that by doing that, I started to see, see more Lisa, find more Lisa…*

Both Lisa and Jessica narrated how their experiences were divided into two stories, one that involved wanting to get better and one that involved not wanting to get better. Although these two stories were easily narrated, how they managed to integrate these two stories is not so clear. Rather, through a gradual process, for them, one story, in their case wanting to get well, becomes the dominant narrative of recovery.

Lisa also speaks about the difficulty of adjusting to *"real life"* after spending months at a treatment centre. She experienced most difficulty in dealing with a lack of structure when returning home and adapting socially to situations which involved food and eating.

> *Lisa: That's I think the most sensitive… period. It's far more difficult adapting to real life all of a sudden. You're dealing with your own portions, eating out again and, and friends and everything wasn't as structured, because… does teach you structure, obviously. I think that's the big thing, I kept on having to like sit back and think to myself, you know, rational versus irrational.*

Lisa suggests a transition from having others structure her recovery to taking personal responsibility for her own recovery, having to monitor herself and her rationality as they vie against the other story she tells about getting well.

Heather narrates the importance of nurturing relationships in recovery within which a non-anorexic way of life can be explored. She expresses the realisation that different aspects of herself could be acknowledged by others rather than gaining attention and being known for anorexic behaviours. This facilitated a process in which her self-esteem increased and previously held convictions that her sense of self worth was reliant on her weight and external appearance were adjusted.

> *Heather: …people like liked me whether I was fat and whether, you know, I was very thin… and those people are the ones that you know, I think of every time, you know. They were still interested in me so obviously, you know, it's got more to do with that…*

Heather seemed surprised that her friends and co-workers were interested in her. She started to develop an awareness of her innate value to others and developed a more positive self perception allowing her to become comfortable with her changing self. Heather also recognized that she needed help from others to recover further and no longer felt the need to hide her eating difficulties from others. She recognized that this support could be gained by being honest about her experiences and finding a voice that she did not have before.

> *Heather: That's probably one of the best changes and I can openly say to somebody else like when they, you know like before when they'd say, "Gee, you're so thin," you know I'd, "Oh ja, I'm just like one of the luckier ones." But now I can say, "Well I wasn't one of the luckier ones, I was starving myself for three or four days at a time, that's why I looked like that." You know, so I am more open about that than I was before.*

Being able to tell these more honest stories of herself allows Heather to place her experiences in context and works against the denial in the stories that she previously used to normalize her weight loss. It is also an affirmation of the struggle that she experienced when she was anorexic and allows her to differentiate herself in the past and the present. Carla also experienced a shift in self-perception albeit in a different way. She spoke about being away from her parents as crucial to her recovery and, while she resisted formal treatment, found comfort and the freedom of self expression while living next door to a lay counsellor. She narrated how being able to speak to this person allowed her to get in touch with her emotional difficulties and learn to express herself and link emotional mismanagement to early childhood experiences. Her experience of "*looking for the roots… of where it started and <u>that's</u> what you have to work with"* allowed her to discard destructive coping mechanisms.

> *Carla: I woke up and I realised you know, the issues have been dealt with in such a way that… that I don't need this crutch…*

Recognizing that she no longer needed anorexia to cope was a very liberating experience and started a process where she had to learn to function without anorexia. While Carla viewed anorexia as a coping mechanism that could be replaced by learning different skills to manage emotions, Lisa described her recovery as a *"complete mental shift*".

> *Lisa: Looking back I, I was like possessed. My friends told me I was possessed. They didn't speak to Lisa any more, I wasn't Lisa, I was like a ghost. It's like, ja, so as soon as I did start talking up about things and stuff it's like, Lisa came back [Laughs] It's like that ghost's kind of left me.*

Lisa speaks here of a reclaiming of herself from anorexia. Through the process of self expression and learning recovery skills she is able to discard her anorexic identity and make contact with a different version of herself.

Some participants experienced different processes of discarding previous ways of thinking about themselves, changing their behaviours and ways of coping in the world and altered perceptions of themselves and others, a discovering of something different. These narratives reflect a reclaiming of the self from anorexia. Through these diverse paths of discovery, participants narrated a story of how they changed and how new meanings were created that played a role in their recovery from anorexia. For other participants, recovery involved relatively superficial changes in weight and eating behaviours while deeply held convictions remained firmly entrenched and excluded the possibility of new meaning to be discovered. The next section considers the participant's perspective of treatment in the process of recovery.

4.4.3. Stories of Treatment

For some participants treatment played an important role in facilitating the recovery process although many participants claimed that treatment experiences were damaging. The stories told about recovery therefore focused mainly on how formal treatment is often not successful in helping a person to overcome anorexia. Of the 9 participants, Chelsea and Rachel did not come into contact with any professionals while recovering, although Rachel has subsequently begun therapy. The other participants sought treatment from a variety of professionals including medical doctors, psychiatrists, psychologists, dieticians and a self-help group. Two participants received in-patient treatment. A tension within the interview material with regards to narratives of treatment is apparent. Participants were asked what their experiences of treatment were and many had stories of how unhelpful, damaging and inappropriate various interventions had been. It is difficult to differentiate between treatment that was not beneficial and treatment that was resisted or rejected as the line between the two was often difficult to define and it was rare that participants themselves told stories of resistance. The structure of this section follows stories told of how participants came to seek treatment and stories of the experience of treatment.

Elizabeth was initially sent to therapy for treatment of depression and to work through the trauma of having had cancer.

> *Elizabeth: …she was mostly sending me there to, um, sort out my depression and also, um, to get over the whole cancer thing because, um, I'd spoken about it but not, you know, it was still very unclear in my mind, the whole picture of how I'd felt at the time, you know. While I was sick it was just happening and everything was just flying past me and um, you know, you couldn't really step back and take a look at how, how you're feeling and exactly what's happening to you. And so, um, I did need to have some time to have a look at what had just happened to me.*

Although Elizabeth was anorexic at the time, it is as if anorexia was not a problem that required intervention. It seems that Elizabeth made the same association between anorexia and cancer being *"sick"* and saw going to a psychologist as a means of gaining attention.

> *Elizabeth: I did sort of want to go to the psychologist because it would mean that I was um, once again I was getting attention for being sick and I would be special and that sort of thing.*

Seeing a psychologist was not associated with recovery but rather with feeling special and with the opportunity to process how she had been feeling when she had cancer. She therefore did not engage in therapy to recover but rather to have other needs met which somehow obscure the presence of anorexia, which is not spoken about. Christine was sent to a psychologist after a suicide attempt. She has been in therapy for a year and a half but at the time of the interview disclosed that she had only recently started speaking about *"the"* eating disorder.

> *Christine: …before this it hasn't been as important in the time that I've been seeing her, it hasn't been that important and only recently it started flaring up again, which I was quite disappointed at because I thought since I'd been seeing her I was making headway, you know?*

Although Christine had not been speaking about anorexia she was disappointed that therapy had not helped her to make *"headway"*. Christine does not make the link between how not talking about anorexia may play a role in the lack of progress she has made. She also minimizes the importance of anorexia and like Elizabeth, does not make recovery a priority in goals for therapy. Therefore although anorexia is central to these stories of the experience of therapy, stories of anorexia are not present in the therapy itself, as if these two participants believe that it is within some other process that recovery can take place.

Most participants emphasized the importance of "readiness" in seeking treatment. Carla was taken to numerous therapists by her parents.

> *Carla: …which was all useless, you know… For, for many reasons, I think, um, I think many therapists are totally clueless… You know I think what's very important as well is that I wasn't the one that was looking for help. You know I wanted to be healthy but at that stage it was always initiated by my parents and they were such (.) they were such a big part of the problem that this was just another thing that they were forcing me to do, you know. So, um, although I think I, I went to the therapists open-minded there was that kind of grudge that I had (.) okay I'm forced to do this…*

She is able to reflect on her experience of the therapists being *"useless"* based on feeling forced by her parents to meet with them. Carla highlights a contradiction in that although she wanted to become healthy she couldn't accept the help that was being offered to her because it was not self initiated and rather felt imposed. She also offers another contradiction, that of being both open-

minded and feeling resentful of being taken to a therapist at the same time. This may indicate that despite being resistant initially, there was also an aspect of Carla that wanted to engage in therapy. Similar to Carla, Rachel experiences difficulty in finding any value in what her therapist has to offer, saying that she *"just has no idea. She really has no idea like and that, that kind of makes it all very pointless".* Rachel's narratives of therapy focus on how her therapist is unable to meet her needs although it remains elusive to Rachel what exactly these needs are and how she would like them to be met.

Carla's difficulty in finding treatment useful rests on her being identified as an anorexic. She argues that she is not just bulimic and anorexic and objects to being labelled in this way. She seems to construe treatment as problematic based on particular perceptions that she believes psychologists have of an eating disordered patient.

> *Carla: …it's not that they're not committed to help the person, I don't think that, you know, I think they're very, most of them are very committed to helping you but they just don't know how… I always felt very boxed in you know, um, oh! This is the diagnosis you know, this is the problem okay, so we've got lists of behaviours and solutions and I felt, you know, this is not necessarily me, you know. This is not necessarily applicable to my situation (.)*

Carla became frustrated with treatment that focused on symptoms and expressed a longing to be understood in her entirety and not just in terms of her anorexic symptoms. She expresses a need to be seen and heard regardless of her anorexia and was only able to accept treatment when her doctor *"was normal towards me".* Being labelled as an anorexic and therefore having treatment focus on these symptoms felt judgemental and resulted in her rejecting a pathologising medical or psychological perception of her.

Carla: …I was Carla to him, I was Carla, you know. And, okay I had bulimia and anorexia but whereas in other therapy sessions when I walked in I immediately received a label, you know, whether it was bipolar or just an anorexic label… but he was normal towards me… I just didn't get that from any other therapist and I didn't get that they got the sickness you know, I didn't get that they really understood what it was about. …and it just makes it (.) it makes it useless in my opinion, you know.

Carla is distinguishing between two kinds of understanding of her as a patient. One is based on her label and the other takes into account her personality, her whole self which is more personalized and allows therapists to *"get"* her sickness while the other is *"useless"*. What Carla is highlighting is not just a general opposition or resistance to treatment but a rejection of being depersonalized by common understandings of anorexia.

Kelly was also able to reflect on her initial encounter with a psychologist and why it was not helpful to her.

Kelly: Then I went off to see a psychologist and ja, I mean, it just it really just got worse …not anything to do with her, she was wonderful, I established this bond with her that was actually too close… but my, my disease just progressed and got worse and worse I was so sick, there was nothing that could help me. It was nothing about the relationship it was just that I was so sick and so like, you know, self-centred and, and, and so much in the disease…

Kelly asserts that not being able to stop the progression of her disease had nothing to do with the psychologist but was because she was too sick and nothing could have helped her in this state. She does suggest however that her psychologist was in fact unhelpful, in that their relationship was too close because of the demands that she placed on her therapist to be there for her 24

hours day. Kelly seems to be identifying that it wasn't helpful to be in a relationship where boundaries were diffuse rather than firmly defined.

Christine on the other hand seems to be uncertain about why her first course of therapy failed. Although she plays with the idea that it might have been the therapist's fault she decides that her experiences were based on her not being ready to have therapy.

> *Christine: ...it was really, really bad. I don't think that I was, I don't know if it was so much, I think it could very well have been the therapist, I think it could very well have been the therapist but I also think I was in a place where I didn't want to have therapy. And I felt like that now as well, like I wasn't ready for it and so the first time that I went, I went there expecting the worst.*

Christine suggests that that it may be resistance to therapy that makes her narrate her past therapeutic encounters as negative. As narrated, a lack of readiness therefore seems to represent a resistance to therapy.

Jessica seems to feel that parental involvement was a barrier to treatment. She felt betrayed rather than supported and believed that if she had been seen privately the outcome may have been different.

> *Jessica: …I went and saw the psychologist and saw her for a while. But, she, she was Afrikaans and she didn't understand a word I said, so the trust issues… Everything I said to her, I thought it was being confidential and she was relating it all to my folks and I just got ticked off with this.*

Jessica feels betrayed by a lack of confidentiality within the therapeutic relationship. Language difficulties also left her feeling misunderstood and hindered the development of trust.

Participants were clear on what they needed from therapy and felt that they did not get.

> *Jessica: …I think at, especially at the initial stages, I think you need more support than to be told what to do. Because I think that it becomes a losing battle because you start fighting because you feel like you're being forced.*

Jessica wanted support rather advice, especially in the early stages of the relationship where trust has not yet been established. It was important for participants not to feel coerced into treatment and obligated to accept the authority of the treatment professional. Rachel feels like advice is an infringement on her self determination.

> *Rachel: I just think it's really difficult when people start infringing on me. If there is maybe more a level of trust with those people before they actually tell you what to do and how to do it. Because I take serious offence to being told what to do and how to do it if I don't want to listen. She doesn't know who I am and she's telling me what to do and I really don't like that.*

Rachel also narrates how she takes offence to being told what to do if she doesn't want to listen. Like Jessica and Carla, internal resistance towards therapy may be narrated as barriers towards therapy.

The following quote indicates the ambiguities inherent in the stories regarding treatment. Christine, when reflecting on what she has gained from therapy, indicates that she is unsure that she accepts therapy but does find the routine of attending therapy and the consistency of her therapist helpful.

> *Christine: I don't know if it's so much the therapy, er, that I was accepting of so much as the therapist. I say this to my therapist but she doesn't like it*

[Laughs] She says that's not what she's there for, I think it's given me routine, it's given me that routine and almost comfort because I don't know, if I had, um, like my best friend, I mean I've had somebody that I can speak to all the time but I don't think I've had someone who can analyse and it gave me that routine firstly but also, um, it gave me another voice inside my head so I could say to myself, well in this situation what would this person say, you know, just, I don't know if it's even just narrowing down emotions to the most pure scientific logic that makes it easier.

Christine identifies the usefulness of having an internalized therapist who can help her to think about situations in different ways. She seems ambivalent about this function and decides at the end of the quote that what helps her most is to reduce emotions to logic. Although she has elsewhere spoken about anorexia as a way of symbolising her emotional distress, it is precisely these emotions that she avoids exploring in therapy.

It is not easy to clarify the difference between resistance to treatment and dissatisfaction with treatment and it seems that both had a role to play in these participants' experiences of treatment. Participants are less likely to reflect on their own dynamics and how this influenced their perceptions of treatment and more likely to attribute fault to those who brought them to treatment and those who treated them. An important issue seems to be that of being labelled in a specific way by doctors and therapists and as highlighted above, resistance may be directed towards this.

4.4.4. Stories of Staying Well

The following stories explore what the participants believe sustains their recovery and how they manage to maintain the changes that they have made. For Elizabeth, Chelsea and Lisa sustained reinforcement from their mothers or other

family members was most helpful in sustaining their recovery, although in different ways. Elizabeth continued with her treatment regime out of guilt while Chelsea, who at times wanted to return to more restricted eating behaviours, felt unable to do so under the watchful eye of her family.

> *Elizabeth: …it was still like I was doing her a favour because she was now spending this money and so I was actually responding to her efforts. I think with my mom's, um, watching over me, I couldn't really pull out of that easily (.) so I just carried on with it.*

This extract implies that Elizabeth has no internal will to recover and if it were up to her she would behave differently to how her mother wants her to behave. As will be elaborated on in a later section, Elizabeth tells two stories of herself, in one she identifies herself as a recovered anorexic and in the other as someone who struggles on a daily basis with eating difficulties. For Elizabeth, the story of her recovery and her actual lived experience diverge and it becomes clear that she struggles to fit her experiences neatly into a narration of recovery. For Chelsea, recovery was sustained by pressure from her family who monitored her food intake.

> *Chelsea: …I wanted to like go back and do the whole like, you know, not eat and stuff again but it's like, um, from like that time like everybody like watches you, you know, [Laughs] so it was hard, it was just hard.*

It is unclear whether this scrutiny is experienced as supportive or not but for both Chelsea and Elizabeth there is a threat of family discord if they did not maintain recovery. A question to be asked is whether recovery based on fear is sustainable or not and how their stories of recovery differ from those who believe themselves to have recovered in a supportive environment. Lisa also believes that her mother helped her to sustain the progress that she had made when at the eating disorder unit and, although irritated by it at first, now realizes that her

mother was *"right"* to monitor her in the way that she did when she came out of hospital.

> *Lisa: …one thing that helped very much is my mother. She was like, okay I hated her at the time because she gave such tough love (.) It really irritated me at first but at the same time I did it for her because I, I don't know like, when I was in … I just realised like what my parents had actually done for me and stuff and how hard it had actually been on them and I know that when I was out that I had to, I knew that even though I didn't want to do it, mom was right at the end of the day. I don't know… being hospitalized scared me.*

At the end of the quote, Lisa adds that what sustains her recovery now is in part her fear of being admitted to hospital. On a deeper level Lisa now recognizes the need to experience a non-anorexic life, one in which she sees a future for herself. Rather than describing the anorexic aspect of herself as a *"ghost"* who was always present her experiences in the past have become nightmares.

> *Lisa: I see the nothingness in that life. It gets you nowhere, I mean, you can't, you can't make the shift and you can't live a future, you know, being in that world. I have sort of nightmares about it, that time, in a way they've become nightmares.*

What sustains Jessica's recovery is a fear of who she became when she was anorexic and feeling out of control.

> *Jessica: It's just not the sort of thing I ever want to get into again. …to get out of it was <u>really</u> daunting. It was more daunting than, you know, getting into it. …I never want to hear that voice again, feeling that I'm, feeling that I've no control. Just knowing what I became, I don't want to see that side*

of me again. …I wasn't really thinking straight, as I say, I'd switch off for days at a time. That really stops me from ever wanting to do that again!

Kelly also fears becoming anorexic albeit for different reasons. Kelly's fear is based on the belief that starving herself will eventually result in binge eating which will then cause weight gain. Kelly still sees anorexia as something that would make her special and make her feel powerful and in control but the fear of weight gain outweighs these payoffs.

Kelly: I know that if I slip back into anorexia I'm going to go back to the bingeing. That is what I don't want. It's not so much that I'm scared of the anorexia than, as I say, I mean the anorexia gives you power, control, makes you feel special, um, but I don't want that if it's going to cause the bingeing.

It is a fear of this weight gain that ultimately makes Kelly adhere to her support group programme. The following quote provides a contrast to the above quote. Here Kelly talks about how the support that she gains from the support group sustains her recovery.

Kelly: I find meetings are amazing where you see other people who've got the same problem as you. You see miracles happen, you see people recovering, you see those who are not recovering and you remember where you came from, um, you know, newcomers and you, you kind of, people share their experience and you can use that. Like, I didn't know that it would help me so much to thank God every time I ate my food (.) and it's wonderful, you know.

For Kelly it seems that both a fear of fatness and the utilization of "tools" with which the group equips her to deal with relapse are sustaining. Kelly tells one story of participating in a support group, that of gaining support and learning new

ways of coping although other areas of her narrative raise the possibility that Kelly has used the support group as a replacement for anorexia and has created something else that is familiar and comforting. Her mother, who questions why Kelly needs to follow such a rigid food plan, raises these concerns.

> *Kelly: …she doesn't like the way I follow such a rigid food plan, she's scared of the, the anorexia, you know, going back there…*

Changing perceptions about weight and its association with attractiveness has been key in Rachel's recovery. She says, *"I don't want to go back to being skinny because I don't think it's attractive".* As Rachel has gained weight she has come to a newfound acceptance of her body and, through attention from men, has come to a different assessment of herself as an attractive woman. For Heather, what keeps her from returning to eating disordered thinking and behaviour is taking stock of how much of her time she has spent on worrying about her weight and obsessing about calories and realising that there is another way to live life.

> *Heather: …so much of my life has been wasted on it that I don't want to waste any more of it on it. …I have to sort it out sometime because if I had kids… if I had kids I wouldn't want any of my negative things to rub off on them. That would be my worst because I know how much of my life has been wasted dealing with it and thinking about it.*

At the same time, her recovery is also sustained by thoughts of the future and how her "illness" might impact on her future children. It is when she is able to think about someone else living his or her life in the way that she has that she can recognize how her life has been dominated by her eating disorder.

Carla places emphasis on how essential practical help is in her day-to-day life.

Carla: …my friends phone me constantly and they always want to know how I'm doing and from slipping back always, you know um, talking about it always helps. Um, if I'm under stress being able to phone somebody and say, "You know what, um, today's been very stressful and I don't feel like I'm coping, or this and this is happening in my life," and to have people that say, "Okay, how can we help you to deal with it in a more practical way?" That's helpful…

In the above quote, Carla speaks about how at times she needs others to take responsibility when she becomes overwhelmed with daily demands. She has recognized that instead of using food to express her distress she can turn to friends for help. This requires an awareness of the distress she is experiencing as well as a willingness to ask for help.

The participants' accounts of recovering from anorexia extend beyond the remission of eating-disorder symptoms to include managing changes in all spheres of life. The narratives presented above offer many ways of doing this. Participants speak about reaching out for support, learning to accept themselves and living for the future as important in helping them to sustain their recovery although fear seems to play a central role.

4.4.5. Stories of How Recovery is Defined

Participants' narratives on what recovery means were important to elicit. In many cases how they defined recovery in general and how they defined recovery as related to their own process differed from one another. Their definitions also offered insight into the status of their own recovery as how they described recovery could be used to gain some perspective on the extent of their recovery. Although recovery is difficult to "measure", how participants view recovery, and therefore what they attempt to achieve, provides a measure of their own recovery.

In the following quote, Elizabeth minimizes the role of weight in anorexia. She expresses a desire to be thin but without dieting and obsessive behaviour. Elizabeth's perception of recovery is paradoxical because from experience she knows the only way to achieve the thinness that she desires is through dieting and starvation. Elizabeth then will never be recovered according to her definition.

> *Elizabeth: …if I was completely recovered, um, then it is being really thin (.) but not dieting and not being obsessive about my eating. It's not really got to do with a healthy weight. Mm, ja, just, um, being able to listen to your, your urge (.) your biological instinct.*

Elizabeth goes on to say that recovery also means that a person is able to listen to natural "appetites" and respond appropriately. This seems at odds with the first part of her definition as, in her mind, thinness can only be achieved through restriction and therefore a denial of instincts to eat.

Christine views recovery in terms of skills development and learning tools to deal with difficult situations in which anorexic behaviours would previously have been used to cope.

> *Christine: I think it's obviously important to be your normal body weight to be classified as recovered but also if someone is equipped with enough (.) equipped with tools enough to deal with the situation when it comes by next time, because it will, to say someone's recovered and they're never going to have that anorexic relapse is stupid, but to say that they have the tools to deal with those situations and not starving yourself then I guess someone's recovered. Not to say that they're not going to go through the feeling of wanting to starve themselves.*

She sees relapse as an inevitable part of recovery and for her, recovery will not take away her feeling of wanting to starve herself but will give her the tools to not act on the desire to starve herself. While Christine believes that having resources to deal with stressors is important, Carla views recovery as a process of getting to know yourself and anorexia better in order to understand vulnerability.

> *Carla: …I think in a sense it's, it's, um, knowing yourself better, knowing the disease better, knowing how it works, knowing where your, your, um, your weak areas are, you know, identifying your weak areas. …Recovered for me is… when you are really fully recovered you don't have any triggers any more.*

Carla speaks about not having emotional reactions which may trigger anorexia while Christine speaks about having tools to deal with emotional reactions. Rachel views recovery as a process not only of trying to get to know oneself but also of self-acceptance.

> *Rachel: …to start accepting yourself for who you are and liking yourself for who you are. (.)I think, to define anorexia as recovered is, you find a sense of self-worth. Okay, now that's perfect (.) the perfect definition for me, actually.*

For Rachel, the development of a sense of self-worth would suggest recovery. For other participants recovery cannot be thought of as having an end point but is rather thought of as an ongoing process. Heather does not believe that a person can ever be fully recovered.

> *Heather: I don't know, like I don't think you can ever be recovered, I think it's like always sitting there waiting for you. … it's not cured. Recovery is like, you're trying to sort it out, you are recovering but I don't think you*

ever are recovered. …it's like a disease …because it's very powerful and controls everything.

It does not seem that Heather is able to think about recovery and what it may mean to be recovering or recovered. Heather compares anorexia to a chronic disease that can reoccur at any moment. Kelly also does not believe in complete recovery.

Kelly: We see us as not being recovered (.) But being in recovery means that I can live life.

Kelly has taken on the philosophy of the support group to which she belongs. In order for her to live her life free of anorexia she needs to be in recovery for the rest of her life. Like Heather and Christine who equate anorexia with alcoholism, Kelly too believes that ongoing support and vigilance is needed to prevent her from falling back into anorexic behaviours. The way that the participants have made sense of anorexia therefore impacts to a large degree on how they narrate stories of their own recovery.

4.4.6 Stories of Personal Recovery: How Different is the Past from the Present?

One would expect a contrast between the stories told about the beginnings of anorexia and recovery. Although the participants often used the distinction of past and present to highlight non-recovery versus recovery, the actual narratives tell a different story. Most common were stories of continued dissatisfaction with weight, although this was narrated in various ways which allowed stories of recovery to remain intact. Elizabeth makes a distinction between weight gain as a result of healthy eating habits and weight gain due to bingeing.

Elizabeth: I'm very unhappy with my figure again. (.) I know that the way I am now, I got like this not because I was eating normally but because of bingeing and purging and that whole cycle and just, you know, having very erratic eating patterns and um, so it doesn't feel normal. If it, if I got to this weight and it was because I was continuing with that initial eating plan (.) then I would feel fine because I would still feel fat but it would feel okay because it would be like (.) this is my natural weight but now I know that this isn't my natural weight.

Elizabeth's new body shape is unfamiliar to her and doesn't feel "*natural".* She suggests that there is a distinction between becoming fat as a result of healthy eating and becoming fat as a result of bingeing. It is interesting that she uses the word "fat" to describe her weight gain whether through healthy means or not. For Elizabeth then it seems that there is no middle ground, she can either be anorexic thin or fat and fat is not something that she wants to identify with. If weight gain can be associated with the development of a new identity, Carla and Rachel too speak about their discomfort with their changing selves.

Carla: Obviously gaining weight is very difficult. It still is for me and I, um, I, I'm hardly ever comfortable in my clothes…

Rachel: I've picked up the weight and I'm not comfortable with it and I mean, the way I'm going to lose it is by exercising and when I don't exercise I feel bad, so (.) I'm still recovering.

Christine also uses how she feels about herself physically to measure her recovery. She believes that being able to control her symptoms rather than being controlled by them implies that she is recovering.

Christine: I look in the mirror and I'm very unhappy. So I know that it's still there and I know that I still have those symptoms, I just am able to keep

them under control a lot more now. Um, ja, so I eat very irregularly and exercise, er, a lot for quite a long time and then it's fine.

Denial of the presence of symptoms is evident in Elizabeth's narrative. After speaking about wanting to lose weight Elizabeth goes on to say that *"I'm trying at the moment to eat the way I did when I was anorexic but it's just impossible…I'm just not able to be as restrictive as I used to be".* At a later stage when asked whether she thinks if any psychological aspects of anorexia remain, Elizabeth replies:

Um, no, none at all. I've let go of all that and, um, that sort of thing…

Elizabeth's view of herself is that she is recovered but she speaks about longing to be able to be restrictive, to control her food intake and to lose weight. This is a different story to the one that she tells about herself as recovered. Elizabeth somewhat acknowledges her denial, not in relation to anorexic symptoms but rather in relation to emerging symptoms of bulimia. Elizabeth hasn't been speaking about binging and purging to her therapist.

Elizabeth: I haven't really been going to therapy lately that much because it's exam time and um, but ja, it's not really, it's something I'm quite ashamed of and I don't really want to, um, to focus on, you know, (.) it's like I'm sort of in denial. And it worries me because I don't really want to say too much because I don't want to have to go to the psychiatrist again, I don't want to have to have my parents' paying too much money again and they make me feel guilty again.

After thinking about recovery and her sense of herself physically, Christine questions that self starvation may not be damaging to her or at least not more damaging than alcohol use.

Christine: …I don't feel like I'd be physically happy until I was really underweight. (.) If I think of starving myself or um wanting to, is that dangerous? I mean I don't feel, even knowing about how the body works and that kind of thing, I don't really feel like it's that dangerous. (.) Um, in moderation I think there's things you're exposed to every day that are even worse, you know. Alcohol, the things it does to the chemicals in your brain are ridiculous and people expose themselves to alcohol. Um, so I still don't think it's, it's that bad, you know.

In this way, she minimizes the effects starvation has on her body and justifies her behaviour. She attempts to normalize starvation in the context of other damaging behaviours which people engage in. There is a denial of the recognition of the pathology of her desire to be underweight. Kelly too has difficulty recognizing pathology.

Kelly: I never feel overweight. Um, you know, and I never feel like, at the moment I don't feel like I want to lose weight, you know.

Interviewer: Are you, would you still be afraid to put on some weight?

Kelly: Yes, I'd be very, very afraid, um, yes.

Kelly views herself as in recovery because she does not want to lose weight which means to her that she is satisfied with her physical appearance. She does not recognize that her fear of gaining weight, which forces her to comply with a strict eating plan, is as significant as the desire to lose weight.

Most of the participants spoke of recovery in terms of increased awareness between anorexic symptoms and internal states. Elizabeth recognizes that her desire to lose weight is related to poor self-esteem.

Elizabeth: I think that if you do want to lose weight, um, you know it's probably not very good because it does still reflect that you have a low self esteem and that you're taking action instead of thinking of other ways to become more comfortable with yourself.

In the above quote, Elizabeth seems to be saying that anorexic behaviours are a way for her to cope and that she doesn't know how else to deal with being uncomfortable with herself. Christine speaks about physically expressing feeling bad about herself.

Christine: …when things become not okay I get really, um, er, self-aware, um, quite self-loathing I think. Um, I think that happens for a small period before I start starving myself. (.) Like I will be angry with myself for doing something and I think it'll come out in a physical way, like I'll feel very disgusted when I look in the mirror (.) that kind of thing.

Jessica has used feeling fat to alert her to the fact that she is feeling insecure. Unlike Elizabeth and Christine, Jessica can now reflect on why she is feeling that way rather than act on those feelings.

Jessica: …I know nowadays, like, if I'm feeling insecure, the first thing I say is, "I'm getting fat," and it's not, "I'm getting fat," it's actually saying, "I'm insecure with this environment I'm in". …And in fact as I say, nowadays I notice that if I am feeling insecure then I'll say, "I'm putting on weight," and I know deep down I'm not putting on weight or I'm not getting fat, it's just the thing that I'm feeling insecure and that normally just says to me, you know, "Back off, something's wrong!" …I, basically what I do is, if I'm feeling like that, then I start reflecting about why I'm feeling like that.

Heather frequently experiences fat days which she knows is unrelated to her actual weight. It is interesting that she labels her mood states in this way, with a

thin day representing confidence and cheerfulness while a fat day represents feeling self-loathing and depressed.

> *Heather: I come in and I feel terrible (.) it's a fat day. I don't want to get up from my seat because whoever's standing around is going to see me on my "fat day." It could be because I missed gym the night before, whatever. …like if my boyfriend phones and he wants to go out and that depends now, am I having a "thin" day or a "fat" day because my quality of life depends on how thin I'm feeling or fat. I may not necessarily look thinner but it's all up here. …There's quite a few "fat" days, not as much as before but it's still there.*

Many of the participants spoke about recovery in terms of their changing identity or thinking about the concept of identity in different ways. In the following quote Carla shows how she came to realize that her identity did not have to rest on what she accomplished but rather, through her religious beliefs, could discover her intrinsic value.

> *Carla: Um, we grow up thinking that, um, what we do is who we are. The, the, how you look, um, the qualifications that you have, the um (.) the things that you have accomplished in life (.) that is what makes Carla, that is what Carla consists of. Um, but I think the way I view it now is that, um, I already have an identity, I already have value, I already have security, I already have acceptance, you know. I've been given it by God and that's the way He created me to be, so it's not something that I constantly have to earn. It's not something I constantly have to perform or do to get that.*

For Carla, the realization that she did not have to continuously earn acceptance from others through activity was a relief and allowed her to think about her value as a human being in a different way. Chelsea also came to think about herself in

a different way and recovery for her was a process of self acceptance and being content with being good enough.

> *Chelsea: …now I feel that, you know, that I am who I am and that's okay, and I'm okay with the way I am, um, and (.) and I don't think that me being good enough means I have to be good enough for someone else. I deserve better than to just have to be the way people want me to be. ...kind of having an opinion of myself that is that is like stable, not changing all the time because this one says that and that one says that, you know, um, that you know if somebody has an opinion that's their opinion and, and it's about, you know, that's about them not about me, so not like just because that's their opinion my opinion has to change.*

She was gradually able to establish a more stable sense of herself which was not reliant on what others thought of her. Heather describes sense of satisfaction with who she is at the moment and is proud that she has the resilience to overcome her eating difficulties.

> *Heather: I'm happier now than I was with myself and even when I was very thin and I'm content, I should just say "content." I'm okay, I'm satisfied and I, you know, I am happy that I have the strength to do this…*

In talking about recovery Heather speaks about herself as *"okay"* and later on says "*I couldn't imagine my life without thinking like this"*. She believes that she can never have a normal relationship with food.

> *Heather: I don't know how a normal person thinks about food, you know. I sit in the office and I, I look at some of the women there and I think, she's like (.) I know this one thinks normally about food and I wonder what, what have I missed, do you know what I mean? Does she know how I think about it? [Laughs] It's, er, I don't know!*

Heather tries to imagine what it would be like to think differently and is certain that others think differently from her. In a sense, Heather sees herself as irreversibly damaged and says that she *"couldn't imagine my life without thinking like this…, if you ask me in ten years' time I'll still be thinking in the same way…"* She does recognize that she has control over how she manages her thoughts and ends by saying that she hopes in ten years time that *"I haven't caused any more harm."* Kelly also offers a pathologised version of herself, as someone who is not normal when it comes to food.

> *Kelly: …it's difficult to realise that, that you're not normal and to accept that you're not normal when it comes to food. But it basically means that you've got to change the way you think, you know. The … has given me a solution, I can live in this solution and it's through finding a higher power which I choose to call God but, you know. Um, and so you kind of, you, you admit that powerlessness (.) I have got no control over food whatsoever and I'm not normal when it comes to food.*

By narrating herself in this way she rejects any possibility that she can recover fully and instead accepts that anorexia is fixed and permanent and cannot be changed but rather needs to be controlled. The programme gives Kelly structure and allows her to maintain restrictive eating behaviours.

> *Kelly: I follow a very rigid food plan so, um, I even have times when I eat. Some people in … only have three meals a day with nothing in between. I have three meals a day and two snacks and food that makes me feel okay.*

Despite being able to recognize that her eating patterns now are similar to when she was anorexic, Kelly prefers to frame it as recovery. In this way anorexia continues to exert control over her and participation in this programme reframes

her restriction as *"controlling natural tendencies"* rather than being located within a narrative of illness.

Participants also identified the importance of finding balance in their lives. Rachel speaks about recovery at first becoming an obsession where she became absorbed in making sure that she was eating healthily and exercising appropriately. Now that she believes that she is recovered, she thinks that finding a balance in her life is important although emotional balance still poses a challenge.

> *Rachel: …and now it's to try and find a balance. It's, one thing I find very hard is trying to balance my emotions and my feelings and that kind of thing.*

Lisa speaks about being able to listen to her body in order to react appropriately. She speaks about an integration of sorts and the ability to be realistic about her expectations of herself.

> *Lisa: Now I'm normal, like doing normal things at a normal pace. If I'm tired, I'm tired (.) I need to sleep. I need to rest. …before you detach from your body in a way, and it is coming together and learning to understand your body and what you can accomplish and when you actually do need to take sort of a break.*

In this last quote, Lisa speaks of the loneliness of being a recovered anorexic.

> *Lisa: Ja, I kind of feel alone in this like rejoicing feeling (.) even though now they know that I was (.) they still don't grasp what I went through and it's also like being recovered now is hard (.) I so, I want to get, I want the people that were there with me to be better too. I mean that was difficult*

now for me and like I wanted also (.) I just wanted to help everyone and I realised, no, that I can't, you know, they've got to make that connection. It's a frustrating thing…

For Lisa, her own recovery has motivated her to help others with similar difficulties. She speaks about not feeling understood by her peers and seems to be saying that she has not yet gained a sense of belonging with peers who have not been anorexic. Lisa conveys a sense that leaving anorexia behind has left a space in her life that has not yet been filled. One way that Lisa seems to have found meaning in her experience and a way to connect with others is to speak publicly about her struggle with anorexia.

Lisa: …from that I've realised like how passionate now I am about it (.) bringing it out to like speaking about it and to you know. This is what I want to do, I've come through it, I'm so lucky to be where I am. I'm living life, I'm not in that cycle any more and I've come out of it, so I've got to speak up.

Lisa's experience of sharing her story with others is a powerful indication of how stories can help a person to make meaning of their experiences.

Although all of the participants believe themselves to be recovered to some degree, the narratives of how they perceive themselves in relation to anorexia in the present questions this belief. Participants used a variety of means to hold onto the belief that they are recovered even in the face of ongoing symptoms. Most of the participants continue to struggle with issues of weight gain, accepting the destructiveness of restrictive eating, poor self-image and learning to separate their sense of self from that of an "anorexic identity". In order for these participants to consider themselves recovered, some change must have taken

place, all of them have restored their weight to within normal limits and follow some kind of healthy eating plan. This then seems, for them, sufficient evidence of recovery. As indicated elsewhere, recovery means very different things for each participant and it would seem that recovery is therefore a personal endeavour to overcome the specific difficulties they face. The narratives in this study highlight the difficulty clinicians' face in determining recovery and the important difference between weight criteria and the range of other thoughts, feelings and behaviours that may indicate recovery.

Chapter 5: Discussion

"If you want to know me, then you must get to know my story, for my story defines who I am. And if I want to know myself, to gain insight into the meaning of my own life, then I too must come to know my story…a story I continue to revise, and tell myself (and sometimes to others) as I go on living. We are all tellers of tales. We seek to provide our scattered and often confusing experiences with a sense of coherence by arranging the episodes of our lives into stories"

McAdams (in Plummer, 2001, p. 43)

The aim of this study was to explore recovery from anorexia through a narrative analysis of participants' accounts of recovery. This study aimed to capture the complexity of young women trying to make sense of anorexia and their efforts to recover from it. It was hoped that the different experiences of recovery would be elicited in order to gain a more nuanced understanding of what it means to be anorexic and how recovery is experienced and understood. The discussion attempts to draw together the themes of the analysis and point to some of its implications.

The analysis of the narratives revealed that the participants had very different perceptions of how they came to be anorexic. Many of the stories told relate to current psychological theories of causation including family dysfunction and social pressures. These explanations are similar to those given in other studies which have found that individuals most commonly perceive family conflict and cultural demands for excellence as contributory dynamics (Beresin, Gordon & Herzog, 1989; Tozzi et al, 2003; Woods, 2004). It could be suggested that familiarity with stories of these kinds in psychological and psychiatric literature potentially influence the stories that have been told here. It was as if the narratives followed particular scripts which limited the complexity and depth of the stories. Stories of causation also seemed more difficult to narrate, with specific focus on external demands and influences, with the implication that it is in fact quite easy to become anorexic, for example Chelsea comparing herself to

her peers. Stories on how personal characteristics or personality features may have influenced the onset of anorexia were largely absent. At times, the stories told provided glimpses of the pain and distress that these young woman experienced in the past and to some extent continue to experience in the present. Heather's account of how she can remember her mother's disgust at her appearance is a powerful illustration of this. It seems that while some participants could explicitly link the development of anorexia with some kind of trauma, for others the link was less clear and, although present in the narratives, did not come through as strongly as other narratives regarding the genesis of anorexia. Narrating causes for both the participant and the audience became a process of searching through the stories for both what was said and what wasn't.

The second section of the analysis turned to narratives on what it meant to be anorexic. Participants spoke in one way or another of how they came to define themselves as anorexic and what meaning this held for them. For Elizabeth and Lisa being diagnosed as anorexic was seen as a starting point to becoming anorexic and in a sense more fully adopt the behaviours and characteristics of what they thought being anorexic meant. The conceptualisation of anorexia as a personal "identity" is not uncommon to these participants, and is considered to be a common phenomenon in patients with anorexia with far reaching implications, particularly in how it relates to the acceptance or rejection of treatment (Tan, Hope, & Stewart, 2003). While some participants embraced the diagnosis of anorexia, others rejected it. These rejections were based on the perception that once identified as an anorexic, a person cannot be seen as an individual and all behaviour, thoughts and emotions can be attributed to "the anorexia". Participants who resisted a complete identification with what it means to be anorexic emphasised the importance of being recognized and acknowledged as more than just a disorder. This emphasises how patients with anorexia cannot be thought of in terms of having a unitary self-perception but rather as narrators of multiple and changing self perceptions which may be interpreted differently in different contexts (Malson et al, 2004).

Within the narratives of what it meant to be anorexic was the idea of the denial of needs and that physical feelings associated with hunger and starvation provide an alternative to experiencing emotional distress. Anorexia was thus not only narrated as a particular way of being but also as a coping mechanism for overwhelming suffering. Central to the stories of identity were stories of how anorexia becomes narrated as a quest for control in an effort to contain these anxieties. All of the participants had a story to tell about how one of the most appealing features of anorexia was the accomplishment of intense self-control. Despite this appeal, many participants came to recognise that they were in the grip of a control paradox in that they had become in the control of anorexia. Although this link was not made by participants it seems that it was this insight, that they in fact were not in control, that alerted them to the fact that they were in need of help. The issue of identity seems to have important implications for treatment. Accepting treatment implies surrendering a large share of their personal identity without any obvious alternative with which to replace it. How then participants came to seek treatment and perceive recovery to be necessary was important to explore.

All of the participants had stories to tell about a turning point which for them represented the beginning of the recovery process. Within narratives of turning points, participants identified the importance of coming to a personal awareness of the destructive nature of their behaviour. Recovery therefore could not be initiated by the demands of others but rather was a process of taking personal responsibility. Of interest was how some participants spoke about a decision to recover, for example Carla saying *“the day that I wanted to recover”* and Rachel saying “*I decided to get better, which I did”*. This reflects how important it was for participants to maintain control and believe in their own autonomy and self-efficacy. For other participants turning points involved a sense of responsibility towards significant others. Here the decision to recover resided outside of oneself rather than arising from personal desire. It has been argued that although turning points can be seen as setting recovery in motion, they are not sufficient

causes of change (Garret, 1998). Once a decision to recover has been made there are further challenges to be overcome and the process of recovery is a cyclical process rather than a linear one. For the participants in this study, this process included managing relapse, overcoming the fear of gaining weight, developing a sense of the self that is dissociated from anorexia, integrating different aspects of themselves, relinquishing control and developing more adaptive coping mechanisms. Interestingly, for most of the participants treatment did not feature prominently in the stories told about how the above was negotiated.

Treatment interventions were generally narrated as unhelpful and most participants had little faith in therapists and other professionals that they came into contact with. Dissatisfaction with treatment is a well documented phenomenon (Ballot et al, 1989). An analysis of the stories regarding treatment suggested that while treatment was most often narrated in terms of dissatisfaction, an alternative interpretation of resistance to treatment could equally apply. The distinction between the two was difficult to define and they could often be substituted for one another. Participants emphasised readiness for treatment and the importance of confidentiality and the creation of a non-judgmental relationship. The issue of identity and how that relates to treatment became apparent. Participants, Carla in particular, narrated treatment as problematic based on how they thought that they were perceived only as anorexic. Rejection of treatment can be seen as a rejection of a medical or psychological assessment of patients which excludes a more personalized understanding of the individual. Anorexia, although central to the stories told in this study, seemed to be absent in the stories told about therapy and treatment. Some participants narrated how they did not discuss their eating difficulties in therapy but nonetheless expected that therapy would help to resolve these difficulties. Stories of anorexia therefore seem to be silent stories in therapy.

The analysis then turned to stories of what sustains recovery; how participants manage to maintain changes and the insights they have gained through the process of recovery. Some participants maintain some semblance of recovery under the threat of further intervention should they return to restrictive eating behaviours. This raises the question of the completeness of recovery as without these external reinforcements behaviour may be different. For other participants threats and scrutiny by family members helped them to sustain their recovery in a different way as there was a corresponding internal desire to recover. External pressures to recover seem therefore not to be sufficient to produce lasting change. Most of the participants spoke about fear playing an important role in sustaining recovery: fear of parental disapprovement, fear of treatment facilities, fear of being controlled by anorexia and fear of restrictive eating behaviours leading to binge eating. Other participants narrated the importance of support, changing perceptions of themselves, thinking towards the future and being able to recognize when help is needed and reaching out for it as crucial to their ongoing well being.

It was interesting how participants defined recovery. What it means to be recovered was narrated in different ways by participants and seemed to reflect an overcoming of that with which they struggle the most. How participants defined recovery also provided clues as to what participants hoped to achieve in their own recovery. Within these definitions exist contradictions. Elizabeth's fantasy of herself as completely recovered, for example, includes both the view of herself as thin as well as able to respond to her biological urges. These seem in opposition to one another as thinness, according to her perceptions, relies on a denial of instincts and therefore cannot be used as a definition of recovery. Thus, there is a desire to be thin without the control and restriction of anorexia. For some participants, recovery means coming to a greater understanding of the self, the development of a sense of self-worth and self-acceptance. For others being in recovery is a life long process with no end point. Recovery was therefore narrated in three ways, firstly as the achievement of an ideal state, as an ongoing

process with the potential for complete remission or lastly as a life long commitment to remaining in recovery similar to a recovered addict or alcoholic. The way that recovery is conceived therefore has implications for how these participants continue with recovery efforts in the future.

Recovery from anorexia is most often used to suggest an absence of eating disorder symptomatology. Recovery studies often make assumptions of the definition of recovery and the meaning of recovery, without making it explicit why the participants in their studies are believed to be recovered. In this study, while anecdotal material has been viewed as a vital source of information which brings us closer to understanding experiences of anorexia and recovery, the question of whether participants were recovered or not frequently arose. While these young women consider themselves to either be recovered or in recovery, it is clear from the stories that they tell about themselves in the present that some aspects of anorexia persist to varying degrees and while they may no longer meet the criteria for a diagnosis of anorexia, dysfunctional thoughts regarding food and weight remain. One of the participants now struggles with bulimia but does not let this interfere with her story of herself as recovered, another questions whether starvation is in fact harmful, and another is satisfied with her weight but is terrified of weight gain. In some way these aspects of their story, while given voice, are not taken as indications of pathology but rather exist side-by-side with stories of recovery. Other participants tell a story of themselves as pathologised in some innate and permanent way, and offer resistance to this pathology, for example developing coping strategies to counteract the desire to starve, as recovery. Narratives also show how perceptions of weight and the body continue to act as expressions of emotions. For the participants who have made this link and can reflect on rather than act on these perceptions, this is taken as evidence of recovery. Recovery for others is reflected in a changing identity, considering oneself “good enough”, finding balance and responding appropriately to needs and desires. The way that participants narrate their recovery therefore reflects the fluidity of recovery and leaves open a range of possibility in terms of whether

these participants are recovered or not. This implies that recovery cannot be seen as static but rather as a process that unfolds over time, possibly with changing perceptions of what it means to be recovered and the further attainment of more healthy ways to relate to the self and others.

The results of the analysis illustrate that there are many different ways in which anorexia and recovery can be narrated, at times the stories told converge and offer similarities of experience while at other times they diverge onto different paths of experience. This research facilitated the telling of these stories as they were told but also cautiously interpreted these experiences and questioned the meanings offered. Through the creation of these stories, the creation of recovery takes place. What has emerged from the study is the dichotomy of recovery versus non-recovery and how they can, at times, be read as both. Throughout the stories of recovery, traces of anorexia can be detected and so simple stories of saying “I’m recovered” are not enough because shades of contradictory stories can be heard which must also be listened to. The participants offered what seemed to be a coherent narrative, flowing from the past to the present but within this seamlessly flowing narrative is something that is difficult to integrate. Ongoing struggles and confusion about weight and shape, food and self-image become an unintegrated addendum to the otherwise coherent narrative of recovery. One is left with a sense that for these participants, further stories are waiting to be told, for some stories about an ongoing struggle to overcome anorexia and for others, stories about continued transformation within recovery. Lock (as cited in Collins, 2005) articulates the process of recovery in the following way:

> “Defeating anorexia nervosa is like climbing a sand hill: you can’t rest until you get to the top or you will slide right back down again” (p. xiv).

This study has explored the perspective of those climbing the sand hill and hopes to have conveyed the shifting landscape of recovery.

Reference List

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th ed.).* Washington DC: Author.

Bachner-Melman, R., Zohar, A.H. & Ebstein, R.P. (2006). An examination of cognitive versus behavioural components of recovery from anorexia nervosa. *The Journal of Nervous and Mental Disease, 194,* 697 – 703.

Bakan, D. (1996). Some reflections about narrative research and hurt and harm. In R. Josselson (Ed.). *Ethics and process in the narrative study of lives.* (pp. 3-8). London: Sage Publications.

Ballot, N.S., Delaney, N.E., Erskine, P.J., Langridge, P.J., Smit, K., van Niekerk, M.S., Winters, Z.E. & Wright, N.C. (1981). Anorexia nervosa – a prevalence study. *South African Medical Journal, 59,* 992 – 993.

Beresin, E.V., Gordon, C. & Herzog, D.B. (1989). The process of recovery from anorexia nervosa. In J.R. Bemporad & D.B. Herzog (Eds.), *Psychoanalysis and eating disorders.* (pp. 103-130). New York: The Guilford Press.

Berg, B.L. (1998). *Qualitative research methods for the social sciences*. Boston: Allyn & Bacon.

Bruch, H. (1973). *Eating Disorders. Obesity, anorexia nervosa and the person within*. London: Routledge & Kegan Paul Ltd.

Chase, S.E. (1996). Personal vulnerability and interpretative authority in narrative research. In R. Josselson (Ed.). *Ethics and process in the narrative study of lives.* (pp. 45-59). London: Sage Publications.

Chassler, L. (1994). “In hunger I am king” – Understanding anorexia nervosa from a psychoanalytic perspective: Theoretical and clinical implications. *Clinical Social Work Journal, 22(4),* 397-415.

Collins, L. (2005). *Eating with your anorexic. How my child recovered through family-based treatment and yours can too*. New York: McGraw-Hill Companies, Inc.

Eisler, I. (1995). Family models of eating disorders. In G. Szmukler, C. Dare & J. Treasure (Eds.), *Handbook of eating disorders. Theory, treatment and research* (pp. 155 – 175). West Sussex: John Wiley & Sons, Ltd.

Eivors, A., Button, E., Warner, S. & Turner, K. (2003) Understanding the experience of drop-out from treatment for anorexia. *European Eating Disorders Review, 11,* 107.

Elliot, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *The British Journal of Clinical Psychology, 38(3),* 215-239.

Fairburn, C.G., Shafran, R. & Cooper, Z. (1999). A cognitive behavioural theory of anorexia nervosa. *Behaviour Research and Therapy, 37,* 1-13.

Fenning, S., Fenning, S. & Roe, D. (2002). Physical recovery in anorexia nervosa: is this the sole purpose of a child and adolescent medical-psychiatric unit? *General Hospital Psychiatry, 24,* 87-92.

Fuller, S. & Hook, D. (2002). Rewriting the body, reauthoring the expert: Reading the anorexic body. In D. Hook & G. Eagle (Eds.), *Psychopathology and social prejudice*. (pp. 110-123). Lansdowne: University of Cape Town Press.

Garner, D.M. & Garfinkel, P.E. (1980). Socio-cultural factors in the development of anorexia nervosa. *Psychological Medicine, 10,* 647-656.

Garrett, C. (1996). Recovery from anorexia nervosa: A Durkheimian interpretation. *Social Science and Medicine, 43(10),* 1489-1506.

Garrett, C. (1997). Recovery from anorexia nervosa: A sociological perspective. *International Journal of Eating Disorders, 21,* 261-272.

Garrett, C. (1998). *Beyond anorexia. Narrative, spirituality and recovery.* Cambridge: Cambridge University Press.

Hollway, W. (1989). *Subjectivity and method in psychology. Gender, meaning and science.* London: Sage Publications.

Hollway, W., Jefferson, J., Spears, R. & Wetherell, M. (2005). Panic and perjury: A psychosocial exploration of agency. /Commentary: Where did Vincent's van go? / Commentary: Unconscious conflict or everyday accountability? / Response: But why did Vince get sick? A reply to Spears and Wetherell. *British Journal Social Psychology, 44(2),* 147-179.

Howard, G. (1991). Culture tales: A narrative approach to thinking, cross-cultural psychology and psychotherapy. *American Psychologist, 46(3),* 187-197.

Hsu, L.K.G., Crisp, A.H. & Callender, J.S. (1992). Recovery in anorexia nervosa: the patients' perspective. *International Journal of Eating Disorders, 11(4),* 341-350.

Jansen, A. (2001). Towards effective treatment of eating disorders: nothing is as practical as a good theory. *Behaviour Research and Therapy, 39,* 1007-1022.

Jarman, M. & Walsh, S. (1999). Evaluating recovery from anorexia nervosa and bulimia nervosa. Integrating lessons learned from research and clinical practice. *Clinical Psychology Review, 19(7),* 773 – 788.

Josselson, R. (1996). Introduction. In R. Josselson (Ed.). *Ethics and process in the narrative study of lives.* (pp. xi-xviii). London: Sage Publications

Keel, P.K., Dorer, D.J., Franko, D.L., Jackson, S.C. & Herzog, D.B. (2005). Postremission predictors of relapse in women with eating disorders. *The American Journal of Psychiatry, 162(12),* 2263-2268.

Lawrence, M. (2001). Loving them to death: The anorexic and her objects. *International Journal of Psychoanalysis, 82,* 43 – 54.

le Grange, D. & Gelman, T. (1998). Patients' perspective of treatment in eating disorders: a preliminary study. *South African Journal of Psychology, 28(3),* 182 – 186.

le Grange, D., Telch, C.F. & Tibbs, J. (1998). Eating behaviours in 1435 South African Caucasian and non-Caucasian college students. *American Journal of Psychiatry, 155(2),* 250-254.

Lester, S. (1999). *An introduction to phenomenological research*. Retrieved 15 June, 2005, from http://www.devmts.demon.co.uk/resmethy.htm.

Lieblish, A., Tuval-Mashiach, R. & Zilbar, T. (1998). *Narrative research. Reading, analysis and interpretation.* Thousand Oaks, California: Sage Publications, Inc.

Long, C. (2005). *Contradicting maternity: HIV-positive motherhood in South Africa*. Unpublished doctoral thesis. University of Cambridge.

Malson, H. (1998). *The thin woman. Feminism, post-structuralism and the social psychology of anorexia nervosa.* London: Routledge.

Malson, H., Finn, D.M., Treasure, J., Clarke, S. & Anderson, G. (2004). Constructing "the eating disordered patient': A discourse analysis of accounts of treatment experiences. *Journal of Community & Applied Social Psychology, 14(6),* 473 -489.

Matoff, M.L. & Matoff, S.A. (2001). Eating disorder recovery: Learning from the Clients healing journey. *Women & Therapy, 23(4),* 43 – 54.

Miles, M.B. & Huberman, A.B. (1994) *Qualitative data analysis. (2nd Ed.)* Thousand Oaks, California: Sage Publications, Ltd.

Miller, J. & Glassner, B. (1998). The "inside" and the "outside". Finding realities in interviews. In D. Silverman (Ed.), *Qualitative research. Theory, method and practice.* (pp. 99-112). London: Sage Publications Ltd.

Minichiello, V., Aroni, R., Timewell, E. & Alexander, L. (1990). *In-depth interviewing: researching people.* Melbourne, Australia: Longman Cheshire Pty Limited.

Minuchin, S., Rosman, B.L. & Baker, L. (1978). *Psychosomatic families. Anorexia nervosa in context.* London: Harvard University Press.

Mishler. E.G. (1986). *Research interviewing. Context and narrative.* Cambridge, Massachusetts: Harvard University Press.

Nasser, M. & Katzman, M. (2003). Sociocultural theories of eating disorders: an evolution in thought. In J. Treasure, U. Schmidt & E. van Furth (Eds.),

Handbook of eating disorders (2nd ed.). (pp. 139-150). West Sussex: John Wiley & Sons, Ltd.

Plummer, K. (1995). *Telling sexual stories. Power, change and social worlds.* London and New York: Routledge.

Plummer, K. (2001). *Documents of Life 2: An Invitation to a Critical Humanism.* London: Sage Publications, Inc.

Redwood, R. (1999). Narrative and narrative analysis. *Journal of Clinical Nursing, 8,* 663 – 674.

Reindl, S. M. (2001). *Sensing the self. Women's recovery from bulimia.* Cambridge: Harvard University Press.

Riessman, C. K. (1993). *Narrative analysis.* Newbury Park: Sage Publications, Inc.

Ross, J.L. (1977). Anorexia nervosa: an overview. *Bulletin of the Menninger Clinic, 41(5),* 418-436.

Steiger, H. & Israel, M. (1999). A psychodynamically informed, integrated psychotherapy for anorexia nervosa. *Journal of Clinical Psychology, 55(6),* 741 – 753.

Strydom, H. & Delport, C.S.L. (2002). Sampling and pilot study in qualitative research. In A.S. de Vos (Ed.), *Research at grass roots. For the social sciences and human service professions (2nd Ed.).* (pp. 333-338). Pretoria: Van Schaik Publishers.

Swartz, D.M., Thompson, M.G. & Johnson, C.L. (1985). Anorexia nervosa and bulimia: The sociocultural context. In S.W. Emmett (Ed.), *Theory and*

treatment of anorexia nervosa and bulimia. Biomedical, sociocultural, and psychological perspectives. (pp. 95-112). New York: Brunner/Mazel Publishers.

Szabo, C.P. & Holland, C. (1997). Abnormal eating attitudes in secondary-school girls in South Africa – a preliminary study. *South African Medical Journal 87,* 524-530.

Szmukler, G. & Patton, G. (1995). Sociocultural models of eating disorders. In G. Szmukler, C. Dare & J. Treasure (Eds.), *Handbook of eating disorders. Theory, treatment and research* (pp. 176 – 192). West Sussex: John Wiley & Sons, Ltd.

Tan, J.O.A., Hope, T. & Stewart, A. (2003). Anorexia nervosa and personal identity: The accounts of patients and their parents. *International Journal of Law and Psychiatry, 26(5),* 533–548.

Tozzi, F., Sullivan, P.F., Fear, J.L., McKenzie, J. & Bulik, C.M. (2003). Causes and recovery in anorexia nervosa: the patient's perspective*. International Journal of Eating Disorders, 32(2),* 143 – 154.

Tutty, L.M., Rothery, M.A. & Grinnel, R.M. (1996). *Qualitative research for social work (1st Ed.).* Boston: Allyn & Bacon.

Vandereycken, W. (2006). Denial of illness in anorexia nervosa – A conceptual review: Part 2 different forms and meanings. *European Eating Disorders Review, 14,* 352-368.

Wagner, A., Barbarich-Marsteller, N.C., Frnak, G.K., Bailer, U.F., Wonderlich, S.A., Crosby, R.D., Henry, S. E., Vogel, V., Plotnicov, K., McConaha, C. & Kaye, W.H. (2006). Personality Traits after Recovery from Eating

Disorders: Do Subtypes Differ? *International Journal of Eating Disorders, 39,* 276–284.

Way, K. (1993). *Anorexia nervosa and recovery. A hunger for meaning.* New York: The Haworth Press, Inc.

Weaver, K., Wuest, J. & Ciliska, D. (2005). Understanding women's journey of recovery from anorexia nervosa. *Qualitative Health Research, 15(2),* 188-206.

Williamson, D.A., Martin, C.K. & Stewart, T. (2004). Psychological aspects of eating disorders. *Best Practice and Research of Clinical Gastroenterology, 18,* 1073-1088.

Wilson, C.P., Hogan, C.C. & Mintz, I.L. (1992). *Psychodynamic technique in the treatment of eating disorders.* New Jersey: Jason Aronson Inc.

Windauer, U., Lennerts, W., Talbot, P., Touyz, S.W. & Beumont, P.J.V. (1993). How well are "cured" anorexia patients? An investigation of 16 weight-recovered anorexic patients. *British Journal of Psychiatry, 163(2),* 195-200.

Woods, S. (2004). Untreated recovery from eating disorders. *Adolescence, 39(154),* 361 – 372.

Ziervogel, C.F. (1995). Anorexia nervosa and bulimia nervosa in young women in South Africa. *South African Journal of Continuing Medical Education, 13(5),* 543.

Zipfel, S., Lowe, B., Reas, D.L., Deter, H. & Herzog, W. (2000). Long term prognosis in anorexia nervosa: lessons from a 21-year follow-up study. *The Lancet, 355(9205),* 721-722.

Appendices

Appendix A: Advert for Participation in Research Study

Recovery from Anorexia Nervosa Study

If you have recovered from Anorexia with or without clinical treatment and would like to assist with this study on your experience of recovery, please contact Samantha on

072 5977125 or e-mail sam-furniss@webmail.co.za

Confidentiality is ensured.

Your input will be important and is greatly appreciated.

Appendix B: Interview Guide

1. Tell me about the journey of recovery you have been on? What has it been like for you?
2. Looking back, when did your eating disorder symptoms begin?
3. How did they start?
4. What, to your mind, led to you developing anorexia?
5. What eating behaviours did you engage in?
6. Was there a key turning point in the initiation of your recovery?
7. What treatment did you receive?
8. What experiences did you find were helpful in the alleviation of your symptoms?
9. What was unhelpful?
10. What do you think played an important role in your recovery from anorexia nervosa?
11. What does being recovered mean to you?
12. Do any physical or psychological aspects of your eating disorder persist? In what way?
13. What do you currently find helpful in keeping you from your former eating behaviour?
14. Looking back, do you believe that you developing anorexia could have been prevented? How?

Appendix C: Participant Information Sheet

RE: Subjective Accounts of Recovery from Anorexia Nervosa

Dear Prospective Participant,

My name is Samantha Furniss. I am currently completing a master's degree in clinical psychology at the University of the Witwatersrand which requires me to complete a research study. My study aims to develop a greater understanding of the process of recovery from anorexia nervosa from the perspective of individuals who have experienced it themselves. Although there are no direct benefits for the participants in the study, it is hoped that the research will contribute to current understanding of recovery from anorexia nervosa.

You are invited to participate in this study. Should you consent to participate in the study, you will be required to answer a series of questions regarding your recovery process. The interview will last for approximately two hours and will be audio taped. I will write out the interview. The tapes and interview material will be kept for a period of two years after which it will be destroyed. All information that you share will be kept confidential as you will not be requested to provide any personally identifying information. Participation in this study is voluntary and you are under no obligation to participate. If you chose to no longer participate, you may withdraw at any time.

Contact numbers of appropriate counselling services will be made available to you should you require further support at the conclusion of the interview. I will also provide you with my contact details and those of my supervisor in the event that you require any additional information.

The findings of this study will be compiled as a research report and may be adapted for possible publication in a scientific journal. If you are interested in the

findings, the research report will be available in the William Cullen Library at the University of the Witwatersrand.

I will be glad to answer any questions that you have regarding any aspects of the research study.

Thank you for your time.

Samantha Furniss

Appendix D: Interview Consent Form

Subjective Accounts of Recovery from Anorexia Nervosa

I hereby consent to participate in the above-mentioned study. I have read and understood the participant information sheet. I understand that as a participant I am guaranteed confidentiality. I also understand that I may choose to withdraw, at any time, from the study and that in the event of my withdrawing; this will not be held against me.

I acknowledge that this is a voluntary contribution in the interest of education and acknowledge on this _____ day of _____ 2005.

_____

Signature

Appendix E: Audiotape Consent Form

Subjective Accounts of Recovery from Anorexia Nervosa

I hereby consent to the audio taping of the research interview. I understand that all information on the audio tape will remain confidential.

The audio tapes and transcripts will not contain any identifying information and will be destroyed after two years from the time of the interview.

_____

Signature

_____

Date

Appendix F: Introduction to Participants

Elizabeth (18) is a first year student. She believes that it is inevitable that she became anorexic because her mother has always been a dieter. She went on Weighless in Std. 5 and continued dieting from then on. Elizabeth was 16 when she was diagnosed with cancer and felt that everything was out of her control; she also put on weight during this time. When she recovered she wanted to lose the weight and started restricting her food intake. Elizabeth links the beginning of anorexia with wanting to be in control and regain the attention she had received from her family when she had cancer. After about 8 to 10 months of losing weight her mother took her to a psychologist, initially to treat her depression. She didn't believe that she was anorexic because she didn't think that she was thin enough or restrictive enough. Although she considers herself to be recovered, at the moment she is very unhappy with her figure and is feeling confused about gaining weight as she has been bingeing. She finds it difficult to control her eating unless it is a very structured eating plan. She recognizes that she probably looks "normal" but feels fatter than everybody else. To her, recovery means being really thin but not dieting and not being obsessive about her eating. Although Elizabeth has symptoms of bulimia she has not been discussing this in therapy and doesn't think that she purges often enough for it to be bulimia.

Rachel also became aware of being anorexic only after recognizing that she was depressed and had withdrawn from relationships and activities that she previously enjoyed. She is 20 years old and is a student. Rachel started having eating difficulties in Standard 8 which became most serious when she was in Matric. She realized that something was wrong after her father told her that she needed to start eating more. Her concern for herself revolved less around her weight and more around the fact that she had no passion for anything and found being depressed very difficult to cope with. Rachel cannot recall a defining moment of starting to get her passion back for life but thinks that is was a gradual process, although she still feels that she is less engaged than she used to be.

The most important part of her recovery has been her own internal drive to get better. She still worries about her appearance and would like to lose weight, although through exercise rather then restrictive eating behaviours. Rachel started seeing a therapist this year. She has not found psychological intervention useful up to this point as she feels that the therapist focuses the sessions and she does not get to speak about her own issues, specifically around weight and body image.

Similar to Rachel's emphasis on the importance on her own will to recover and reinvest in the external world, Kelly (19) believes that recovery only begins with the recognition that there is a problem and that help is required. She further emphasizes that no matter how well-meaning a professional is there is nothing that can be done to help a person gain this awareness. Kelly compares anorexia to alcoholism in that she believes that she will never be recovered but will need to be in recovery for the rest of her life. Kelly started dieting after becoming aware of others girls' figures at age 15 and thought that her stomach wasn't flat enough. She had a friend who encouraged her to diet, which she did, although in secret. She also began exercising regularly. After dramatic weight loss she was taken to a dietician and later to a psychologist. After further weight loss to 35 kilograms her psychologist refused to see her and she was admitted to an eating disorder unit. At this stage she was petrified of putting on weight and found the experience at hospital traumatic, convincing her father to discharge her after three days. She then started bingeing and later decided to consult a dietician. Kelly attended an Overeaters Anonymous meeting which had a major impact on her. Kelly finds the principles of OA helpful to keep healthy. She follows a rigid eating plan which excludes any of her trigger foods, which she believes she will never be able to eat. Kelly is fearful that if she restricts her eating further she may begin to binge again. At present she is fearful of gaining weight and sticks rigidly to her eating plan. Her mother is sceptical of the programme and is concerned that she may be slipping back into anorexic behaviours.

Like Kelly, Christine (20) also believes that anorexia is comparable to alcoholism and views herself as “in recovery”. Christine stopped eating for a few months after her mother died when she was 15 years old and since then she has had frequent episodes of both restrictive and binge eating behaviours. They are particularly pronounced when she feels unable to cope with life but she considers that she is recovering because she has more control over her symptoms than she did previously. Christine believes that social influences are important and being bombarded with media images of what an “ideal” body shape is has important implications for women who struggle with weight issues. Christine also links starving herself with feeling that she has to punish herself for having done “something wrong or stupid”. Christine’s father thought that she needed help after she took an overdose of sleeping tablets and she then started seeing a psychologist. Christine has been seeing a psychologist for the last year and a half. When she started seeing the psychologist she realized that she did need help although she has only been opening up about her eating difficulties in the last month and a half. Christine has recently had a period of starvation and thinks that she is getting back into old habits. She speaks about projecting feeling bad about herself onto her body which triggers anorexic behaviours. At present Christine is unhappy with her body and finds it difficult to think of being in a place where she can be accepting of herself without being underweight.

While Christine’s experience of the media on young woman has been wholly negative, Lisa has found talking about her experience of anorexia and recovery to the media to raise awareness a useful tool in her own recovery. Lisa (19) is a second year student. She became anorexic at age 15 when she was in boarding school. Although she had been restricting her eating she didn’t start “living being an anorexic” until she was given that label. She didn’t believe that she could be anorexic and thought that it meant not to eat at all. She was taken home by her parents and restricted her food intake further. She started seeing a nurse therapist, and when her weight continued to drop, was admitted to an eating disorder unit. A turning point for Lisa was being in hospital and using techniques

to differentiate between reality and her “anorexic voice” which allowed her to find more of herself. A further motivator for getting well was seeing how ill other patients were and being identified with them. She also realized that the control she had over her eating and weight loss was damaging and that she had become “blocked off” from others. She describes her anorexia as being “an alien”. After leaving hospital she continued to see a therapist and took a year and a half to fully recover. Lisa believes that although she is recovered she still has tendencies towards being anorexic. She still has “funny” eating habits and is an “exercise freak”. She also recognizes that she lacks confidence in herself. She maintains a healthy diet from which she has cut out food groups that she believes that she can’t eat and she is fearful of gaining weight.

Heather (27) is an office manager. Heather traces her difficulties with self image to comments about her weight made by both her parents from the age of 5 or 6 years old. Heather is very angry with her parents and blames them for her difficulties around food. She recalls starving herself to lose weight when she was 9 years old, was abusing laxatives at 12 and had become bulimic by the time she was 13. Heather saw a school psychologist who she thought took her parents side and she never felt comfortable speaking to him, she didn’t see him more than 4 times. Gywnn’s weight fluctuated for a number of years and at age 17 she started taking appetite suppressants. With the help of the appetite suppressants she started restricting her food intake and weight loss followed. She describes being anorexic from 17 to 24 years old. Intervention was sought from doctors who she would see intermittently but if she felt threatened by their questions she would seek help elsewhere. When she was 24 years old Heather became sick and had to have her thyroid removed. She then gained 15 kilograms which was a turning point for her. The weight gain made her think that she hadn’t really been fat before as she now saw herself as “really fat”. The weight gain helped her to gain perspective on her size and although she lost the excess weight with the use of diet pills she says that she did not return to previous destructive eating behaviours. At present Heather is still preoccupied with weight loss although she

follows a normal diet. Her quality of life is determined by how thin or fat she feels which also influences her social interactions. She recognizes that these feelings are not linked to her actual weight but are “all up here”, in her mind. Heather cannot imagine a life where weight preoccupation is not a constant companion. Heather views recovery as a day by day process and doesn’t believe that she could ever be fully recovered.

Carla (23) describes being raised in a very conservative family where she was not allowed to make any decisions for herself. She describes her father as very controlling, determining when, how much and what she should eat. She describes her life as “out of the book” in terms of what is written about anorexia and bulimia. Like Heather, she locates the development of anorexia within her family. At school, her eating difficulties began with bulimia which started after feeling “frustrated” and “awful”. She also started restricting her food intake and describes periods of restrictive eating interspersed with binge eating followed by purging. Carla identifies more with an “anorexic mindset” based on the reading that she has done i.e. being a perfectionist, being driven, intelligent, analytic and taking things to extremes. Carla identifies being drawn to the control aspect of anorexia, being able to take control of something that was her own. Her anorexic symptoms became worse when she went to university although she also believes that it was leaving home that started the healing process for her. Carla was taken by her parents to numerous therapists who she thought were “useless” and “clueless”. Carla places emphasis on the fact that her perceptions of the help that she received may be coloured by the fact that she was forced into the interventions rather than it being a decision that she made herself. A turning point in her recovery was meeting a lay counsellor who did not make an issue of her eating or not eating and provided her with the space to talk about the “roots” of her problems. Carla also emphasises how her faith in God has helped her to think about her value as a human being. Carla considers herself to be in recovery but still struggles with weight gain. She believes that she will be fully recovered when she is able to identify her triggers and work through issues rather than

automatically reacting to external stressors. She struggles to eat fatty foods and food prepared by others. Furthermore, her eating schedule is strictly structured and she has quite rigid eating patterns.

Unlike the other participants, Jessica and Chelsea consider themselves fully recovered and also believe that they no longer experience any of the symptoms of anorexia. Jessica is a 25 year old computer programmer. Jessica's eating difficulties began in Primary school after her father commented that she had been gaining weight. She was also having a "rough" time at school. She started exercising frequently although she did not lose any weight. She did not enjoy high school either and when she was in Std. 8 her father moved the family to the Western Cape. Jessica felt cut off from friends and hobbies and felt that she had to "show a brave face". Jessica began losing weight steadily until her grandmother informed her parents that she thought Jessica was anorexic. After Jessica's parents made efforts to seek advice Jessica agreed to go on Weighless. This was seen by her as a less threatening intervention because it was a diet. After starting Weighless she saw a psychologist in Cape Town for a once off session and another for a longer period of time. It took Jessica a year to get to her average weight and a further 3 years before she felt recovered. Although no symptoms remain, Jessica recognizes that when she is feeling insecure she starts to "feel fat". This acts as a warning for her to take a step back and evaluate what is upsetting her.

Chelsea is a 21 year old student. Chelsea's father died when she was 5 weeks old and she was raised by her grandmother. Chelsea started restricting her eating when she was 15 years old in response to her friends commenting on her weight. She lost 17 kilograms in 3 months and after her grandmother found her passed out in the bathroom her mother threatened to take her to a psychologist if she didn't start eating. Chelsea was fearful that it would mean that she was "mad" if she went to see a psychologist. She did not believe that she needed to gain weight but thought that she shouldn't lose any more weight as she might

die. The issue of being in control was also strong in Chelsea's mind and she recognized that further weight loss may result in her becoming out of control. Chelsea marks the point of recovery when she started to feel better about herself. Before that she found that it was easy to slip back into an "anorexic" pattern of thinking. She was unable to comment on the process of her recovery and says that it "just happened" that she started eating regularly again. She also states that she no longer believes that if she loses weight people will like her more and believes that being good enough for herself does not necessarily mean that she will be good enough for others, which is okay. She also started to think about her identity and who she was outside of her relationship which was at first daunting but made her realise that she wanted to find out who she was. At present, she eats less when under stress but maintains that there is no conscious process behind the weight loss and weight gain follows naturally. Recovery for her is being herself in a more positive way, being realistic about herself and being happier with who she is. Chelsea stressed the importance of having a caring and supportive family during recovery and believes that it would have made her recovery process a lot easier if she had been supported from the start.