CLINICIANS’ UNDERSTANDING AND USE OF THEIR PERSONAL RECOVERY IN THE TREATMENT OF EATING DISORDERS

by

ALESSANDRA URBANO

(Under the Direction of Edward Delgado-Romero)

ABSTRACT

The limited estimates available (Barbarich, 2002; Bloomgarden, Gerstein, & Moss, 2003; Costin & Johnson, 2002) indicate that the prevalence of eating disorders (EDs) among professionals who treat EDs is significantly higher than the prevalence of EDs in community samples. Despite this indication, little is known about how “recovery” is defined or how recovered clinicians use their personal recovery in the treatment of EDs.

The present study contributes to this largely underdeveloped body of literature by providing an in-depth examination of a sample of nine clinicians’ understanding and use of their personal recovery in the treatment of EDs. More specifically, this study used a feminist research orientation (Striegel-Moore, 1994) and the Corbin/Strauss (2008) approach to qualitative analysis to produce findings in the form of two classificatory schemes with accompanying diagrams regarding recovered ED clinicians’ (a) understanding/definition of ED recovery and (b) use of personal recovery in the treatment of EDs. To enhance the credibility of the findings, verification standards and procedures were incorporated into each stage of the recursive research process, including member
checks of transcripts, demographic information, and the classificatory schemes and diagrams; the use of multiple data analysts and routine team meetings; reflexive journal writing on behalf of all three researchers; theoretical sampling; and peer debriefing. A discussion of the major findings and conclusions drawn from the current study, their implications for practice and training, and recommendations for future research is included.

INDEX WORDS: Eating disorder treatment; use of self; bulimia; anorexia; disordered eating; eating disorder recovery; recovered clinicians; wounded healers
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DEDICATION

It is with profound gratitude that I dedicate this dissertation to my mother Diane and father Jim, whose continued sacrifice, generosity, and love have gotten me where I am. This dissertation is a product of the collective “us.” Thank you for giving me both the space and support to pursue my passion.
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May your strength give us strength
May your faith give us faith
May your hope give us hope
May your love give us love

Thank you all. Your strength, faith, hope, and love will be with me always.
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CHAPTER 1

Introduction

Brief Overview of the Current Study

The extremely limited estimates available (Barbarich, 2002; Bloomgarden, Gerstein, & Moss, 2003; Costin & Johnson, 2002) indicate that the prevalence of eating disorders (EDs) among professionals who treat EDs is significantly higher than the prevalence in community samples. Despite this indication, there is no consensus in the current literature about how “recovery” is defined and little is known about how recovered clinicians use their personal recovery in the treatment of EDs. The present study contributes to this underdeveloped body of literature by providing an in-depth examination of a sample of nine clinicians’ understanding and use of their personal recovery in the treatment of EDs.

Background and Context

As many as 10 million females and one million males in the United States struggle with an ED such as anorexia nervosa (AN) or bulimia nervosa (BN) while about 25 million additional Americans struggle with binge-eating disorder (BED) (National Eating Disorder Association, 2005), which currently falls under the Diagnostic and Statistical Manual of Mental Disorders' (American Psychiatric Association [APA], 2000) diagnostic category “eating disorder not otherwise specified” (EDNOS). Relapse rates for AN and BN are commonly cited around 30% or more (Herzog et al., 1999; Keel & Mitchell, 1997; Olmsted, Kaplan, & Rockert, 1994) and repeated admissions to treatment
facilities are common (Woodside, Kohn, & Kerr, 1998). Only a small minority of people who meet the diagnostic criteria for EDs receive mental health care, however, (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001; Cachelin & Striegel-Moore, 2006; Hoek & van Hoeken, 2003) and weight related concerns and perfectionistic tendencies tend to continue in women who have suffered from EDs post physical recovery (Jones, Harris & Leung, 2005; Srinivasagam et al., 1995; Stein et al., 2002).

Eating disorders are complicated illnesses that impact one’s physical, psychological, interpersonal, sexual, and cognitive functioning. Many individuals with EDs experience concurrent depressive symptoms, mood disorders, substance abuse, and/or anxiety disorders in addition to self-harm and/or suicidal ideation (Cockell, Zaitsoff, & Geller, 2004; Maxmen & Ward, 1995; Steinhausen, 2002). Individuals with EDs also tend to feel ambivalent about treatment and recovery (Cockell et al., 2004), and often have longstanding beliefs and fears relating to abandonment, vulnerability to harm, unrelenting standards, and/or incompetence that are difficult to change (Jones et al., 2005). Further, the course of EDs and recovery varies widely among individuals (Kordy et al., 2002; Woodside et al., 1998). For these reasons, treatment is complicated and full recovery is difficult to attain for the long-term (Field et al., 1997; Keel & Mitchell, 1997; Stein et al., 2002; Steinhausen, 2002).

Justification of the Present Study

No consensus on criteria for recovery from EDs exists in the current empirical literature (Kordy et al., 2002; Noordenbos & Seubring, 2006), which makes gaining an accurate understanding of recovery rates problematic (Herzog, Keller, & Lavori, 1988; Jarman & Walsh, 1999). For example, some outcome studies have relied solely on
physical signs of recovery (i.e., normal weight, menstruation, and the absence of binging, purging, and compensatory behavior) (e.g., Commerford, Licinio, & Halmi, 1997) while others have also included psychological and social signs (e.g., reduced fears of weight, fat, and food; improved body image) (e.g., Noordenbos & Seubring, 2006; Strober, Freeman, Morrell, 1997). Despite the fact that research suggests that recovery rates differ significantly based on the operating definition of recovery (Jarman & Walsh, 1999; Saccomani, Savoini, Naselli, Cirrincione, & Matricardi, 1989), no operationalized definition has been universally adopted in outcome studies to date. Although recovery from an ED is typically a difficult, long, and non-linear process (D’Abundo & Chally, 2004; Keel & Mitchell, 1997; Stein et al., 2002; Steinhausen 2002), many individuals attain either partial or full recovery (Strober et al., 1997; Wilson, Grilo, & Vitousek, 2007), which varies in meaning depending upon the operating definition of recovery in the study at hand. Outcome studies have reported ED recovery rates widely ranging from 24% to 76% (see D’Abundo & Chally, 2004).

In addition to widespread inconsistencies relating to recovery criteria and rates among community samples of individuals with EDs, there is also a problematic void in the literature examining prevalence and recovery rates among professionals providing ED treatment (Barbarich, 2002; Costin & Johnson, 2002). In one of three published studies that could be located investigating prevalence rates of EDs among professionals in the field, Barbarich (2002) surveyed members of the Academy for Eating Disorders (AED) listed in the year 2000 membership directory and found that the overall lifetime prevalence of EDs for the 399 total respondents was 27.3% \((n = 109)\). Similarly, Bloomgarden, Gerstein, and Moss (2003) surveyed approximately 150 staff members at a
large treatment facility regarding self and family history of EDs and found that 24% of the participants reported personally experiencing an ED at some point in their lives.

In the third published study exploring prevalence rates of EDs among professionals in the field, Costin and Johnson (2002) surveyed ten treatment programs in the United States regarding their experiences with staff members’ personal recovery. Four of the ten programs actively hired staff with personal recovery, which was defined loosely as “normal weight and abstinence from binging and purging” (p. 294) for one or two years depending on the particular site. According to these four programs, the estimates of members who had recovered from EDs ranged from 30% to 80% (Costin & Johnson, 2002).

Based on the findings presented in these studies, the estimated prevalence of EDs among recovered professionals working in ED treatment centers (24% or more) is significantly higher than estimates of prevalence rates of EDs among community samples (around 0.3% for AN and 1-2% for BN, Hoek & van Hoeken, 2003). Further investigation is necessary, however, due to limited research in this area and the potential for important treatment implications.

Furthermore, previous literature suggests that connecting with individuals who have recovered from EDs has been helpful in patients’ recovery processes because it provides hope for the future and facilitates feelings of trust and understanding (Pettersen & Rosenvinge, 2002). A similar positive pattern has also been observed with recovered ED mental health treatment providers in the context of the therapeutic relationship (Johnston, Smethurst, & Gowers, 2005; Costin & Johnson, 2002), which has the potential to enhance treatment efficacy. Before examining the effectiveness of treatment provided
by recovered ED professionals, however, it is first essential to understand how recovered clinicians both define and use their own recovery in the provision of ED treatment, which has not yet been studied beyond a qualitative dissertation completed by Bowlby in 2008.

**Statement of the Problem**

There is a lack of information in the current ED literature relating to (a) a thorough and operationalized understanding of ED recovery and (b) the nature of recovered ED clinicians’ use of their personal recovery in the treatment of EDs. The present study contributes to this largely underdeveloped body of literature by providing an in-depth examination of a sample of nine clinicians’ understanding and use of their personal recovery in the treatment of EDs. More specifically, the present exploratory study investigates the following two research questions:

(a) How do clinicians who have recovered from EDs’ (i.e., recovered clinicians) understand and define ED recovery?

(b) How do recovered clinicians use their personal recovery in the treatment of EDs?

Additionally, because this study focuses on women who are recovered from EDs, it is consistent with counseling psychology’s dedication to positive human functioning (American Psychological Association, 1999). More specifically, the present study views clinicians’ recovered status as a valuable strength and a potentially powerful therapeutic tool (rather than as a deficit), which is consistent with counseling psychology’s emphasis on human strengths, resilience, and potential (Hage, 2003; Lopez et al., 2006). This operating framework provides a notable contrast to the majority of preexisting ED literature, which tends to operate from a deficit model by examining eating pathology. In these ways, the present study intends to:
(a) serve as one of the first studies to examine recovery from the perspective of recovered ED clinicians;
(b) contribute to the lack of literature relating to recovered clinicians’ experiences providing ED treatment; and
(c) apply the unique lens of a counseling-psychologist-in-training’s strengths-based and feminist perspective to a topic that is typically approached from a deficit-based, disease-oriented framework.

**General Hypothesis**

I hypothesize that each participant will have unique experiences and insights that will contribute to a greater understanding of the two phenomena under study, including recovered clinicians’ (a) understanding and (b) use of their personal recovery in the treatment of EDs. Because this is an exploratory study based on the lived experiences of participants, I do not have specific hypotheses about the nature of these experiences and insights. Rather, I expect hypotheses to develop through the reflexive and recursive research process in pursuit of the two aforementioned research questions.

**The Researcher’s Background and Guiding Assumptions**

An essential part of the qualitative research process involves describing the researchers’ personal experiences with the phenomena under study. Corbin and Strauss (2008), for example, advocate that researchers openly acknowledge their relevant biases and experiences, and “use experience to enhance the analytic process” (p. 85). Being open about and aware of one’s relevant experiences and values allows both the researchers and the readers to understand how the researchers’ biases and assumptions influence the analytic process (Corbin & Strauss, 2008). In an effort to be faithful to this
practice, I have actively reflected upon and documented my own experiences related to the current subject matter.

I am an Italian American female clinician who recovered from BN about five years prior to undertaking this study. I have also been an ED clinician in both outpatient and inpatient settings. For these reasons, I relate strongly to the participants’ identity as recovered ED clinicians, although our specific experiences both recovering from and treating EDs vary widely. My personal experiences recovering from and treating EDs directly impacted my choice of, interest in, and commitment to this research topic; my experiences also impacted the way that I approached and understood each phase of the research process given that it is impossible to fully separate my research identity from my personal identity (Creswell, 2007, Striegel-Moore, 1994).

I operate from a strengths-based perspective and assume that it is possible to recover from an ED. I believe, however, that recovery is a dynamic and ongoing process rather than a fixed and quantitatively measurable outcome. For this reason, I do not view all deviations from “normal” eating and thinking as pathological, and I believe that each individual who has recovered from an ED is likely to understand, experience, and define recovery differently beyond minimal behavioral criteria (i.e., normal weight range for one’s age and height and the absence of binging, purging, and compensatory behaviors for at least one year).

Further, because I assume that recovery from EDs is possible, I use the term “suffering from AN or BN” whenever possible as opposed to labeling someone as “anorexic” or “bulimic.” The former terminology avoids dehumanizing the person, is tentative, and implies that one can recover from the illness as opposed to being the illness
as the latter terminology implies. Finally, I operate from a feminist research orientation (Striegel-Moore, 1994) and believe that (a) EDs represent an individual’s best attempt to cope and therefore serve functional purposes in dysfunctional environments, (b) an emphasis on context (e.g., power dynamics, gender expectations, and one’s social, cultural, and political context) is essential in understanding individual functioning and behavior, (c) bias is an inherent part of research and human inquiry and, therefore, self-reflection is a critical component of the research process, and (d) each person is her/his own best expert. Thus, I believe that each participant in this study is an expert on her unique experiences and my role as the researcher involves asking facilitative questions that provide participants the freedom to share whatever feels comfortable and meaningful to them in the moment. These assumptions actively informed the lens with which I approached and understood the participants and the material they provided in this study in pursuit of the aforementioned research questions.

Defining Disordered Eating: A Feminist View

A feminist view of ED development and recovery guided this study. In this conceptualization, the objectification of females’ bodies, impossible physical and social standards, and oppressive gender dynamics are internalized, and then manifested (or externalized) through disordered eating. Sick eating behaviors are viewed as an adaptation to a sick culture (Hutchinson, 1994), and the cry “I am fat” is interpreted more deeply as “I am in pain” or “I am powerless—help!” Matoff and Matoff (2001) capture the essence of this view:

. . . as sociocultural norms for female shape and size have shrunk, expectations and demands on women to be mothers, employees, caregivers, and a myriad of
other social personas have increased. In search of a way to conform to these near impossible physical and social demands, many women have found temporary solace in disordered eating behavior—a symbolic expression of the cultural, political, and body partitioning of “female,” and an effective silencing and isolating mechanism against a more unified protest. The battlecry, reduced to “I feel fat,” rather than “I feel powerless,” or “I feel oppressed,” becomes entrenched in the new and pernicious eating disorder identity. (p. 45)

This feminist conceptualization contextualizes EDs—it provides a lens through which the pathological behaviors and symptoms described in the *DSM-IV-TR* (APA, 2000) can be understood and treated as functional, yet destructive, adaptations.

**Delimitations**

After receiving Institutional Review Board (IRB) approval, the primary researcher and two data analysis team members conducted an in-depth qualitative examination of a sample of nine recovered ED clinicians’ understanding and use of their personal recovery in the treatment of EDs. More specifically, this study used a feminist research orientation (Striegel-Moore, 1994) and the Corbin/Strauss (2008) approach to qualitative analysis to investigate the following two questions: (a) how do clinicians who have recovered from EDs’ understand and define ED recovery? and (b) how do recovered clinicians use their own recovery in the treatment of EDs?

Because specific and information-rich cases were sought, purposeful sampling (Patton, 2002) in the form of snowballing and criterion sampling was used to recruit participants that met pre-established criteria. Email flyers (see Appendix A) were distributed to two ED treatment centers in order to seek participants who meet the
following inclusion criteria: (a) were employed as a master’s or doctoral level mental health treatment provider for EDs at the time of recruitment for this study; (b) met full criteria for an ED (either AN, BN, or EDNOS) at some time in their lives; and (c) no longer met the criteria for an ED at the time of recruitment for this study as indicated by a self-reported normal weight and the absence of binging, purging, and compensatory behavior for at least one year.

The data collection and analysis process was recursive in nature. Data collection included a brief demographic survey and one in-depth, semi-structured interview with each of the nine participants ranging in length from 46 to 110 minutes (mean = 77 minutes). Follow-ups included member checks of the participants' transcripts, the information in the demographic tables (see Table 3.1 & Table 3.2), and both the descriptions and figures associated with each classificatory scheme that were identified through data analysis (see Chapter IV, Table 4.1, Table 4.2, Figure 4.1, & Figure 4.2) to ensure accuracy of the participants’ voices and experiences. To enhance credibility of the findings, verification standards and procedures were incorporated into each stage of the research process. Member checking of transcripts, demographic information, and the classificatory schemes; the use of multiple data analysts; reflexive journal writing on behalf of all three researchers; and peer debriefing were utilized to maximize the trustworthiness of findings.

Definitions and Operationalized Terms

Amenorrhea: Amenorrhea is characterized by the absence of three or more consecutive menstrual cycles.

Anorexia Nervosa (AN): Anorexia nervosa is characterized by restricted food
consumption and refusal to maintain normal body weight (i.e., less than 85% of what is expected for one’s age and height), negative self-evaluation that is overly influenced by weight or shape, intense fear of weight-gain, and amenorrhea in postmenarcheal females (APA, 2000).

**Binge Episode:** A binge episode is characterized by uncontrolled eating of a large amount of food within a 2-hour period (APA, 2000).

**Body Image:** “An internal and subjective sense a person has of her body” (Hutchinson, 1994, p. 153).

**Bulimia Nervosa (BN):** Bulimia nervosa is characterized by recurrent binge episodes and the use of inappropriate compensatory behaviors (e.g., self-induced vomiting, laxatives, fasting, excessive exercising), both of which occur at least twice per week for three months, along with negative self-evaluation that is overly influenced by weight or body shape (APA, 2000).

**Disordered Eating:** Maladaptive eating behavior that does not yet rise to the level of a clinical diagnosis.

**DSM-IV-TR:** The American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.); used to define anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified for the purposes of this study.

**Eating Disorder (ED):** The *DSM-IV-TR* (APA, 2000) term that includes the diagnoses of anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified.

**Eating Disorder Not Otherwise Specified (EDNOS):** This category encompasses eating disorders that do not meet the exact criteria for anorexia nervosa or bulimia nervosa. This category also includes binge-eating disorder (APA, 2000). For the
purposes of this study, participants who reported a previous diagnosis of EDNOS specified the symptoms that resulted in this diagnosis.

*Eating Disorder Symptoms (ED Symptoms)*: For the purposes of this study, eating disorder symptoms include both cognitions/mental schemas (e.g., intense fear of weight-gain, self-evaluation that is overly influenced by weight or shape, denial of the seriousness of one’s eating patterns, distortions in the way one experiences her body) and behaviors (e.g., fasting, self-induced vomiting, excessive exercising, inappropriate laxative use, binging). Throughout this paper, the term “ED symptoms” is intended to refer to both the cognitions and behaviors described above.

*Expected Weight*: For the purposes of this study, expected weight is calculated based on Hamwi’s formula: 100 lbs for 5ft of height plus 5 lbs for each additional inch of height (Hamwi, 1961 as cited in Rorty, Yager, Rossotto, 1993).

*Normal Weight*: Normal weight refers to a self-reported weight by the participant that is between 90% and 125% of the expected weight for her height (Rorty et al., 1993), which was calculated according to Hamwi’s (1961) formula.

*Purge Episode*: A purge episode is characterized by the presence of at least one compensatory behavior, including self-induced vomiting, fasting, excessive exercising, or the misuse of laxatives, diuretics, and/or enemas.

*Recovery*: For the purposes of this study, recovery refers to any master’s or doctoral level clinician who (a) has met the full criteria for an eating disorder (i.e., anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified) at some time in her life, and (b) no longer meets the criteria for an eating disorder at the time of
recruitment for this study as indicated by normal weight and the absence of binging, purging, and compensatory behavior for at least one year. Recovery does not imply that the participant no longer experiences any unhealthy thoughts related to body image and eating. Rather, her eating disorder related symptoms no longer rise to the level of a clinical diagnosis as indicated by self report. Further understanding of what “recovery” looks and feels like for each participant beyond these minimal criteria is explored in this study.

*Recovered Clinician(s):* Throughout this paper the term recovered clinician(s) refers to clinicians who are no longer underweight, have not engaged in any binging, purging, or compensatory behaviors for at least one year, and have not experienced impairment in functioning due to eating disorder related symptoms for at least one year. Additional understanding of what “recovered” means to each participant beyond these minimal criteria is explored in this study.
CHAPTER 2
Review of Relevant Literature

Overview of Eating Disorder Symptoms, Prevalence, and Prognosis in the United States and Western Europe

Anorexia nervosa (AN) is characterized by restricted food consumption and refusal or inability to maintain normal body weight (i.e., <85% of what is expected for one’s age and height), negative self-evaluation that is overly influenced by weight or shape, intense fear of weight-gain, and amenorrhea in postmenarcheal females (i.e., the absence of at least three consecutive menstrual cycles) (APA, 2000). AN typically begins during adolescence and most often affects girls and young women between the ages of 15 and 19 (Hoek & van Hoeken, 2003). An average prevalence rate of 0.3% has been found for females while the overall incidence (i.e., the number of new cases in the population over a specified period of time) is at least 8 per 100,000 people per year (Hoek & van Hoeken, 2003). It is estimated that up to 50% of individuals with AN eventually fully recover, 20% to 30% show residual symptoms, 10% to 20% remain severely ill, and 5% to 10% die from related causes (Steinhausen, 2002).

Bulimia nervosa (BN) is characterized by recurrent binge episodes (i.e., uncontrolled eating of a large amount of food within a 2-hour period) and the use of inappropriate compensatory behaviors (e.g., self-induced vomiting, laxatives, fasting, excessive exercising), both of which occur at least twice per week for three months, along with negative self-evaluation that is overly influenced by weight or body shape (APA,
Individuals with BN typically have normal body weights, and females aged 20-24 years are the group at highest risk for this disorder (Hoek & van Hoeken, 2003). BN has a prevalence rate of about 1%-2% in community samples and the overall incidence is at least 12 per every 100,000 people per year (Hoek & van Hoeken, 2003). Estimates of remission range from 31% to 74% over time (see Wilson et al., 2007) while relapse is estimated to occur in about 30% of individuals with BN (Herzog et al., 1999; Keel & Mitchell, 1997; Olmsted et al., 1994).

The eating disorder not otherwise specified (EDNOS) category encompasses variations of BN and AN, disorders containing symptoms of both AN and BN, and binge-eating disorder (BED) (APA, 2000). EDNOS is the most common ED diagnosis encountered by health care professionals in clinical practice (Fairburn & Bohn, 2005). The prevalence rate of BED is estimated to be around 3% in adults and significantly higher among obese individuals (Grilo, 2002).

Disparities in Eating Disorder Recognition and Treatment Based on Race and Ethnicity

The aforementioned prevalence and recovery rates should be regarded as underestimates given that many individuals with EDs do not seek or have access to treatment and due to the fact that significant disparities exist impacting the recognition and treatment of EDs in ethnic minorities (Cachelin, Veisel, Barzegarnazari, & Striegel-Moore, 2000; Thompson, 1994). A stereotype that permeates the field of psychology and U.S. society at large involves the association of EDs with middle and upper class White females of Anglo and European descent (Becker, Franko, Speck, & Herzog, 2003). Ethnic minority groups, especially African Americans, are often assumed to be immune to eating disturbances and body dissatisfaction because of their cultures’ different views of
attractiveness (Gordon, Brattole, Wingate, & Joiner, 2006). There is substantial data, however, suggesting that EDs affect - and are “equal opportunity illnesses” among - all ethnic and socioeconomic groups in the United States (Becker et al., 2003; Cachelin et al., 2000), but are often overlooked, undiagnosed, and untreated in these groups.

Research on ethnic differences in body image and eating pathology has produced inconsistent findings due to a combination of factors, including poor fit between current diagnostic categories and the ways that diverse populations differentially manifest ED symptoms, a lack of culturally valid ED instruments (Smolak & Striegel-Moore, 2001), clinician biases (Becker et al., 2003; Gordon, Perez, & Joiner, 2002; Gordon et al., 2006), biased clinical samples (Cachelin et al., 2001), and biased research samples (Thompson, 1994). For example, there is substantial research available, especially from the 1980’s and early 90’s, indicating that ethnic minority groups have a decreased risk for, and experience lower rates of, eating pathology in addition to lower perceived pressure to be thin than their White counterparts (Gray, Ford, & Kelly, 1987; Kemper et al., 1994; Stice, 1994) while many more recent studies report minimal or no significant ethnic differences in disordered eating behaviors and risk factors (Hrabosky & Grilo, 2007; Shaw, Ramirez, Trost, Randall, & Stice, 2004; Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000; Wilfley et al., 1996). Of note, a majority of the available ED research in this area tends to compare White and Black females while omitting or significantly underrepresenting other ethnic and racial groups (Smolak & Striegel-Moore, 2001), which presents a problematic bias in the current literature.

In response to the noted inconsistent research findings on the prevalence of and risk factors for EDs among different ethnic groups, Shaw and colleagues (2004) designed a
study to test ethnic differences in ED symptoms and risk factors in a sample of 785 ethnically diverse females, including 64 Asians (8%), 49 Blacks (6%), 108 Hispanics (14%), and 564 Whites (72%) who ranged in age from 11 to 26 years. The researchers evaluated the sociocultural model of eating pathology, which assumes that pressure to be thin promotes the internalization of the “thin ideal” and body dissatisfaction, which then places individuals at risk for dieting and eating pathology (Striegel-Moore, Silberstein, & Rodin, 1986 as cited in Shaw et al., 2004). Therefore, according to this model, if ethnic minorities are in fact subject to less sociocultural pressure to be thin, then they should report lower scores on risk factors for eating pathology. The study found, however, that there are overwhelmingly more similarities than differences in body image, eating disturbances, and risk factors across ethnic groups. Only one main effect was significant after correcting for alpha inflation: Asians and Whites revealed significantly more internalization of the thin ideal than did Blacks and Hispanics. The results did not yield significant ethnic differences in mean levels of any of the other “eating pathology risk factors” (which included pressure to be thin; modeling of ED behavior by parents, peers, family, and friends; body dissatisfaction; dieting; negative affectivity; and self esteem) or in any of the “eating disorder symptoms” (which included fear of fat, weight and shape concerns, amenorrhea, compensatory behaviors, low BMI, and high BMI) (Shaw et al., 2004).

Further, a study by Striegel-Moore et al. (2000) that examined differences in ED symptoms in a community sample of 1,628 African American and 5,741 White women via telephone surveys revealed that African American women were as likely as White women to report that they had engaged in binge eating and self-induced vomiting during the
previous three months, and were more likely to report the use of laxatives, diuretics, or fasting to control their weight. Collectively, these research findings suggest that ED symptoms are not limited to privileged, White females. On the contrary, these studies suggest that EDs and sociocultural factors influence ethnic minorities and White individuals similarly.

An explanation for the inconsistencies reported in the prevalence and risk factors for EDs in middle and upper class Whites as compared to minority ethnic groups proposes that ED patterns are overlooked in minority groups because of various ethnic stereotypes. Gordon et al. (2002, 2006) tested this hypothesis by examining the impact of racial stereotypes on ED recognition in two studies. In the first study, a sample of 160 undergraduates (126 Whites, 8 Hispanics, and 26 African Americans with a mean age of 18 years) read a journal written by a fictitious 16-year-old adolescent girl named Mary who displayed ED symptoms. The passages were all identical except for Mary’s race, which changed between African American, White, and Hispanic. After reading the passages, participants were asked to write whether they believed Mary had any notable problems and, if so, to provide a description of the problem. Lastly, they were instructed to complete the Eating Disorder Inventory as if they were Mary. Results revealed that the race of Mary had a significant impact on the participants’ detection of her ED symptoms. Specifically, the participants were significantly more likely to recognize disturbed eating patterns when they read about the White subject than when they read about the African American or Hispanic subjects (Gordon et al., 2002).

In the second study (Gordon et al., 2006), the experiment described above was replicated with 91 clinicians, including 22 clinical psychology graduate students and 69
clinicians with mental health graduate degrees. Approximately 77% of the sample held either a master’s or a doctoral degree. Eighty-one of the participants were White, four were Hispanic, two were African American, three identified as “other” and one participant did not specify. After reading the description of Mary, participants were asked “Do you think Mary has any problems and, if so, what are they?” They were also asked to rate Mary’s anxiety on the BAI, her depression on the BDI, and her ED symptoms on the EDI. Finally, they were asked “What should be done to help Mary? The results indicated that Mary’s race influenced clinicians’ responses. More specifically, when Mary was White, 44.4% of the participants recognized the symptoms, when Mary was identified as Hispanic, 40.5% of the participants recognized that she had an eating problem, and when Mary was African American only 16.7% of the participants stated that Mary had an eating problem. Clinicians were also less likely to refer Mary for help if she was portrayed as African American than if she was portrayed as White or Hispanic. Collectively these findings support the existence of a race-related clinician bias and suggest that racial stereotypes—such as the stereotype that minority groups, and especially African Americans, are immune to EDs because they are not subject to the same Western societal ideals about physical attractiveness as Whites—may affect the detection, diagnosis, and treatment of EDs in these groups (Gordon et al., 2002; Gordon et al., 2006).

Other studies have also revealed a clinician-bias that impacts the detection, diagnosis, and treatment of EDs in ethnic minority groups. For example, two studies that evaluated the impact of ethnicity on access to health care for ED symptoms found that clinician bias is an important barrier to attaining treatment for ED symptoms in ethnic minority populations (Becker et al., 2003). More specifically, these studies compared both
clinician referral and subject treatment-seeking patterns between ethnic minority and White subjects in a group of over 9,000 participants that was gathered from the 1996 National Eating Disorders Screening Program (NEDSP), a voluntary educational and screening program for EDs held on college campuses across the U.S. (Becker et al., 2003). The ethnic and racial composition of the first sample was 81.6% White, 6.6% African American, 3.4% Latino, 3.0% Asian or Pacific Islander, 0.9% Native American or Alaskan Native, and 2.5% Other. The ethnic and racial composition of the second sample was 92.1% White, 4.3% African American, 1.8% Asian, and 1.1% Latino.

Findings from both studies indicate that clinicians demonstrated a greater likelihood of referring White participants than ethnic minority participants for further evaluation of their symptoms even though Latinos showed the most severe symptoms in the first study and both the ethnic minority and the non-ethnic minority groups showed comparable symptoms in the second study (Becker et al., 2003). Further, ethnic minority participants with self-reported eating disturbances were significantly less likely than non-minority participants to have been asked by a doctor about eating symptoms. These findings suggest that clinician bias is likely to contribute to disparities in the acknowledgement of, access to care for, and treatment of ED symptoms.

In light of the findings described above, it is important to note that the overwhelming majority of literature cited in this paper is problematically based on middle and upper class White participants and norms, and therefore has limited generalizability.

Eating Disorder Treatment

EDs are complicated illnesses that affect an individual’s physical (e.g., low energy level, sleep disturbance, disturbed blood pressure and heart rate), psychological
(e.g., obsessive, rigid, and/or perfectionistic thinking), interpersonal (e.g., rigid, passive, or dependent interpersonal styles) (Cockell et al., 2004), sexual (e.g., problems with intimacy) and cognitive (e.g., reduced working memory ability) functioning. Further, the course of EDs varies widely among individuals (Kordy et al., 2002; Milos, Spindler, Schnyder, & Fairburn, 2005) and often involves concurrent symptoms relating to self-harm, drug and alcohol abuse, depression, anxiety, and/or suicidal ideation (Cockell et al., 2004; Maxmen & Ward, 1995). EDs also affect one’s body image, “the psychological space where body, mind, and culture come together” (Hutchinson, 1994, p. 153), in such a way that healing from the disorder cannot take place without first attending to the dysfunctional relationship between self and body (i.e., moving from “disembodiment,” or the objectification of one’s body, to “embodiment,” the integration of body, mind, and soul in such a way that one’s body is experienced “as a reference point for being in the world”) (Hutchinson, 1994, p. 155). Cockell and colleagues (2004) articulately describe the difficulties involved in providing treatment for such complicated illnesses:

Each person’s reasons for engaging in eating disorder behaviors vary, but there seems to be a general theme of avoidance coping. Typical areas of avoidance include thoughts and feelings related to difficult early life experiences as well as current intra- and inter-personal conflict and distress (Cockell et al., 2003). Thus, recovery requires not only developing new ways of thinking and behaving in relation to eating, shape, and weight, but addressing core issues with new coping strategies. When one takes these various factors into consideration, it is not surprising that the process of recovery is often slow and bumpy. (p. 528)
Walsh, Wheat, & Freund (2000) conducted an extensive review of the literature on the epidemiology, diagnosis, and treatment of EDs. They concluded that optimal treatment of EDs should include a multidisciplinary treatment team, including a primary care provider, a nutritionist, and a mental health professional. They further reported that immediate treatment interventions for both AN and BN should ideally be aimed at weight restoration through “nutritional normalization and recovery of normal eating patterns” (p. 580) since psychotherapy is unlikely to be effective when an individual is in starvation mode. Based on the research they reviewed, they also concluded that individual and family psychotherapy are important components of treatment for both ED types in combination with stringent contract setting, nutritional management based on food diaries, and concrete goal-setting. They further noted that cognitive behavioral therapy was found to be the most effective psychotherapy approach for BN and that medication (either fluoxetine or imipramine) has proven to be more effective in the treatment of BN than AN.

Wilson and colleagues (2007) published an article that reviews evidence-based treatments for EDs, which supported Walsh et al.’s (2000) findings. Wilson et al. documented that family therapy based on the Maudsley model (Dare & Eisler, 1997; Lock & le Grange, 2005 as cited in Wilson et al., 2007) has the most empirical support for the effective treatment of AN among young adolescents, while antidepressants are often ineffective with this population partly due to low body weight. Wilson et al. (2007) also reported that the use of cognitive behavioral therapy is helpful in increasing engagement in treatment, although no strong conclusions were made about its overall effectiveness in treating AN.
Wilson et al. (2007) further reported that manual-based cognitive behavioral therapy (Fairburn, Marcus, & Wilson, 1993) is the treatment of choice for adults with BN, while interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) that has been adapted for BN (Fairburn, Jones, Peveler, Hope, & O’Conner, 1993) and dialectical behavior therapy (Linehan, 1993) provide two additional promising treatment approaches for BN. Further, they noted that antidepressants may help to treat comorbid psychopathology in these individuals. Finally they reported that although only a few well-controlled studies have been conducted on the treatment of binge-eating disorder, cognitive behavioral therapy (Fairburn et al., 1993), interpersonal therapy, and dialectical behavior therapy also provide promising treatment approaches for this ED.

Feminist treatment approaches tend to conceptualize ED recovery multidimensionally as “a process of human development and identity formation” (Peters and Fallon, 1994, p. 353), and therefore aim for healing beyond behavioral symptom alleviation. Feminist treatment also tends to utilize the therapeutic relationship as a powerful tool for change and one of the primary contexts for emotional healing. Peters and Fallon (1994) skillfully capture the relational essence of feminist therapy as it applies to BN, which can also be applied to the treatment of other EDs:

Feminist therapy for bulimia acknowledges the complexity of the disorder and the individual meanings that bulimic behaviors have for women. Feminist therapy fosters genuine connections, which are recreated outside the therapeutic setting. Furthermore, as therapists refuse to collude in denial, family secrets, and cultural oppression of women, they model the expression of feelings and provide an opportunity to challenge the patriarchal mandates for women. (p. 353)
Further, feminist therapy for disordered eating is strengths-based and context-oriented. For example, feminist therapy traditionally includes a critical and explicit examination of the role that “sick culture” plays in the development of “sick eating behaviors,” which serves to reduce the shame and self-blame that often underlie and perpetuate EDs. Hutchinson (1994) articulately describes the empowering treatment implications of this practice:

A feminist approach to the treatment of disordered eating must deal with negative body image as a destructive adaptation, shared by most women, to a culture that is sick. . . But while we wait for the culture to change, we must also heal our psyches, releasing the effects of centuries of brainwashing . . . We must take back our bodies as homes, not as enemies, or as commodities. (p. 153)

Thus, feminist treatment focuses on a multidimensional progression of physical, emotional, and psychological changes in relation to one’s body, mind, family, and culture within the context of an empowering and healing therapeutic relationship.

*Professional Training in the Treatment of Eating Disorders*

Literature suggests that professional training in the treatment of EDs is inadequate for psychiatrists (Williams & Leichner, 2006), primary care providers (Gurney & Halmi, 2001), and psychologists (Haas & Clopton, 2003; Wilson et al., 2007). von Ranson and Robinson (2006), for example, identified the full range of mental health professionals and paraprofessionals providing psychotherapy for EDs in the Canadian Calgary-area in an effort to assess “who is providing what type of psychotherapy to eating disorder clients?” (p. 27). The final sample included 43 women and nine men who regularly provided psychotherapy to individuals with EDs. Fifty percent had master’s degrees, 34.6% had
doctorate degrees, 9.6% had bachelor’s degrees, and 5.7% had high school diplomas or less education. The participants’ professional fields included counseling psychology (38.5%), clinical psychology (21.2%), social work (19.2%), nursing (3.8%), education (1.9%), marriage and family counseling (1.9%), medicine (1.9%), occupational therapy (1.9%), psychiatry (1.9%), general psychology (1.9%), and social psychology (1.9%). Most psychologists were licensed through the College of Alberta Psychologists (48.1%), the Alberta College of Social Work (19.2%), the American Association of Marriage and Family Therapy (9.6%), or the Canadian College of Physicians and Surgeons (1.9%) (von Ranson & Robinson, 2006).

Ninety-six percent of respondents reported having received some form of training in ED treatment (von Ranson & Robinson, 2006), although the type of training varied greatly. More specifically, the most common reported form of training included attending workshops or seminars (71.2%), which was followed by informal supervision such as receiving ad hoc supervision from a trained colleague (57.7%), self-education/reading (53.8%), clinical training in the form of formal training in graduate school (42.3%), and formal supervision from a trained colleague (32.7%). Eight percent of respondents reported receiving training after being hired at a clinic specializing in ED treatment. The therapeutic approaches most frequently used by respondents were eclectic therapy (50%) and cognitive behavioral therapy (33%). Eclectic approaches were described as mixing interpersonal psychotherapy (IPT), cognitive behavioral therapy (CBT), eye movement desensitization and reprocessing (EMDR), strategic or solution focused therapy, addiction-based therapy, and feminist therapy among others (von Ranson & Robinson, 2006).
According to these findings, less than half of the respondents in this study received formal training in graduate school in any type of treatment for EDs (von Ranson & Robinson, 2006) despite the fact that 85% of the sample held graduate degrees. Therefore, these findings suggest that the majority of specialized professional ED training takes place formally or informally outside of the context of graduate school.

In another study, Woody, Weisz, and McLean (2005) conducted a 10-year follow-up to a survey conducted in 1993 that was intended to identify and promote empirically validated psychological treatments. More specifically, in 1993 Division 12 of the American Psychological Association (APA) established a task force led by Diane Chambless to assess the degree to which APA-accredited clinical psychology doctoral and internship programs in the U.S. and Canada were providing didactic instruction or supervised training in empirically supported treatments (Woody et al., 2005).

In Woody et al.’s (2005) follow-up study, which was conducted in 2003, directors of all clinical psychology doctoral programs (n = 333) and predoctoral internships (n = 468) in the U.S. and Canada were invited to participate. Respondents included 136 doctoral program training directors and 184 internship training directors who “reviewed a list of treatments and indicated the degree to which their program teaches each psychotherapy modality” (p. 6) based on several response options including, “taught in course briefly”, “taught in course thoroughly”, “supervised clinical training”, or “formal clinical training or certification”. In regard to EDs, “interpersonal therapy for bulimia” and “CBT for bulimia” were the only two treatments included. Findings revealed that only 35.7% of the responding doctoral programs and 24.6% of the responding internship programs offered supervised training in cognitive behavioral therapy for bulimia while
only 25.6% of doctoral programs and 12.0% of internship programs offered supervised training in interpersonal therapy for bulimia (Woody et al., 2005).

In Woody et al.’s (2005) study, 28 directors of clinical training in doctoral programs and 12 internship directors also shared their perspectives on perceived obstacles to providing training in empirically validated treatments. The main obstacles included lack of time, shortage of training supervisors, inappropriateness of established ESTs for a given population, and philosophical opposition (Woody et al., 2005).

In a third study, Haas and Clopton (2003) surveyed psychologists in clinical practice regarding their treatment of a recent client with an ED, and found that the treatment of EDs in clinical versus research settings differed significantly. For example, there are notable differences in the frequency of comorbid diagnoses and conditions (such as histories of sexual trauma) seen in clinical practice, which are often not addressed in research studies, thereby limiting their applicability. The authors suggest that psychologists in clinical practice are not using empirically validated treatments because of a lack of training in addition to concerns regarding the relevance of empirically validated treatments to their clients.

In their recent article on the evidence-based treatment of EDs, Wilson et al. (2007) speak to the inadequate ED training opportunities available to doctoral psychology students:

Involved as we are in the training of graduate students in clinical psychology, it is our view that doctoral training programs in the United States provide insufficient and inadequate educational opportunities for training in eating disorder treatment.
More specifically, opportunities for learning evidence-based treatments are too limited. (p. 207)

Based on the dearth of literature available on specialized ED training for psychology students, it seems that this statement holds true for all types of professional training in the area of EDs for psychologists-in-training; that is, there seem to be “insufficient and inadequate educational opportunities for training in eating disorder treatment” (Wilson et al., 2007, p. 207) regardless of the type of treatment. Additional research in this area is essential in order to better understand barriers to ED training and to improve the quality of ED treatment.

_How is Eating Disorder “Recovery” Defined?_

Regardless of the specific treatment approach utilized, no consensus on criteria for recovery from EDs exists in the current empirical literature (Kordy et al., 2002; Noordenbos & Seubring, 2006), which makes comparison between outcome studies problematic (Herzog et al., 1988; Jarman & Walsh, 1999) and limits the potential for a universal understanding of what recovery entails. Herzog et al. effectively voiced this concern in 1988, which still remains over two decades later:

Absence of an agreed upon definition of the term recovered within eating disorder literature means that researchers often make implicit assumptions of the definitions and meaning of recovery, resulting in a variety of definitions of recovery being operationalized during research. (p. 132)

For example, Saccomani et al. (1989) found that when physical/somatic criteria were solely considered for recovery outcomes, 79% of individuals with AN had recovered, but when psychological and personality criteria were considered the recovery rate dropped to
As this and other studies demonstrate (see Jarman & Walsh, 1999; Noordenbos & Seubring, 2006), recovery rates differ significantly based on the operating definition of recovery.

Criteria in outcome studies have tended to overemphasize behavioral signs of recovery (i.e., weight gain, menstruation, and the absence of binging, purging, and compensatory behavior typically for at least eight weeks) while underemphasizing psychological signs of recovery (e.g., reduced fears of weight, fat, and food; improved body image) (Jarman & Walsh, 1999). More recently, however, research evaluating AN and BN has moved towards the inclusion of both physical and psychological outcome criteria for recovery. For example, Strober, Freeman, and Morrell (1997) used the more stringent and inclusive concept of “full recovery,” which they defined as normal weight, the absence of all compensatory behaviors, and the absence of “deviant attitudes regarding weight and shape” (p. 345) for at least eight consecutive weeks. Although more studies are including psychological criteria similar to Strober et al., the definition and measurement of recovery criteria remain variable.

In addition to behavioral and psychological recovery from EDs, feminist literature has promoted a more transformative and empowering definition that captures the complexity and multidimensional nature of change: “Recovery is a multidimensional process and involves a progression of changes in relationship to self, body, family, and culture” (Peters & Fallon, 1994, p. 352) and, further, that it entails “a personal awakening to secrets, alienation, and powerlessness” (p. 353). Peters (1990) conducted a qualitative interview study that aimed to examine the complexity of change among 30 female clients who were recovering and/or recovered from BN, and identified three multidimensional
continua of recovery: “denial to reality” (e.g., accepting that BN is a problem rather than a solution; accepting and experiencing feelings rather than avoiding them), “alienation to connection” (e.g., disclosing one’s experiences with BN, exposing one’s shame-based secrets, reconnecting with one’s sexuality and interpersonal connectedness), and “passivity to personal power” (e.g., increasing commitment to treatment and changing one’s attitude towards problematic cultural standards of female thinness from compliance to outrage) (cited in Peters & Fallon, 1994).

Further, Hutchinson (1994) describes a feminist conceptualization of body image, and maintains that recovery from negative body image entails moving from disembodiment (in which “. . . we are numb to our bodies, repressing so much bodily experience that our bodies feel alien to us,” including “. . . dimensions of our experiences that frighten us or make us feel vulnerable-- pain, sexuality, hunger, anger, and even excitement and pleasure”, p. 155) towards embodiment (“to feel alive, to perceive bodily states as they change from pleasure to pain, from hunger to satiety, from energy to fatigue, from vitality and excitement to calm and tranquility,” p. 155).

Interestingly, Root (1990) proposed three general perspectives on recovery from BN to which therapists and clients tend to subscribe. She describes the first perspective as being analogous to the “Twelve-Step” program of Alcoholics Anonymous, which views the disorder as a disease. Although it is possible to abstain from behavioral symptoms (e.g., binging and purging), this view holds that “once a bulimic always a bulimic” (Root, 1990, p. 397). The second perspective is derived from feminist theory and suggests that women can recover from BN, but that they will continue to struggle with weight, food, and/or body-image issues because these are pervasive societal issues. The third
perspective maintains that full recovery is possible, in which case a person no longer struggles with weight, food, or body-image (Root, 1990).

Root (1990) surveyed 21 undergraduate and graduate students who previously met the criteria for BN (and who identified themselves as recovered at the time of the study for at least three months) about which of the three definitions of recovery was consistent with their experience: (1) “I am recovered; I no longer struggle with food, weight, and/or body image”; (2) “I am recovered, but I still struggle with food, weight, and/or body image”; or (3) “I will never be completely over my eating disorder; I will always struggle with an eating disorder” (p. 399). The overwhelming majority of women identified with the second definition (n = 15, 71.4%), while only two women identified with the first definition and four women identified with the last definition. This finding suggests that the notion “I am recovered but still struggle with food, weight, and/or body image” in some capacity may be the most realistic expectation of recovery for both professionals and clients, and may even be normative (Root, 1990, p. 400). This is consistent with other findings suggesting that recovery is a dynamic process rather than a static state and tends to involve residual preoccupations with food, body image, perfectionism, and/or weight (D’Abundo & Chally, 2004; Jones et al., 2005; Srinivasagam et al., 1995; Stein et al., 2002).

In sum, current literature seems to support a more expansive and multidimensional definition of recovery criteria including physical, psychological, and social dimensions over the long-term (Jarman & Walsh, 1999; Noordenbos & Seubring, 2006), although no operationalized definition has been universally adopted in empirical
studies to date, which prevents the attainment of a reliable understanding of recovery and recovery rates.

*Estimated Eating Disorder Recovery Rates*

Although recovery from an ED is difficult and is rarely a linear or stable process (D’Abundo & Chally, 2004; Keel & Mitchell, 1997; Steinhausen, 2002), many individuals attain either partial or full recovery (Cockell et al., 2004; Strober et al., 1997), which varies in meaning depending upon the operating definition of recovery based on the study at hand. Strober and colleagues (1997), for example, conducted a long-term analysis on treatment outcomes of 95 patients with severe AN and found that about 76% of the individuals met the criteria for “full recovery” of their ED at follow-up (i.e., an absence of both dysfunctional behaviors and thoughts related to body weight and shape for at least eight weeks), which took place 10-15 years after their initial assessment. About 30% of the patients had relapses, most of which occurred within the first year after hospital discharge, which suggests that the likelihood of both partial and full recovery increases over time. More specifically, based on Strober and colleagues’ findings, attaining full recovery entails a long process (about ten years or more), but when achieved, the rate of relapse becomes very low.

In a 7.5-year long follow-up study evaluating recovery and relapse in AN and BN, Herzog et al. (1999) also found that full recovery rates (as ambiguously defined by “the absence of symptoms or the presence of only residual symptoms for at least 8 consecutive weeks,” p. 831) increased over time. More specifically, they found that 73.8% of women with BN and 33.7% of women with AN achieved full recovery by 90 months of follow-up while only 8% of AN participants (restricting type) and 53% of BN participants
reached full recovery prior to the 2-year follow-up. Similarly, they found that 99.0% of subjects with BN and 83.7% of subjects with AN achieved partial recovery (defined by “a reduction of symptoms to less than full criteria for at least 8 consecutive weeks,” p. 831) by 90 months of follow-up while only 88% of women with BN and 61% of women with AN (restricting type) attained partial recovery prior to the 2-year follow-up. In addition to suggesting that recovery rates increase over time, these findings further suggest that subjects in the BN group were more likely to achieve recovery than those in the AN group (Herzog et al., 1999).

Other outcome studies have reported ED recovery rates ranging from 24% to 76% (D’Abundo & Chally, 2004; Eckert, Halmi, Marchi, Grove, & Crosby, 1995; Field, et al., 1997; Keel & Mitchell, 1997; Steinhausen, 2002). Differences in reported rates of recovery can be explained by methodological variations related to definitions of recovery criteria and duration; variations in assessment and follow-up methods, and attrition (Herzog et al., 1988; D’Abundo & Chally, 2004; Jarman & Walsh, 1999).

**Factors that Support Recovery**

Despite the absence of an operationalized definition of recovery, several qualitative studies have attempted to expose a clearer idea about the recovery process by examining the perspectives of individuals who have “recovered” from EDs. Cockell and colleagues’ (2004), for example, conducted qualitative interviews with 32 individuals six months after they were discharged from a residential ED treatment center. Their findings indicate that 65.6% of participants achieved or maintained partial recovery (i.e., met criteria for EDNOS rather than meeting the full criteria for AN or BN); 15.6% recovered (i.e., no longer met the criteria for an ED); and 18.7% relapsed (i.e., met the full criteria
for AN or BN). The participants identified several factors that helped to maintain change post-discharge, including maintaining ongoing connections with both professionals and family/friends who offered validation and support; applying cognitive strategies (e.g., challenging distorted thinking, trusting meal plans) and affective skills (e.g., expressing emotions, journaling, acting assertively); and focusing on experiences beyond the ED (e.g., making life changes such as moving, getting a new job, getting a pet; focusing on leisure and new relationships).

Other qualitative studies investigating factors that support the maintenance of ED recovery in the perspective of recovered individuals suggest similar findings to Cockell et al. (2004). The three most common findings that participants identified as important in maintaining recovery from AN or BN in the sample of studies reviewed by the current researcher include: (1) positive relationships with, and the ability to be supported and understood by, caring friends, family, and/or health professionals (Beresin, Gordon, & Herzog, 1989; Cockell et al., 2004; D’Abundo & Chally, 2004; Federici & Kaplan, 2008; Hsu, Crisp, & Callender, 1992; Keski-Rahkonen & Tozzi, 2005; Matoff & Matoff, 2001; Pettersen & Rosenvinge, 2002; Rorty et al., 1993); (2) commitment to recovery and a desire for a better and/or more meaningful life (Cockell et al., 2004; D’Abundo & Chally, 2004; Matoff & Matoff, 2001; Pettersen & Rosenvinge, 2002; Rorty et al., 1993); and (3) the development of coping, acceptance, decision-making, and/or communication strategies (Cockell et al., 2004; Federici & Kaplan, 2008; Matoff & Matoff, 2001; Pettersen & Rosenvinge, 2002; Rorty et al., 1993; Vanderlinden, Buis, Pieters, & Probst, 2007). Faith and spirituality (D’Abundo & Chally, 2004; Garrett, 1997; Hsu et al., 1992), the therapeutic alliance (Hsu et al., 1992; Matoff & Matoff, 2001), and connecting with
individuals who have recovered from EDs (Pettersen & Rosenvinge, 2002; Rorty et al., 1993) were also identified by recovered individuals as important in achieving and maintaining recovery.

Factors that Impede Recovery

Cockell and colleagues’ (2003) qualitative interviews also yielded findings suggesting hindrances to the recovery process post-discharge. These factors included losses (in relation to daily structure, specialized professional support, and the feelings of connectedness that are inherent in residential treatment); self-defeating beliefs (e.g., unrealistic expectations about recovery, the need to be in control); and dealing with the harsh realities of daily life (e.g., exposure to triggering media, moving home, stressful situations at work). The majority of participants in Rorty et al.’s (1993) study identified parents and not feeling understood as impeding recovery while findings from D’Abundo & Chally’s (2004) study suggest that irrational thinking, struggling for control, loneliness, and withdrawal also serve as roadblocks to recovery. Thus, based on the studies reviewed for the current literature review, it appears that a lack of effective social support and interpersonal connectedness serve as overarching barriers to recovery.

Estimated Prevalence of Eating Disorders among Professionals in the Field

There has been minimal study of the nature and history of EDs among professionals providing ED treatment despite the important treatment implications and the potential effects on the providers themselves (Barbarich, 2002; Costin & Johnson, 2002). In one of the three published studies investigating prevalence rates of EDs among professionals in the field, Barbarich (2002) surveyed 823 members listed in the year 2000 directory of the Academy for Eating Disorders (AED), a multidisciplinary association of
clinical and academic professionals who have demonstrated interest and/or expertise in the area of EDs. The *Eating Disorders Background Survey* was developed for this study, which included 14 self-report items assessing demographic variables, personal history of an ED, policies regarding employment of recovered clinicians, and outlets for support at current place of employment.

Of the 399 participants who responded to the questionnaire, the overall lifetime prevalence of an ED was about 27.3% (*n* = 109 with 107 females and 2 males). Of this sample, 46.8% reported a history of AN, 49.5% reported a history of BN, 23.9% reported a history of BED, and 16.5% reported a history of a subclinical ED. Of the 99 participants who provided clear data on the length of illness, 71 participants reported a history of only one ED with a mean duration of 104.65 months while 38 participants reported a history of more than one ED with a mean duration of 136.41 months. Further, of the 106 participants with a history of an ED who responded to the treatment question, 68 participants (64.2%) reported having received treatment for their ED. Individual treatment was the most common type of treatment received across diagnostic categories (Barbarich, 2002).

In regard to relapse, Barbarich (2002) found that the duration of the ED, a history of more than one ED, a history of AN (purging type), and receiving treatment for an ED predicted a greater rate of relapse among the professionals. Interestingly, the length of time spent in recovery prior to entering the field as a clinician did not predict a lower rate of relapse. Of the 109 professionals with a history of an ED, complete data on relapse was available for 97 participants. Of these 97 participants, 27 relapsed after entering the field as a professional. It is also interesting to note that only 38.5% of the participants (*n*
reported that the treatment facility where they were currently employed was aware of their history of an ED. The high percentage of employers that are not aware of their employees’ ED histories makes it difficult to ascertain an accurate representation of the true prevalence of recovered clinicians among professionals in the field (Barbarich, 2002).

Similarly, Bloomgarden, Gerstein, and Moss (2003) surveyed approximately 150 staff members at a large ED treatment program regarding self and/or family history of EDs and found that 24% of the participants reported having an ED, 7% endorsed having eating problems, and 13% reported having a family member with an ED. This finding is similar to the 27.3% prevalence rate found in Barbarich’s (2002) study.

In the third published study that could be found exploring the prevalence of EDs among professionals in the field, Costin and Johnson (2002) surveyed 10 established treatment programs in the United States regarding their experiences and current positions related to the hiring of staff members with personal recovery. Four of the 10 programs actively embraced the hiring of staff with personal recovery, five programs reported that personal recovery was not a hiring consideration one way or the other, and one program actively avoided the hiring of clinicians with personal recovery. Among the four programs that embraced hiring clinicians with personal recovery, the estimates of recovered staff members ranged from 30% to 80% (Costin & Johnson, 2002). It is interesting to note, however, that none of the sites specified formal definitions or criteria for recovery. They also did not have procedures set in place to monitor recovered clinicians’ recovery (Costin & Johnson, 2002).
Based on the findings of these studies, estimated prevalence rates of EDs among recovered professionals working in ED treatment centers (ranging from 24% to 80%) are significantly higher than estimates of prevalence rates of EDs among community samples (around 0.3% for AN and 1-2% for BN; Hoek & van Hoeken, 2003). Further investigation is necessary, however, due to limited research in this area.

Clinicians’ Use of Self, Self-Disclosure, and Personal Recovery in Psychotherapy

The therapeutic relationship comprises the foundation of clinical practice. As Teyber (2006) notes:

The relationship between the therapist and the client is the foundation for therapeutic change. Across different theoretical approaches, and in short- or longer-term modalities, researchers find that the therapist’s ability to establish a strong working alliance early in treatment may be the best predictor of treatment outcome. (p. xix)

Both the client’s and the therapist’s identities, and expression of those identities, invariably impact the therapeutic alliance. As Satir (2000) notes:

Common sense dictates that the therapist and the patient must inevitably affect each other as human beings. The involvement of the therapist’s ‘self,’ or ‘personhood,’ occurs regardless of, and in addition to, the treatment philosophy or the approach. (p. 19)

Achieving a powerful “I-Thou” relationship as opposed to a superficial “I-It” relationship (Buber, 1970) requires the therapist to be authentically in the relationship and to humanize, rather than distance, him- or herself. Thus, the therapist’s “self” often functions as his or her most powerful therapeutic tool. As Hayes and Gelso (2001) note:
The carpenter has a hammer, the surgeon has a scalpel, the therapist has the self.
The therapist’s professional experience, theoretical knowledge, clinical skills, and personal history all shape the therapeutic self, and, in turn, affect the process of therapy. (p. 1041)
The therapeutic use of self is therefore a complicated and multifaceted art and science (see Baldwin, 2000), which involves a critical and ongoing evaluation of one’s personal reactions, experiences, values, and beliefs in addition to how these elements can hinder or enhance the therapeutic process.

More specifically, the therapist’s authentic reactions to clients, countertransference, and past or present personal difficulties have the potential to both hinder and enhance the therapeutic alliance based on how they are managed and/or utilized. For example, unresolved personal issues can result in “getting stuck, avoiding the issue, skewing the information, or losing focus” (Lum, 2002, pp. 181-182) while resolved “wounds in the healer may contribute to the helper’s own wholeness” (Miller & Baldwin, 2000, p. 256) and to her/his empathy, compassion, and therapeutic presence. Therefore, ongoing self-awareness and personal healing are essential to the effective use of self. Lum (2002) underscores the importance of self-awareness in relation to the therapeutic use of self, which she distinguishes from the use of self-disclosure:

The use of self encompasses much more than sharing a common experience of self with clients. A different use of self is enhanced by being in touch with, being aware of, and monitoring self….This practice enables therapists to be emotionally available to connect deeply with their clients’ inner worlds. (Lum, 2002, p. 182)
Therefore, self-awareness is a prerequisite for the effective use of self, which has the potential to enhance both the therapeutic alliance and treatment outcomes when used thoughtfully, authentically, and skillfully (Baldwin, 2000).

The subject of therapist self-disclosure in psychotherapy, which is one of the many manifestations of use of (the therapist’s) self, has been at the center of a long-standing theoretical debate in the field of psychology (Barrett & Berman, 2001; Curtis, 1981; Hanson, 2005; Watkins, 1990). While some theoretical orientations (e.g., psychodynamic) argue that therapist self-disclosure may interfere with the therapeutic process by disrupting neutrality and objectivity and by moving the therapeutic focus away from the client (see Curtis, 1981; Curtis, 1982), others (e.g., feminist, humanistic, and interpersonal/relational) value the judicious use of therapist self-disclosure as a powerful therapeutic tool with the potential to improve the therapeutic relationship and increase the client’s trust and openness (see Bloomgarden & Mennuti, 2009; Maroda, 2009; & Tantillo, 2004).

Barrett and Berman (2001) empirically tested these conflicting stances by instructing therapists at a university counseling center to increase their number of self-disclosures in response to comparable client self-disclosures during the treatment of one designated client, and to refrain from making self-disclosures during the treatment of another client. Data analyses revealed that although the frequency and intimacy of client disclosures did not differ depending on the degree of therapist disclosure, clients who received psychotherapy from therapists with increased self-disclosure reported lower levels of symptom distress and reported liking their therapist more, which suggests that therapist self-disclosure can positively impact both the therapeutic alliance and treatment
outcomes (Barrett & Berman, 2001). This is consistent with previous findings suggesting that therapist self-disclosure can improve clients’ views of the therapist in regard to helpfulness, friendliness, and/or trustworthiness (Hill, 1992; May & Thompson, 1973; Murphy & Strong, 1972).

In a conceptual article related to therapist self-disclosure, Tantillo (2004) advocates the use of self-disclosure in a Relational Therapy (RT) approach to ED treatment. More specifically, she proposes that verbalizing the patient’s impact on the therapist promotes mutuality in the therapeutic relationship. She provides case illustrations within the RT framework demonstrating the potentially positive impact of therapist self-disclosure in regard to promoting empathy and validation, fostering universality by moving from “me” to “we”, normalizing clients’ experiences, promoting trust and understanding by sharing relational dilemmas, and empowering clients by sharing similar experiences. However, no studies could be found that have empirically evaluated the effectiveness of this practice in ED treatment.

Interestingly, findings from a meta-analytic study supported the notion that “counselor self-disclosure of a shared stigmatized state has a strong positive impact on client perceptions of the counselor” (Priester, 2003 as cited in Priester, Azen, Speight, & Vera, 2007, p. 19). For example, some studies have found that counselors with a visible disability were viewed more favorably (e.g., more attractive, expert, and/or trustworthy) than counselors without a visible disability among clients with disabilities (Leierer, Strohmer, Leclere, & Cornwell, 1996; Nosek, Fuhrer, & Hughes, 1991). It should also be noted, however, that counselor self-disclosure of a similar status alone without
adequately developed attending and counseling skills is not sufficient for the development of a positive counseling relationship (Leierer et al., 1996).

Another interesting body of literature focuses on the effects of personal therapy on therapists’ practice. Macran, Stiles, and Smith (1999), for example, found that the participants in their qualitative study seemed to translate their experiences as clients into skills and attitudes used in their roles as therapists. More specifically, they found that, through therapy, participants gained an understanding of the importance of their own personal therapeutic presence and how to manage that presence; they learned how to tolerate clients’ pain, maintain patience throughout the therapeutic process, and provide clients the space to work through their difficulties without interference; and they acquired the ability to work with their clients at a deeper level. Therefore, the authors suggest that “by experiencing helpful conditions in their own therapy, participants seemed better able to provide them for their clients” (p. 419). This is consistent with Macran and Shapiro’s (1998) findings from a review of the literature on personal therapy for therapists, which suggest that the majority of therapists included in the study felt that they benefited professionally from personal therapy.

Substance abuse treatment is an area of psychological practice that has a long-standing history of recovered counselors serving as treatment providers, and, accordingly, there has been a great deal of research in this area (see White, 2000a; White, 2000b). Alcoholics Anonymous (AA), for example, is a treatment approach that was founded in 1935 by two alcoholics as a “mutual-help fellowship whose members share ‘their experience, strength, and hope that they may solve their common problem and help others to recover from alcoholism’” (McIntire, 2000, p. 1). Thus, it should be noted that
AA originated as a self-help treatment as opposed to a professional treatment. A large meta-analysis of 21 controlled experiments examining the effectiveness of AA concluded that although residential AA-modeled treatments tended to perform no better or worse than non AA-based residential treatments, several components of AA were supported (Kownacki & Shadish, 1999). More specifically, the meta-analysis revealed that the involvement of recovering alcoholics as therapists was one of the components of AA that was more effective than the use of non-alcoholic or traditional therapists in non-AA treatments.

Although the current research is inconclusive in this area (for example, Culbreth’s (2000) meta-analysis of 16 studies concluded that addicts’ treatment outcomes are similar regardless of the recovery status of the counselor), other empirical studies have supported Kownacki and Shadish’s (1999) finding and revealed benefits of recovering alcoholic counselors as compared to non-alcoholic counselors relating to various aspects of treatment (Argeriou & Manohar, 1978; Priester et al., 2007). Argeriou & Manohar (1978), for example, found that a positive change in drinking behavior occurred significantly more often among younger patients (under age 35) served by recovered alcoholic counselors than among young patients served by non-alcoholic counselors. This difference was not present in participants over age 35, however.

In a more recent study, Priester and colleagues (2007) recruited 116 participants who were active members of AA. The participants were given a description of a Ph.D. level counselor that was identical except for the description of the counselor as a recovering alcoholic, a non-recovering alcoholic, or neither (i.e., the recovery status was not addressed, which served as the control condition). Participants then rated the
counselor using the *Counseling Rating Form—Short* (Corrigan & Schmidt, 1983), which measured their perceptions of the counselor on three subscales, including Attractiveness, Trustworthiness, and Expertness. Findings revealed that recovering alcoholic counselors were perceived significantly more positively than were non-recovering counselors (Priester et al., 2007). This finding suggests that disclosed recovery status can facilitate positive initial perceptions of the counselor.

Further, White (2000a; 2000b) published a two-part comprehensive historical account of the *History of Recovered People as Wounded Healers* in which he concluded that recovered counselors in addiction treatment have contributed positively to treatment over time in eight important ways. These include (1) having knowledge of addiction that is derived from lived experience; (2) a capacity for emotional identification with the addict; (3) a sense of equality due to their shared experience and vulnerability with clients; (4) a calling to heal others based on their deep gratitude for their own recovery; (5) the ability to use their own experiences to inspire hope; (6) a willingness to be more confrontational with early recovery addicts; (7) the ability to serve as a role model to clients; and (8) the ability to personally orient clients to AA and other treatment services (White 2000b). In light of these strengths, White (2000b) also discussed unique vulnerabilities of professional helpers who are in personal recovery, such as experiencing interprofessional conflicts related to differing views about addiction and recovery, and having an increased risk of overextending themselves, over-relating to clients (i.e. countertransference), and relapsing. White (2000b) concluded that ultimately, “a personal history of recovery from addiction does not, *in and of itself*, qualify or disqualify one as an effective facilitator of recovery for others” (p. 19).
Clinicians’ Use of Personal Recovery in the Treatment of Eating Disorders

In a recent survey study Johnston et al. (2005) assessed the views of 202 members of the UK Eating Disorders Association, including a combination of patients (n = 95), carers/relatives of patients (n = 11), professionals with a history of an ED (n = 32), and professionals without a history of an ED (n = 64), on the suitability of employing people with a history of an ED as ED therapists. Participants were asked to rate how they felt a therapist who had a history of an ED would differ on selected attributes/traits related to the therapeutic relationship as compared to a therapist who had never suffered from an ED. Twelve traits were included and each was rated on a five-point scale from 0-4 (significantly less, slightly less, equally, slightly less, significantly more) (Johnston et al., 2005). The total was added and a higher score indicated that the respondent perceived that a therapist who had a history of an ED would possess more positive traits (i.e., clinical advantages) related to the therapeutic relationship. The respondents were also presented with three types of advice (related to (a) physical aspects of recovery, (b) cognitions, and (c) social issues) that might be offered during the course of treatment and were asked to rate how they felt the quality of this advice would differ when offered by a therapist with an ED history as compared to a therapist without an ED history (Johnston et al., 2005).

Of the total sample, 165 respondents (81.7%) thought it was appropriate for a professional who had a previous history of an ED to work in an ED service while only six respondents (3%) felt that it was inappropriate and 29 (14.4%) were undecided. Results revealed a widespread belief among patients that recovered therapists would have therapeutic advantages as a result of their experience, such as having greater empathy
(endorsed by 87.4% of patients), having a better understanding of the treatment process (i.e., expertise; endorsed by 47.4% of patients) and serving as a role model (endorsed by 28.4% of patients) (Johnston et al., 2005). The professionals with a history of an ED also communicated an advantage of recovered therapists in relation to therapist empathy (84.4%), expertise (62.5%), and acting as a role model (28.1%). The majority of carers/relatives (63.6%) believed that recovered therapists have an advantage related to empathy while a minority believed this to be true in regard to expertise (27.3%) and in regard to serving as a role model (18.2%). Finally, the professionals with no history of an ED scored the previously eating disordered therapists significantly lower than each of these other groups did in regard to empathy (59.4%), expertise (31.3%), and serving as a role model (6.3%). All patients, professionals, and carers perceived the therapist with a previous ED as being able to offer more useful advice than a therapist without an ED history. This trend was most pronounced for carers and those currently suffering with an ED and least pronounced for professionals without an ED history (Johnston et al., 2005).

In regard to disadvantages of treatment provided by a professional with a history of an ED, 57.9% of patients, 50% of professionals with a history of an ED, 53.1% of professionals without a history of an ED, and 45.5% of carers expressed concern that the therapist might become over involved/enmeshed (Johnston et al., 2005). Further, 34.7% of patients, 31.3% of professionals with a history of an ED, 32.8% of professionals without a history of an ED, and 27.3% of carers expressed concern about therapist vulnerability. About 30% of all groups also expressed concern about therapist subjectivity. It is important to note that these responses tended to reflect concern related to the vulnerability of the therapist, rather than the patient (Johnston et al., 2005).
It is also interesting to note that of the 127 respondents who reported a history of an ED, 25 (19.7%) stated that someone who played a significant role in their treatment had shared with them that they had suffered from an ED. Eighteen (72%) of these individuals believed this disclosure had a positive influence on the outcome of their treatment, four (16%) believed that it had no influence, and three (12%) thought that it had a negative influence (Johnston et al., 2005). This finding suggests that being a recovered ED treatment professional may positively impact treatment outcomes in the perception of ED clients.

Collectively, these results suggest that patients, recovered ED professionals, and carers generally perceive an ED history to be an asset in terms of the quality of the therapeutic relationship and the usefulness of advice given, while professionals without a history of an ED have a neutral, but not negative, view (Johnston et al., 2005). These results also suggest that moderate concerns exist among all groups related to enmeshment and vulnerability on behalf of the therapist.

Only one published study and one recent dissertation could be located examining the nature of clinicians’ use of their personal recovery in the treatment of EDs. Costin and Johnson (2002) shared their experiences with recovered clinicians at their respective treatment centers. Craig Johnson, who is affiliated with Laureate Psychiatric Clinic and Hospital in Oklahoma, stated that he actively recruited staff who had suffered from an ED in an effort to evaluate what the costs and benefits are to treatment. He reported that over the past ten years he had 11 staff members with personal recovery, three of whom “wobbled with recovery” (p. 295) (i.e., felt psychologically vulnerable, which subsided after several weeks of intensified supervision); one who had a moderate relapse (i.e., a
behavior relapse that resulted in outpatient treatment); and one who had a severe relapse (i.e., required residential treatment and did not return to the Laureate program). He also noted that “the fact that we have staff with recovery is consistently mentioned in patient satisfaction surveys as one of the strengths of the program” (p. 295).

Carolyn Costin, who is affiliated with Monte Nido Treatment Center in California, shared her own history of AN and reported that 22 of her 30 staff members (almost 75%) recovered from an ED. She described that in her experiences, “recovered” staff (as distinct from “recovering” or in “recovery”) “exude confidence in understanding and dealing with patients’ ED symptoms while offering hope and inspiration that becoming fully recovered is possible” (p. 296). She reported that only two staff members during the previous six years left Monte Nido due to feeling uncomfortable or triggered by the patients, and that none of her staff members relapsed.

Based on their respective experiences working with recovered clinicians, Costin and Johnson (2002) reported both clinical advantages and disadvantages of staff with recovery. In regard to clinical advantages, they described the ability of recovered staff members to provide “light at the end of the tunnel” (p. 297) by serving as a living example that recovery is possible. In this way, personal recovery symbolizes hope and serves as motivation. Costin and Johnson (2002) also cited the ability of recovered staff members to establish trust and rapport quickly due to their shared personal experiences with EDs in addition to their increased leverage and willingness to confront patients’ hopelessness. They noted that staff members who have not experienced EDs can become too sympathetic and immobilized by the patients’ despairing states while staff members who have recovered from EDs are less ambivalent about confronting patients’
helplessness. In this way, recovered clinicians have the leverage to directly or indirectly communicate “been there, done that. If I can do it, so can you.” (p. 298).

Costin and Johnson (2002) further described that recovered clinicians provide a unique opportunity for patients to safely expose the most shame-filled aspects of themselves, which they believe is one of the most powerful experiences that occurs in the recovery process. Finally, the authors reported that recovered clinicians tend to avoid getting stuck in the complicated dynamics behind EDs at the expense of the direct treatment of ED symptoms, which can be difficult for staff members who have not had EDs.

In regard to clinical disadvantages, Costin and Johnson (2002) reported that recovered staff members have an increased risk for relapse in addition to a variety of countertransference issues. For example, recovered staff members can become narrow-minded about how recovery occurs for patients based on their own process of recovery. In other words the “been there, done that” approach can sometimes impede the patients’ process by preventing them from finding their own path to recovery. Therefore, the recovered staff members’ dedication to helping people recover can result in working harder than clients and/or taking over their recovery processes (Costin & Johnson, 2002).

Only one other study in the form of a recent dissertation (Bowlby, 2008) could be found examining recovered clinicians’ use of personal recovery in the treatment of eating disorders. Bowlby (2008) conducted a phenomenological study involving 13 licensed mental health workers in recovery from a diagnosable eating disorder who were treating ED clientele at the time of her study. The participants were solicited via the Academy of Eating Disorders listserv and local treatment centers. Bowlby utilized Moustakas’ (1994)
methodology to study the participants’ overall experiences (1) as women personally affected by an eating disorder and (2) working as ED therapists after personally recovering from an ED. Semi-structured interviews included questions related to participants’ personal histories of EDs, their experiences related to the recovery process, the impact of their personal ED history on the decision to enter the ED field, and the various challenges and benefits of working in the therapeutic process.

Transcripts were analyzed using “a modification and adaptation of the Stevick-Colaizzi-Keen method” (Bowlby, 2008, p. 50) for phenomenological data. Data analysis revealed eleven themes related to the experience of the participants as clients who had struggled with EDs, which included two themes regarding the nature of eating disorders (tools for coping and debilitating/dangerous illnesses), six themes regarding recovery (non-linear process, multi-faceted, understanding and valuing the self, de-identification with the illness, purpose and meaning in life, and developing meaningful relationships), and three themes regarding change factors for recovery (support, self-expectation, and closing the door). Data analysis also revealed twelve themes related to the experience of the participants as mental health workers, which included two themes related to the nature of one’s occupation as an ED therapist (source of meaning and purpose, and a spiritual enterprise), five themes regarding the treatment process (treatment frame, empathy and understanding, grace/patience, hope for recovery, and leverage), three themes regarding the concept of countertransference and difficulties within treatment (resistance and physical danger, family of origin issues, and struggling professionals), and two themes regarding the concept of self-disclosure (complexity and intended
purpose). This study provides a preliminary understanding of recovered ED professionals’ experiences as both clients and therapists.

No other studies could be found examining recovered clinicians’ use of personal recovery in the treatment of individuals with EDs, nor could any empirical studies be found evaluating the effectiveness of this clinical practice aside from Johnston and colleague’s (2005) survey. Additional research is needed to gain a better understanding of recovered clinicians’ experiences treating EDs in addition to the accompanying treatment implications.

The Current Study

Given that previous literature suggests that connecting with individuals who have recovered from EDs was helpful in patients’ own journeys to recovery because it provided hope for the future and inspired feelings of acceptance and understanding (Pettersen & Rosenvinge, 2002), and that a similar positive pattern has recently been observed with recovered ED mental health treatment providers in the context of the therapeutic relationship (Johnston et al., 2005; Costin & Johnson, 2002), it is possible that having a personal ED history can enhance treatment outcomes. Before examining the effectiveness of treatment provided by recovered ED professionals, however, it is first essential to gain a better understanding of how recovered clinicians understand and use their own recovery in the provision of ED treatment.

The present study contributes to this largely underdeveloped body of literature by providing an in-depth examination of a sample of nine clinicians’ understanding and use of their personal recovery in the treatment of EDs. Whereas Bowlby’s (2008) dissertation provides a preliminary understanding of recovered ED professionals’ experiences as both
clients and therapists in relation to recovery, change-enhancing features of treatment, the process of becoming a therapist, use of self in therapy, countertransference, and the use of self-disclosure, the current study more narrowly focuses on clinicians’ current understanding of their ED recovery and use of that recovery in the treatment of EDs. More specifically, this study uses a feminist research orientation (Striegel-Moore, 1994) and the Corbin/Strauss (2008) approach to qualitative analysis to develop classificatory schemes (i.e., the organization of data into categories/themes according to their properties, dimensions, and relationships) and accompanying diagrams related to recovered ED clinicians’ (a) understanding/definition of ED recovery and (b) uses of their recovery in the treatment of EDs.
CHAPTER 3
Methods and Procedures

Research Design

Corbin/Strauss (2008) Approach to Qualitative Analysis and Guiding Philosophical Assumptions

Berrios and Lucca (2006) note that qualitative methodology provides the opportunity “to explore the richness of the personal experience of our profession for both the counselors and the participants…” (181). They describe several characteristics of qualitative research that make it a fitting methodology for counselors, including the fact that both qualitative researchers and counseling professionals must “emphasize the undergoing processes while observing, listening, relating, and interpreting” (p. 175).

Qualitative studies are often exploratory in nature; therefore, they tend to generate hypotheses rather than test them, and to discover variables rather than control them (Corbin & Strauss, 2008). Further, qualitative methods describe the experiences of participants in their own words based on their own experiences rather than relying on predetermined categories or theories (Ponterotto, 2002). Corbin & Strauss (2008) poignantly describe the appeal and utility of qualitative research:

It is the freedom to think, the ability of the researcher to change his or her mind, to check out ideas, and to follow the data trail wherever it leads that makes the findings derived through qualitative research so compelling and relevant and the process of getting there such an exciting voyage of discovery. (p. 228)
Thus, qualitative research is especially appropriate when the researcher’s goal is to discover new and in-depth knowledge in a given area (as opposed to testing preconceived hypotheses), which is directly aligned with the aim of the current study.

Because the current study aimed to explore the personal experiences of participants and discover new empirical knowledge in an understudied area of inquiry (i.e., recovered ED clinicians’ understanding and use of their personal recovery in the treatment of EDs), the Corbin/Strauss (2008) approach to analysis was utilized. This methodology is derived from a combination of Chicago style Interactionism and the philosophy of Pragmatism largely associated with the American philosophers John Dewey and George Mead, who assumed that knowledge is created through action and interaction (see Corbin & Strauss, 2008). More specifically the Corbin/Strauss (2008) method maintains that knowledge is derived from the “acting and interacting of self-reflective beings” (p. 2). Assumptions that the world is complex and that there are no simple explanations for things also underlie this methodology. Therefore, the goal is to capture as much of this complexity as possible while accepting that it is impossible to capture it all (Corbin & Strauss, 2008).

The Corbin/Strauss (2008) method is based on identifying significant concepts in the data and exploring their relationships. It is related to Glaser and Strauss’ (1967) grounded theory methodology, which is utilized to build theories that are grounded in, and derived from, qualitative data. The Corbin/Strauss (2008) approach uses the term “grounded theory” more generally, however, to denote “theoretical constructs derived from qualitative analysis of data” (p. 1), which can range from in-depth descriptions to theoretical interpretations. Regardless of the aim of the study (i.e., description, conceptual
ordering, or theorizing), this methodology is both inductive and deductive and requires that the researcher grounds findings in the data while bringing his or her “whole self into the process” (p. 13). Corbin and Strauss (2008) write:

Since no researcher enters into the process with a completely blank and empty mind, interpretations are deductions or researcher’s abstraction of what the data are indicating. This method is inductive in the sense that findings are derived from the data. It’s deductive in the sense the concepts and the linking statements are interpretative; that is, constructed by the analyst from data. (p. 326)

Thus, researchers and participants have reciprocal influence on each other and on the research process. Therefore, researcher sensitivity (i.e., the ability to present the view of the participants and take the role of the other by immersing oneself in data collection and analysis as fully as possible) in combination with reflexivity (i.e., the examination and awareness of one’s influence on the research process) (Corbin & Strauss, 2008) were ongoing and integral parts of the current research process.

Several philosophical assumptions guide qualitative research (Creswell, 2007) and the current study. In regard to rhetoric, the language of research, I value the participants’ voices and an informal, first person writing style. For this reason I use the first person whenever describing my personal position, biases, or theoretical orientation related to the study at hand. In regard to ontology, the nature of reality, I assume that reality is complex and that there are multiple socially constructed and equally valid realities. In regard to epistemology, the relationship between the researcher and that being studied, I assume that deeper meaning results from increased interaction and decreased distance between the researcher and the subject(s) under study. Therefore, I aimed to use
my shared recovered ED status to facilitate trust and relationship-building with the participants. In regard to axiology, the role of values in the research process, I assume that research is value-laden and inevitably biased, and therefore, that my biases should be openly discussed and monitored. Finally, in regard to methodology, the process of research, I value naturalistic inquiry, recursivity, and reflexivity (Creswell, 2007).

In addition to the aforementioned philosophical qualitative assumptions, the current research study was further shaped by a constructivist worldview (Vygotsky, 1978). More specifically, I believe that meaning is socially constructed and context dependent. Therefore, rather than starting with preconceived hypotheses and theories, my goal was to derive new meaning from the unique and subjective material that surfaced throughout this research process. Further, I believe that my own personal and cultural background directly shaped my interpretation of the data collected in this study. Therefore, one of my primary tasks was to acknowledge how my identity and personal biases informed the socially constructed meaning-making and analytic processes.

Finally, the current research study was informed by my feminist theoretical orientation, which directly guided the ways that I conceptualized the research process, constructed meaning, and interpreted the data in this study. Because gender and gender identity are experienced differently for each person, I consciously assessed my personal position with regard to gender and power, and considered how it impacted my understanding of the participants’ experiences in this study. More specifically, I recognized my belief that gender is a basic organizing identity component that directly and inevitably shapes one’s experiences. My views of feminist qualitative research, and my role as a feminist qualitative researcher, closely mirror the following description of

Feminist fieldwork is predicated upon the active involvement of the researcher in the production of social knowledge through direct participation in and experience of the social realities she is seeking to understand….however, feminist field researchers add [another dimension] which is not included as part of conventional field methods…*the necessity of continuously and reflexively attending to the significance of gender* as a basic feature of all social life and…*understanding the social realities of women as actors* whom previous sociological research has rendered invisible. (DiIorio, 1982 as cited in Reinharz, 1992, p. 46)

Based on this research conceptualization and Striegel-Moore’s (1994) *Feminist Agenda for Psychological Research on Eating Disorders*, I aimed to achieve the following feminist research goals:

- To give voice to women’s experiences and avoid androcentric biases.
- To establish collaborative and non-exploitative relationships with participants (e.g., by placing myself *within* the study by explicitly owning my status as a recovered ED clinician in order to avoid objectification of the participants).
- To conduct research that is empowering, strengths-based, and non-oppressive (e.g., by viewing recovery as a resilience factor rather than as a deficit).
- To avoid reductionistic thinking and, on the contrary, to actively consider and value the context, complexity, and depth of women’s experiences.
To consciously incorporate reflexivity and assess how my own identity, experiences, and biases affect my understanding and meaning-making throughout the research process.

**Procedure**

*Analytic Team*

Corbin and Strauss (2008) note that researchers are stimulated in their thinking by the ideas of others and that analysis tends to proceed faster in teams as a result of this “reciprocal stimulation of ideas” (p. 170). The use of multiple coders also reduces the influence of individual bias. For these reasons, the current study utilized a team approach to analysis. The research team was comprised of three women: the primary researcher (a third-year Italian American doctoral student in counseling psychology who has a personal history of BN), a third-year South Asian Indian doctoral student in counseling psychology who has struggled with body image dissatisfaction and sub-clinical disordered eating due to her inability to meet the dominant culture’s standards for “thin White women”, and a master’s level White counselor who has never struggled with disordered eating or significantly impaired body image. All three researchers identified with a feminist theoretical orientation and had previous training and experience conducting qualitative research. The team initially met to reflect upon their relevant experiences and biases related to the topic under study, and then met biweekly throughout the data analysis stages of the research process to consensus code, discuss analytic reflections, and identify themes.

*Researcher as Instrument*
Corbin and Strauss (2008) view the researchers’ relevant experience to the topic under study as an asset to the analytic process. More specifically, they maintain that:

Background, knowledge, and experience not only enable us to be more sensitive to the concepts in the data, they also enable us to see connections between concepts….we have to have some background, either through immersion in the data or through personal experience, in order to know [that] what we are ‘seeing’ in data is significant and to be able to discern important connections between concepts. (p. 34)

Thus, in contrast to objectivity, Corbin and Strauss advocate that researchers consciously use themselves and their experience to enhance the analytic process, which is known as sensitivity. The Corbin/Strauss (2008) approach to qualitative data analysis also recognizes that biases are inevitable and encourages researchers to acknowledge their biases by engaging in ongoing reflexivity. Therefore, an integral part of the current research process involved describing the researchers’ personal experiences with the phenomena under study and recording relevant thoughts, reactions, and feelings. In an effort to be faithful to this practice, all three researchers actively reflected upon and documented their own prejudgments, assumptions, and experiences related to (a) EDs, both personally and/or professionally, (b) recovery from EDs, and (c) self-disclosure in therapy. Below is a summary of each research team member’s relevant experiences and assumptions as documented prior to data analysis:

**Primary Researcher’s Positionality**

I am a 27-year-old, Italian American female doctoral candidate in counseling psychology at the University of Georgia. I am both professionally and personally
invested in the experiences of recovered eating disorder clinicians. More specifically, I share this identity based on my experiences recovering from BN over the span of five years through outpatient treatment, self-determination, and support from family and friends. Several years after my recovery I became interested in working with this population in a professional capacity. I spent several months working at a residential eating disorder treatment facility in Cambridge, MA between my master’s and doctoral programs, and then continued my training through a year-long advanced doctoral practicum at an outpatient treatment center in Athens, GA. I have never explicitly disclosed my status as a recovered clinician to my clients, although I suspect that several of them have speculated this to be the case based on my approach to treatment.

Over the recent years, I became progressively more aware of the dissonance I felt as a result of “hiding” my identity, which perpetuates the very dynamics and patterns that tend to drive the disorder—inauthenticity, secrets, and shame. I began to wonder if it would help or hinder the therapeutic process to expose my identity. I wondered if it might help to reduce my clients’ shame while simultaneously increasing their hope; I also feared that it might constitute an unnecessary or counter-therapeutic disclosure, or that it would lead to a series of questions to which I would not know how to respond. When I turned to the scientific literature to seek guidance, I was surprised to learn that research is scant on this subject outside of publications relating to drug and alcohol treatment models that utilize recovered counselors. With some trepidation, I decided that this would be a heartfelt, professionally meaningful, and potentially healing dissertation topic for me.

My bias as a researcher includes an assumption that recovery is (a) possible, (b) multidimensional, and (c) an ongoing, non-linear process rather than a fixed destination.
Therefore, I do not view all deviations from “normal” eating and thinking as pathological. My bias also includes an assumption that EDs represent an individual’s best attempt to cope and therefore serve functional purposes in dysfunctional environments. I further believe that my disclosed identity as a clinician who has both recovered from an ED and provided treatment to individuals with EDs could help to increase participants’ trust and comfort in sharing their own experiences. Finally, my bias includes a belief that the information shared by participants is likely to contribute to a deeper understanding of clinicians’ understanding and use of their personal recoveries in the treatment of EDs.

**Researcher 2’s Positionality**

I am a 31-year-old, first generation South Asian Indian female. I am currently a third-year counseling psychology doctoral student at the University of Georgia. My early family experiences and cultural influences have shaped my view of disordered eating. My experiences living in the U.S. and being married to a White male have also made me keenly aware of the pressure to fit, and the experience of not fitting, the standard of the “thin White woman.”

As a female in my family it was expected that I would be educated and look a certain way in preparation for marriage and children. My body did not have to be thin, but there was an expectation of being “small”. In college I struggled with depression and stopped eating, and it felt good to be thin in the midst of the American college experience. As I healed from the depression, fortunately my eating and body image began to normalize as well.

At age 25 I became pregnant with my first daughter. I feared having children and the damage it would do to my body. My mother felt that having children negatively
affected her body, and this fear stuck with me. After the birth of my first daughter followed by two other children, however, my view of my body dramatically shifted. I became grateful for what my body could do (i.e., give birth) rather than being concerned with how it looked.

My professional eating disorder experience has been limited to one year in a doctoral practicum at an outpatient ED treatment facility conducting groups with adolescent and young adult women. My bias as a researcher includes an assumption that recovery is a process as opposed to an outcome, and that recovery is individually defined. Additionally, I believe that recovery leaves a person changed and does not return them to a pre-eating disorder state. My bias of self-disclosure used in a therapeutic setting is that it can facilitate the healing of others when timing and appropriateness of the disclosure are taken into consideration.

Researcher 3’s Positionality

I am a 33-year-old, White female counselor with a master’s degree from the University of Georgia. My mother is a feminist who celebrates women and the female body—in all forms, shapes, and weights. Growing up, my mother carefully guarded the messages I internalized about my body as an American female: I wasn’t allowed to own or play with Barbie dolls; I was permitted to subscribe to Seventeen Magazine only after a series of serious conversations critiquing the magazine’s messages about standards of beauty and health; and television shows that sexualized women like “Baywatch” and “Beverly Hills 90210” were banned from our household.

As a teenager and young adult I danced with a professional ballet company. I was aware of disordered eating among the dancers of the company, but the negative messages
I sometimes received about my body and my weight were countermanded by the powerful maternal messages about my beautiful, healthy, strong, feminine body. I knew that the ballet aesthetic wasn’t necessarily healthy or realistic for my frame, and that a successful professional career in classical ballet was out of the question unless I was willing to starve—I wasn’t.

I’ve struggled with embodiment in regard to ignoring my body’s messages about fatigue, stress, or illness, often in the pursuit of idealistic projects or “selfless” aims. “Doing” has sometimes taken priority over self-care.

Clinically, I have had no experience in working with disordered eating. My bias about self-disclosure is a belief that it can be powerful and effective if done appropriately. I also believe a great deal of self-awareness and self-discipline is needed for counselor use of self to be therapeutic for clients. With regard to recovery, I believe that healing is a process that never ends. The challenges we face in life we always carry with us—they can be sources of vulnerability or incredible strength—but they become indelible threads in the fabric of our life journey. I believe this is particularly true in the case of disordered eating—a truly complicated disorder that is unfortunately compounded by oppressive standards of feminine beauty and ideal body image by American society at large.

All three researchers shared the following assumptions:

- A degree of body-consciousness is inevitable being a woman in U.S. society.
- Objectification of the female body is pervasive in U.S. society (e.g., media, male gauze).
o The power of using one’s voice is healing.

o Disclosure could be a healthy therapeutic technique when used in a purposeful way that is grounded in self-awareness.

o The simultaneous vulnerability and strength of being recovered become a lifelong part of a person.

o Recovery is a strength as opposed to a deficit, and a process as opposed to a destination.

**Description of the Sample**

Because specific and information-rich cases were sought, purposeful sampling (Patton, 2002) in the form of snowballing and criterion sampling was used to recruit participants who met pre-established criteria. An email recruitment flyer (see Appendix A) was distributed to two ED treatment centers, including the Monte Nido Treatment Center in California and the Laureate Psychiatric Clinic and Hospital in Oklahoma, which both employ recovered ED clinicians (see Costin & Johnson, 2002), in order to seek participants who met the following inclusion criteria: (a) were employed as a master’s or doctoral level mental health treatment provider for EDs at the time of recruitment for this study; (b) met full criteria for an ED (either AN, BN, or EDNOS) at some time in their lives; and (c) no longer met the criteria for an ED at the time of recruitment for this study as indicated by normal weight and the absence of binging, purging, and compensatory behavior for at least one year. A raffle for a $50 Visa gift card was offered as incentive to participate in this study. Participants who expressed interest were screened by the primary researcher to ensure that the above inclusion criteria were satisfied.
Participants included nine women who: (a) held a master’s or doctoral degree in a mental health field (e.g., counseling, social work, clinical psychology); (b) were employed in a setting where they treated clients with EDs at the time of this study (i.e., private practice, outpatient treatment center, or residential ED treatment facility); (c) met full criteria for an ED (either AN, BN, or EDNOS) at some time in their lives and (d) no longer met the criteria for an ED at the time of recruitment for this study as indicated by normal weight and the absence of binging, purging, and compensatory behavior for at least one year based on self-report. Normal weight refers to a self-reported weight that is between 90% and 125% of the expected weight for her height, which was calculated according to the following formula: 100lb for 5ft of height plus 5lb for each additional inch of height (Hamwi, 1961 as cited in Rorty et al., 1993). Recovery does not imply that the participants no longer experienced any negative thoughts related to body image and eating. Rather, their eating disorder related symptoms no longer rose to the level of a clinical diagnosis.

The participants’ ages ranged from 27 years to 55 years, with an average age of 44.9 years. All participants identified as White females. Seven of the nine participants worked in private practice, one of whom concurrently worked in an outpatient center and another of whom concurrently worked at a residential ED center. One participant worked as the clinical director of several ED facilities and another worked exclusively at a residential ED center. The total length of time that the participants treated EDs in a professional capacity ranged from 4 years to 32 years (mean = 15.8 years).

Two of the participants had a history of BN; three of the participants had a history of AN, restricting type; two of the participants had a history of both BN and AN,
restricting type; one of the participants had a history of both AN, restricting type, and EDNOS (with predominantly restrictive symptoms), and one of the participants had a history of both BN and EDNOS (in the form of binge-eating disorder). The age of onset ranged from 16 years to 23 years while the duration of the participants’ diagnosable eating disorders ranged in length from 1.5 years to 13 years. The participants’ length of time in recovery (i.e., continuously not meeting DSM-IV-TR criteria for an ED) at the time of this study ranged from 6 years to 35 years with a mean of 19.8 years. A summary of participant demographics is provided in Table 3.1 and Table 3.2.

**Instruments**

*Demographic questionnaire.* Each participant completed a brief demographic questionnaire via email indicating her choice of pseudonym, age, race, ethnicity, gender, age, highest level of education, work setting and job title, and personal history with an eating disorder(s) (including, type; duration; treatment received, if any; length of time in recovery; number of relapses, if any; and employer awareness of ED history). A copy of the demographic questionnaire is provided in Appendix C.

*Semi-structured interview.* Each participant completed one semi-structured interview with the primary researcher ranging in length from 42 minutes to 110 minutes (mean = 77 minutes). The interview protocol was developed based on a literature review and the primary researcher’s personal experience recovering from an ED combined with her professional experiences working at ED treatment facilities. The interview questions and process were piloted with a recovered ED clinician who did not participate in this study and feedback from the pilot was then incorporated into the ongoing interview protocol. Interview questions related to participants’ understanding and definition of their
own recovery; their experiences providing treatment to ED patients (e.g., with regard to supervision, perceived effectiveness, challenges, strengths, triggers, and workplace support); and their experiences using their personal recovery in the provision of treatment. Follow-up questions to each of these broad topic questions varied and were guided by the unique material provided by each participant. Further, each completed interview influenced subsequent data collection (i.e., if new and relevant information or questions surfaced during an interview, the researcher included this topic of inquiry in subsequent interviews) in an effort to achieve theoretical sampling. The interviews were notably interactive in nature. A copy of the semi-structured interview is provided in Appendix D.

Data Collection and Analysis Procedures

After each potential participant was screened by the researcher to ensure that the aforementioned inclusion criteria were satisfied, a consent form was sent to the participant as an email attachment (see Appendix B), which explained the study’s purpose, procedures, risks, and benefits. Once the participant’s questions were answered if she happened to have them, the participant returned the signed consent form electronically. The researcher and participant then set up a time and date to conduct a phone interview. A demographic questionnaire (see Appendix C) was emailed to the participant and the participant was asked to return the form electronically prior to her interview. All nine interviews took place over the phone and were audiotaped. Prior to proceeding with the semi-structured interview, the researcher checked in with the participant about informed consent and answered any potential questions. The researcher then introduced herself, the study, and her status as a recovered ED clinician prior to
initiating the interview. If participants did not specify a pseudonym on their demographic forms, one was assigned to them. To protect confidentiality, all participants were referred to by their pseudonyms for the duration of this study.

After each participant’s interview was completed, transcribed, and proofread, a copy of the transcript was emailed to her with an invitation to check its accuracy related to content, insert additional thoughts, comments, or reactions, and amend anything that might seem unfitting. Follow-ups included member checks of the participants’ transcripts, demographic information, and the classificatory schemes and accompanying diagrams that were identified during data analysis to ensure accuracy of the participants’ voices and experiences.

The Corbin/Strauss (2008) approach to qualitative data analysis involves a continuous process of data collection, followed by analysis, coding, and memo writing, which leads to additional questions, which leads to more data collection etc. More specifically, analysis is the recursive process of giving meaning to data, which can range from superficial description (i.e., skimming the surface of data) to theoretical interpretation (i.e., digging beneath the surface of data). “Concepts” are derived from the data and serve as the foundation of analysis in this method: “They represent an analyst’s impressionistic understandings of what is being described in the experiences, spoken words, actions, interactions, problems, and issues expressed by participants” (Corbin & Strauss, 2008, p. 51). Concepts vary in level of abstraction from low-level to high-level (i.e., lower-level concepts describe and provide detail for the more abstract higher-level concepts) and provide a method of grouping and organizing the large volume of data.
Coding is the process of transforming raw data into concepts, which involves interacting with the data, asking questions about the data, and making comparisons between data. Microanalysis is a more detailed type of coding that tends to be used at the beginning of analysis when the analyst is trying to break down the data and consider all possible meanings, while general analysis involves stepping back and looking at the data from a broader perspective (Corbin & Strauss, 2008). The aim of the Corbin/Strauss (2008) research approach can range from “description” (i.e., the most basic form analysis that involves telling a story without a lot of interpretation or explanation) to “conceptual ordering” (i.e., the precursor to theorizing, which involves creating a classificatory scheme by organizing data into discrete categories according to their properties and dimensions, and using descriptions to clarify those categories) to “theorizing” (i.e., the development of a theoretical framework that explains the what, how, when, where, and why of some phenomenon) (Corbin & Strauss, 2008, p. 54-55).

Because the current study was one of the first examinations of recovered ED professionals’ understanding and use of their personal recovery in the treatment of EDs, the researchers aimed to achieve an in-depth exploration of each phenomenon rather than a theoretical explanation or interpretation. Therefore, this study aimed to contribute to the current empirical literature by providing an in-depth conceptual ordering of each phenomenon in the form of classificatory schemes, which ultimately could serve as precursors to future theories on the topics at hand.

The data collection and analysis process was recursive in nature and included seven processes, which often occurred simultaneously rather than sequentially. Because two distinct phenomena were studied, the researchers analyzed each one separately. Thus,
the current study used Corbin and Strauss’ (2008) methodology to discover new knowledge and develop classificatory schemes with accompanying diagrams related to recovered ED clinicians’ (a) understanding/definition of ED recovery and (b) uses of their recovery in the treatment of EDs. The seven data collection and analysis procedures included:

1. *Researcher Reflexivity & Consensus Coding:*

   Researchers reflected upon their personal experiences, biases and assumptions related to the phenomena under study by describing them in detail prior to data collection. Throughout the analytic process the analysts continued to actively reflect upon who they are and how they were both shaped by, and contributed to shaping, the research process (Corbin & Strauss, 2008) in both group (i.e., research team discussions) and individual (i.e. personal journals) forums. In doing so, the team members were able to compare and contrast their perspectives and more thoroughly explore differences in data interpretation. In order to resolve differences in points of view, the researchers utilized reflective team discussions in combination with a reexamination of the relevant raw data in order to reach a satisfactory level of group consensus. More specifically, “a satisfactory level of group consensus” was achieved when all three researchers reported feeling comfortable with the name, description, and presentation of the particular concept under analysis.

   For example, during several of the team analytic meetings it became evident that two of the researchers interpreted the data differently than the primary researcher in regard to the participants’ beliefs about their effectiveness.
treatment EDs as compared to non-recovered professionals’ effectiveness. More specifically, researchers 2 and 3 believed that the participants communicated that they were *more* effective than non-recovered professionals at treating EDs while the primary researcher believed that the participants described unique treatment advantages of their recovered status *without* implying that they were “more effective.” As the team members continued to explore their differences in interpretation, it became evident that the primary researcher was uncomfortable with the idea of creating a dichotomy between recovered versus non-recovered professionals’ effectiveness without evidence that the participants explicitly stated this, while researchers 2 and 3 believed that this was a logical and implicit conclusion based on the participants’ lengthy descriptions of their clinical advantages. By continuing to reflect on how our personal reactions and feelings were impacting our respective interpretations of the data while simultaneously reexamining the relevant text in the transcribed interviews, the team members ultimately came to consensus and concluded it was appropriate to explain that the participants all described “unique advantages” of their recovered status without drawing the conclusion *for* readers about their perceived treatment effectiveness as compared to non-recovered professionals.

In a second example, researcher 3 noted that she became “nervous” when reading about one of the participant’s newfound dedication to competitive cycling. She explained that she feared this level of exercise was risky and potentially unhealthy for an individual who had recovered from an ED. The primary researcher shared her differing perception that movement and non-
obsessive exercise are often essential ingredients for healthy and ongoing recovery from an ED. Thus, researcher 3 saw competitive exercise as a risk factor while the primary researcher saw it as a protective factor. We noticed that we had different biases and perspectives related to what was “healthy” and “normal” based on our personal experiences related to food, exercise, and EDs. These discussions were essential in highlighting that perceptions of “normal” are subjective and, in doing so, they helped to illuminate our understanding of the finding “what is ‘normal’ in U.S. society?”

2. *Concurrent Data Collection & Analysis:*

One in-depth, semi-structured interview was conducted with each of the nine participants who responded to the recruitment flyer and who met the aforementioned inclusion criteria. Data analysis began after the first interview was transcribed, proofread, and sent electronically to the participant for member checking so that theoretical sampling could be employed and the emerging themes and questions could inform subsequent data collection (i.e., interview questions).

3. *Immersion in the Data:*

After an interview was transcribed and member checked, the research team individually initiated the process of immersing themselves in the data by reading through the transcript from start to finish in an effort to enter into the life of the participant and to become acquainted with the big picture. Immersion in the data included ongoing analysis of the transcribed interviews and consensus coding among the three researchers, which continued throughout the year-long project.
4. *Microanalysis*:

In order to begin to generate ideas, each analyst individually coded the first transcript using open coding, which is a brainstorming approach to data analysis aimed at opening the data to all possible meanings within them (Corbin & Strauss, 2008). During this stage of detailed data analysis, the analysts attempted to act like “microscopes” by examining each piece of datum “up close” (Corbin & Strauss, 2008, p. 59) while “‘mining’ the data, digging beneath the surface to discover the hidden treasures contained within data” (Corbin and Strauss, 2008, p. 66). More specifically, this phase consisted of three steps: (a) the material in the transcript was broken down into manageable chunks, (b) the researchers scrutinized the raw data in order to understand the essence of what was being expressed, and (c) the researchers delineated a conceptual name (i.e. concept) to describe that understanding (Corbin & Strauss, 2008).

Each researcher kept a list of concepts in what the team called “codebooks,” which documented the identified concepts accompanied by brief textural quotes, descriptions, and/or line numbers directly from the transcript (see Appendix E for an example). Lower-level concepts were used to explain the properties or dimensions (i.e., variations within properties) of the higher-level concepts (i.e., categories/themes) (Corbin & Strauss, 2008). The distinction between these concepts became clearer in the later stages of data analysis.

Each researcher developed her own system for documenting her personal reactions to each transcript in her personal journal and for noting her analytic thoughts/questions/reflections related to the data in dated memos. The team then
met as a group and used each member’s individual codebooks, personal journal entries, and memos to guide the analytic meeting. The primary researcher tape-recorded and took notes during each team meeting, which served as team memos (see Appendix F for an example of a written team memo). Memos were utilized to “reflect the mental dialogue occurring between the data and [the researchers]” (Corbin & Strauss, 2008, p. 169).

5. General Analysis

During this process, the researchers looked at the data from a broader perspective and asked, “What are all these data telling us?” (Corbin & Strauss, 2008, p. 60). More specifically, the researchers attempted to put the data back together after breaking it apart by linking themes/categories and relating concepts to each other (e.g., “understanding mind-body connection” and “understanding the purpose of ED beyond a drive for thinness” were both placed under the category “cognitive shift”). Making links and connections between concepts helped the researchers to develop classificatory frameworks related to recovered ED clinicians’ understanding and use of personal recovery in the treatment of EDs.

6. Theoretical Sampling & Comparative Analysis

The first coded transcript served as the foundation for further data collection and analysis, which is a process called theoretical sampling. In other words, concepts that appeared to be relevant in the first transcript (e.g., embodiment, insider knowledge) informed the questions in the next interview, and any new concepts that appeared to be relevant in the second transcript (e.g.,
looser boundaries) informed the third interview etc. Comparative analysis was also utilized. More specifically, if a chunk of new data was conceptually the same as data from the previous interview, then it was coded using the same conceptual name; any new descriptive material that enhanced understanding of the overarching concept was added to the list of properties and dimensions of that code. New concepts that were not in the previous data were added to the emerging list of concepts. This helped the researchers to differentiate themes from one another and to identify properties and dimensions specific to each theme while also accounting for variation within themes.

This entire data collection and analysis process continued until no new categories/themes were identified (following the eighth interview) and the researchers agreed that they had sufficient data to fully describe each category/theme in terms of its properties and dimensions (i.e., “conceptual saturation,” Corbin & Strauss, 2008, p. 197). Corbin and Strauss (2008) note that:

Though total saturation (complete development) is probably never achieved, if a researcher determines that a category offers considerable depth and breadth of understanding about a phenomenon, and relationships to other categories have been made clear, then he or she can say sufficient sampling has occurred, at least for the purposes of this study. (p. 149)

The researchers believed they reached this point after the eighth interview given that no new categories could be identified and, further, that the identified
categories, properties, and dimensions related to each phenomenon under study were sufficiently developed to effectively articulate classificatory frameworks.

7. Putting it All Together

The researchers used all of the resulting analytic materials (i.e., journals, codebooks, transcripts, feedback from the participants, and both audiotaped and written memos) to articulate classificatory schemes and accompanying conceptual diagrams related to recovered ED clinicians’ understanding and use of personal recovery in the treatment of EDs.

Credibility of the Findings

In qualitative research “validation” refers to “an attempt to assess the ‘accuracy’ of the findings, as best described by the researcher and the participants” (Creswell, 2007, pp. 206-207). Corbin and Strauss (2008) propose that qualitative research findings should be “‘credible’; that is, believable or plausible, and ‘applicable’ in the sense that findings can be readily used because the findings provide insight, understanding, and work with diverse populations and situations to bring about desired change…” (p. 301). In order to maximize the credibility of the current findings and minimize the effects of researcher bias, several verification standards and procedures were built into each stage of the research process.

First, member checking of (a) transcripts, (b) demographic data, and (c) the classificatory schemes and diagrams was used in order to verify the accuracy of the participants’ experiences and voices, and to solicit their views on the validity of the findings and interpretations. Two of the nine participants edited their transcripts and all nine participants confirmed the accuracy of their demographic data. Five participants also
provided positive feedback on the classificatory schemes while one participant edited some of her quotes that were included in the classificatory schemes. This participant’s edits were incorporated into the final presentation of the results. A minority of participants (three) did not respond to the researcher’s invitation to provide feedback related to the classificatory schemes and/or accompanying diagrams.

Second, the constant comparative method (Glaser & Strauss, 1967) was utilized in order to compare each concept in the data to other concepts for similarities and differences. This helped the researchers to alter their initial interpretations of the data as disconfirming evidence surfaced and to avoid making premature interpretative conclusions. The negative case analysis method was also used, in which the researchers looked for and discussed cases that did not fit the dominant patterns or concepts. Identifying negative cases helped the researchers to provide a fuller exploration of the phenomenon and highlight that there are exceptions to points of view (Corbin & Strauss, 2008). These are reflected in the “underdeveloped categories” sections of the results.

Third, the ongoing practice of reflexivity was utilized in order to clarify the researchers’ biases at the outset of the study and to continuously be aware of their judgments and reactions throughout the study. More specifically, throughout the analytic process the analysts actively reflected upon who they are and how they were both shaped by, and contributed to shaping, the research process (Corbin & Strauss, 2008) in both group (i.e., research team discussions) and individual (i.e. personal journals) forums (see the Researcher Reflexivity & Consensus Coding section of Chapter 3 for specific examples). Researcher reflexive journals were used by each researcher in order to monitor personal judgments and reactions to the research procedures and data, and to
intentionally consider the following questions: (a) Why am I doing this research?; (b) How might my identity, values, and prejudgments influence the research process?; and (c) What are my frustrations and excitement during this research process and how might they impact this study?

Finally, routine team meetings and the use of multiple trained data analysts (one of whom shared the status of “recovered ED clinician” with participants and two of whom did not) helped to minimize individual subjectivity and biases, while prolonged immersion in the data and repeated review of the transcripts helped to deepen the researchers’ connection to and understanding of the data. Memos were also utilized to facilitate analytic reflections and “reflect the mental dialogue occurring between the data and [the researchers]” (Corbin & Strauss, 2008, p. 169).

In sum, according to Stiles’ (1993) criteria for the validity of interpretations of qualitative data, the current study achieved testimonial validity (i.e., the majority of participants confirmed the accuracy of the findings through member checks of the classificatory schemes and accompanying diagrams), reflexive validity (i.e., all three researchers gained new understanding of, and increased self-awareness related to, the two phenomena under study), and high consensus among the three researchers about the analytic interpretations and the resulting presentation of findings. We concur with Macran and colleague’s (1999) conclusion that, ultimately, “readers must judge for themselves whether the themes and our organization of them represent a coherent account or uncover new understandings” (p. 428).
Table 3.1

*Participant Demographics Part I*

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Age</th>
<th>Race/Ethnicity</th>
<th>Highest Level of Education in Mental Health Field</th>
<th>Total Length of Time Treating EDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Augusta</td>
<td>Female</td>
<td>55</td>
<td>White- Norwegian</td>
<td>MSW</td>
<td>15 years</td>
</tr>
<tr>
<td>Bianca</td>
<td>Female</td>
<td>51</td>
<td>White- Jewish</td>
<td>MSW</td>
<td>23 years</td>
</tr>
<tr>
<td>Carolyn</td>
<td>Female</td>
<td>55</td>
<td>White- Caucasian</td>
<td>M.A.</td>
<td>32 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M.Ed.</td>
<td></td>
</tr>
<tr>
<td>Cleo</td>
<td>Female</td>
<td>48</td>
<td>White- Irish</td>
<td>Ph.D.</td>
<td>28 years</td>
</tr>
<tr>
<td>Ella</td>
<td>Female</td>
<td>27</td>
<td>White- Eastern European</td>
<td>M.A.</td>
<td>5 years</td>
</tr>
<tr>
<td>Frankie</td>
<td>Female</td>
<td>47</td>
<td>White- Eastern European</td>
<td>Ph.D.</td>
<td>16 years</td>
</tr>
<tr>
<td>Nicole</td>
<td>Female</td>
<td>31</td>
<td>White- Caucasian</td>
<td>M.A.</td>
<td>4+ years</td>
</tr>
<tr>
<td>Phoebe</td>
<td>Female</td>
<td>47</td>
<td>White- Eastern European</td>
<td>M.A.</td>
<td>5 years</td>
</tr>
<tr>
<td>Rose</td>
<td>Female</td>
<td>43</td>
<td>White- Italian American</td>
<td>M.A.</td>
<td>14 years</td>
</tr>
</tbody>
</table>
Table 3.2

Participant Demographics Part II

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Type of ED(s)</th>
<th>Duration of ED</th>
<th>Type of Treatment</th>
<th>Length of Time in Treatment</th>
<th>Total Length of Time in Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Augusta</td>
<td>BN</td>
<td>5 years (active)</td>
<td>Individual psychotherapy</td>
<td>8 years</td>
<td>25 years</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10 years (disordered thinking)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bianca</td>
<td>AN (Restricting type)</td>
<td>2 years</td>
<td>Individual psychotherapy</td>
<td>N/A (Treatment was for non ED symptoms)</td>
<td>30 years</td>
</tr>
<tr>
<td></td>
<td>BN</td>
<td>5 years</td>
<td></td>
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CHAPTER 4

Results

Presentation of Findings: Classificatory Frameworks

Because the current study was one of the first examinations of recovered ED professionals’ understanding and use of their personal recovery in the treatment of EDs, the researchers aimed to achieve a preliminary exploration of each phenomenon rather than a theoretical explanation. Therefore, this study aimed to contribute to the current empirical literature by using Corbin/Strauss’s (2008) qualitative methodology to identify significant concepts in the data, explore their properties, dimensions, and relationships, and thereby achieve a classificatory framework of each phenomenon, which could serve as precursors to future theories on the topics at hand. This chapter presents key findings in the form of two distinct classificatory schemes with accompanying diagrams, which resulted from the research team’s analysis of the transcribed interviews with recovered ED clinicians regarding their: (a) understanding of ED recovery and (b) use of their personal recovery in the treatment of EDs. Feedback from the participants, peer debriefing, team memos/reflections, and the researchers’ codebooks informed the following findings.

Classificatory Scheme 1: Recovered Clinicians’ Definition of Eating Disorder Recovery

Findings related to the definition of ED recovery through the lens of recovered ED clinicians include three overarching, interrelated categories (individualized process; towards balance, freedom, and embodiment across multiple dimensions; and societal
context), each containing sub-concepts (i.e., properties and dimensions) that elucidate the categories and the relationships between them. More specifically, findings revealed that recovery is an individualized and multidimensional process towards balance, freedom, and embodiment (i.e., being authentically and fully expressed), which is perpetually influenced by societal standards and messages (see Figure 4.1). A fourth category including underdeveloped findings is also included.

For clarity, the overarching categories are denoted with Roman numerals; the properties (i.e., “characteristics that define and describe concepts” [Corbin & Strauss, 2008, p. 159]) are denoted with the same Roman numerals as the categories that they describe in addition to capital letters; and the dimensions (i.e., “variations within properties that give specificity and range to concepts” [Corbin & Strauss, 2008, p. 159]) are denoted with corresponding Roman numerals and capital letters in addition to Arabic numerals (see Table 4.1). With the exception of the underdeveloped concepts, all categories, properties, and dimensions were endorsed by a majority of the participants (6 or more). It should also be noted that because many of the concepts are interrelated, several of the citations are relevant to multiple categories and subcategories. Therefore, concepts that could not be fully separated from one another are described jointly (e.g., individualized and process are described together as individualized process; reconnection and risk are described together as reconnection and risk, etc).

I. Individualized Process:

I.A. Beyond Symptom Recovery

Each participant understood the purpose of her ED differently and noted different paths to recovery; therefore, the recovery process was individualized. All participants
agreed that recovery entailed a process of healing beyond ED symptom abatement and along multiple dimensions, which varied depending on the individual’s unique personal vulnerabilities, environmental triggers, and life experiences. For this reason, *individualized* was placed at the core of the ED healing circle (see Figure 4.1). Augusta, for example, stated that:

… Again there are certain things that are not negotiable, but, you know, getting past the symptom recovery looks really different. We all come out of different pods, so we all need to heal in different ways.

Similarly, Cleo highlighted the individualized and multidimensional nature of healing:

I would say it’s only after our symptoms are abated significantly that what I mean by recovery even has a chance to begin….In addition to the symptomatic perspective, I think that recovery happens on many other levels and for each of us the degree to which we need to address change there will vary.

Other participants also highlighted the evolving nature of recovery beyond the cessation of ED behaviors. Phoebe, for example, expressed that:

I was on a meal plan and, behaviorally, you probably could say that I was no longer underweight, I mean no longer anorexic. I could not be diagnosed as anorexic anymore. And I was eating, but I really wasn’t recovered because mentally I was tormented and terrified.

Likewise, Ella highlighted that:

Like I would eat intuitively and eat foods that I wanted to eat, and sometimes feel guilty about my food choices. That was still left over….like I had to deal with the thoughts, but it didn’t affect my behavior that much…I think it took me years
after that to be recovered in terms of my relationship with food and my relationship with my body.

Therefore, although each individual’s recovery process was different, the participants unanimously agreed that recovery entailed healing beyond symptom abatement.

II. Towards Balance & Freedom/Embodiment across Multiple Dimensions of Healing:

In addition to describing recovery as an individualized process beyond symptom abatement, all participants also described the need to heal along the specific dimensions of their personal functioning that were imbalanced pre ED development (or any time thereafter), including psychological, existential, social, spiritual, physical/behavioral, and/or emotional dimensions. More specifically, they discussed the need to restore balance by decreasing the role of their ED ruminations and behaviors while increasing their healthy coping and involvement in other areas of life. In this way, the ability to recognize imbalance and make subsequent life changes to restore balance was integral to the participants’ recovery processes. Therefore, balance was placed at the center of the ED healing circle, bordering and encompassing each of the six dimensions of functioning (see Figure 4.1). Bianca, for example, described that her recovery entailed restoring mental balance by redistributing her energy from her ED to other areas of her life:

I think that recovery, it’s really a state of mind….I think of it as, how big is the rest of your life versus your eating disorder?…For me it was like, I want to enjoy my life more than I want to try to control my weight and how I look, and it is in the way and ruining perfectly good times. And this is just ridiculous, and it’s in my way and it’s wasteful. So I think it’s an emotional thing. I mean obviously

1 All italicized words within quotations indicate that the participant emphasized the word(s) during the interview.
there are behaviors, you know....but I think for me it was about a state of mind. It was kind of like being at peace and having other interests and becoming bigger in other ways in my life.

Similarly, Cleo described understanding body dissatisfaction as a signal that she needs to restore balance in her life as opposed to a need to change or fix her body:

So [body dissatisfaction] doesn’t mean I need to change my body. It means I need to look after the body of my life and go, ‘Ok what’s missing, what’s lacking, what’s too much, what’s out of control? What doesn’t feel right?’

Thus, recovery signifies the ongoing ability to (a) recognize imbalance and then (b) restore balance, which leads to enhanced comfort, harmony, and empowerment along each of the six dimensions of functioning—a concept the researchers termed “freedom/embodiment.” More specifically, the category freedom/embodiment signifies first, freedom from ED mind, body, and soul torment (i.e., freedom) and, second, the intentional use of that freedom to be authentically, healthily, and “fully expressed” (Augusta) psychologically, existentially, socially, spiritually, physically/behaviorally, and emotionally (i.e., embodiment). In this way, freedom/embodiment is aspirational and requires ongoing efforts to maintain balance and congruence in the face of life’s inevitable personal, familial, environmental, and societal triggers. Therefore, freedom/embodiment was placed along the outer perimeter of the ED healing circle along with process to symbolize the overarching, ongoing goal of recovery (see Figure 4.1). In order to further elucidate the category towards balance and freedom/embodiment across multiple dimensions of healing, a description is provided of the participants’ recovery processes and experiences along each of the six dimensions of functioning.
II.A. Psychological:

II.A.1. Cognitive Shift-- Understanding the Purpose of One’s ED & Responding Differently to ED Triggers/Signals

All participants described a metamorphosis in the way they understood their ED and the purpose it served. For example, they described the need to tolerate—rather than “numb”—distressing emotions (Rose), feel heard (Augusta), risk being loved and loving (Cleo), feel safe (Nicole), and fill the void of loss and loneliness (Frankie). Similarly, Bianca viewed her ED as:

A symptom, as a communication, as a way of saying, ‘I’m stuck, I’m developmentally stuck. I’m confused. I’m depressed.’

Likewise, Nicole described recovery as:

A freedom from food and weight issues with the acceptance of body size and ability to maintain my weight with the absence of behaviors, and insight into why my behaviors existed, what they did for me, and the demonstrated ability to use healthier coping skills for those issues.

Thus, all participants viewed their EDs as serving a purpose, and recovery symbolized an understanding of this purpose in combination with a commitment to meet the underlying needs in more adaptive ways.

Further, while participants unanimously concurred that symptom recovery is fully attainable and necessary, most participants described that healing related to body image and the psychological aspects of recovery is a persistent and ongoing process. In other words, recovery seems to symbolize a person’s ability to respond differently to life triggers and subsequent thoughts or urges to engage in ED behaviors (rather than a
complete absence of ED related vulnerabilities, thoughts, or urges). Cleo poignantly described this concept:

I believe that it’s critical to distinguish between ‘recovery’ on the physical (symptomatic) vs. psychological, social and familial levels. I definitely believe the former is completely possible. On the other hand, and as with body image, I believe we are in a constant process of recovering from and addressing our specific temperamental, social, and relational flaws, fears, and challenges….I believe the symptom world of our EDs is much more successfully and resolutely resolved. Why we developed the problem- the people, situations, traumatic losses, psychic/temperamental inclinations- persist in their levels of compromise or interference to varying degrees…For example, my family issues and dynamics continue to be a significant challenge in my life but I certainly don't starve, exercise or resist connection or support because of it. Quite the opposite!

She proceeds to highlight an integral aspect of ED recovery beyond the abatement of behavioral symptoms — the ability to understand and respond differently to body dissatisfaction:

All of us have body image issues from time to time. The difference in recovery is that we can translate it much sooner into what is the ‘body-of-life’ issue that feeling fat is otherwise speaking to….feeling fat and that kind of body disturbance in the way I experience my body, I know is not about my body. I know it’s a body-of-life issue and it’s a signal. So the difference I would say is that somebody with a recovered body image knows that when our body talks, it’s trying to get us to pay attention to our life, not our butt.
Nicole also described the need to understand the purpose of her ED so that she could find healthier alternatives to meet the underlying needs. More specifically, she described the need to understand:

…What your eating disorder does for you. And then how you can start to use that or, not use it, but how you figure that out and then find other ways to get that in your life. So I will say for me a big issue is feeling safe or having security. And my eating disorder gave me that feeling whether it’s rational or irrational. It’s not that now that I’m recovered I no longer have a need to feel safe. It’s that now that I’m recovered I know other ways to have that feeling.

Similarly, Ella described that when ED thoughts and judgments resurface, recovery signifies that:

I’m able to look at them and try to find the underlying issues going on.

Thus, recovery symbolizes an imperative cognitive shift in the way that the participants understand their EDs— an acceptance that EDs are more than a drive for thinness and that they function as a response to underlying “body-of-life issues” (Cleo), which may relate to unresolved grief, family of origin dynamics, inadequacy, or feeling silenced, alone, or unsafe. Therefore, understanding the underlying personal and environmental dynamics that influenced the development of participants’ EDs was essential in finding new ways to respond to ED “signals” and to healthily cope with their personal vulnerabilities and ongoing life stressors. Further, recovery for many participants seems to represent the ability to respond differently to sporadic body consciousness and/or ED related urges rather than a complete absence of them.

II.A.2. Body Acceptance
Participants also described the need to achieve “body acceptance” (Ella) during the recovery process. Frankie, for example, described the powerful shift she experienced in her view of her body and its function as she progressed in her recovery:

I feel very calm and very accepting of my body. I do love my body now. That’s another thing: I feel like I’m so appreciative, grateful, and proud of it even for having made it through all this stuff, and I appreciate it for what it is. I don’t expect it to be anything other than a vehicle for me to live. It’s not supposed to look perfect. It doesn’t have to look a certain way. I try to take care of it more like you take care of anything, your car or whatever. I want to try to take care of it so it’ll last long and I’ll feel good. I view my body differently, its function is different. Food is fuel. I enjoy it.

Similarly, Nicole described the “acceptance of body size” as essential to her recovery process and Bianca described letting go of “the quest for a perfect body.” Further, when describing her view of recovery, Carolyn expressed:

You won’t betray your soul to be a certain size and you care more about yourself than the way you look.

Therefore, recovery for the participants in this study involved a shift from the objectification of their bodies to an acceptance of them, and a transition towards appreciating their bodies for what they do rather than how they look.

II.A.3. Built-in Wake-up Call System

Interestingly, several participants described that momentary relapses in ED behaviors facilitated, rather than inhibited, the recovery process because they served as wake-up calls to attend to imbalances. In other words, recovery signifies the ability to
respond differently to the resurgence of ED symptoms when triggering life events occur by reinvesting in the healing process and taking action to restore balance. For example, Augusta expressed that:

The types of experiences I had where I would um, like once every six months or once every three months, I think I would categorize them as sort of momentary lapses into insanity or into old behavior caused by stress, caused by, in my case it was always around not feeling heard….it was like getting slapped in the head because I would do it and I’d go ‘What am I doing?’ You know, you’d stop and go, ‘Ok you’ve got to sit down here and you’ve got to really think about this’…. your body is telling you something that you need to pay attention to that doesn’t have anything to do with food.

Similarly, Rose articulated that:

A realistic ‘recovered’ is that, you know, we might say like with a bulimic it might be six months between a binge and purge. But I do not look at like short relapses as anything less than part of the journey. So I really do think that a lot of times we revisit the symptoms to remember why we don’t want to do them.

Phoebe also described that relapses facilitated her recovery process:

Like every time I relapsed, when I got better, I became even better than I was the first time I relapsed.

Therefore, temporary relapses seemed to serve as a motivating and functional part of the recovery process for many of the participants in this study.

II.A.4. Freed Mental Space:
Participants also noted that recovery entails a marked shift in mental focus, reduced “mental torment” (Phoebe), and freed “headspace” (Augusta). More specifically, they experienced notably reduced food and weight fears and ruminations, which allowed them to focus on life outside of their EDs. For example, Bianca described that recovery to her is “more of a mental thing” in that she needed to heal from the torture that ED related obsessions caused:

I felt like when so many thoughts were revolving around my weight, how my body looked, what I was going to eat, whether I was exercising or not….I would say I felt tortured by it. Mentally tortured. And I think that was one of the things that I don’t think I consciously realized, but maybe unconsciously realized, is that if I wanted to have a life, I really couldn’t be doing this or focusing on my body so much. You know, it was like anti-life, anti-socializing, anti-everything I was trying to do.

Frankie also described the need for mental balance during recovery. She stated:

I think recovery is, number one, not spending a whole lot of time thinking about eating, food, and body image…. the mental part [of recovery] is how I’m thinking about my body and what I expect of it. How I feel towards it if I gain a little weight or it’s the winter and I don’t exercise much. I go through periods where I don’t exercise much other than walking my dog. And other times I am exercising more for osteopenia to try to take care of my body and keep my bones healthy. So my motivation for exercise isn’t because I’ve got to lose weight or I have to look firm and fit.
Similarly, Bianca described a shift in her ED’s level of interference in her life as her recovery progressed:

I would say what I eat or, you know, thinking about how much I eat is, compared to how it used to be, is probably in the way one hundredth the amount that it used to be when I was in an active eating disorder. And I’m happy with that. I can deal with the one hundredth. You know it’s like, hey I remember what it used to be like. I was tormented and now it’s like a mild annoyance at times.

In the same way, Phoebe described that, when recovered:

Your mental state is not swayed by all the constant eating disorder thoughts and fears, and your relationship with food is normalized where you’re not afraid of eating.

Thus, all participants described a cognitive shift related to their EDs. More specifically, they described viewing the function of their EDs differently, developing new responses to old ED patterns, responding to momentary relapses as wake-up calls to restore balance rather than as interferences, and enjoying newfound mental freedom due to a reduction of ED ruminations.

II.B. Existential:

II.B.1. Meaning-making & Identity Development

All participants described meaning-making and/or identity development that was inspired by their EDs and necessary for recovery, which the researchers broadly termed “existential growth.” Nicole, for example, described the “over-guiding [agency] philosophy” that helped her and her clients to recover, which underscores the complex, evolving, and integrative nature of their ED identities:
…Soul, like healthy self or ‘soul self,’ what we call it, versus eating disorder self; and those are two parts of one whole, not that the eating disorder is something outside of you, but that it’s part of you and that we just try to reintegrate the eating disorder part into the healthy part to figure out what it is that the eating disorder is doing for you. What is that? Being able to talk back to that voice from your healthy voice. And healing kind of from the inside out.

In another example of meaning-making and identity development, Phoebe described her transformative realization that her ED thoughts were not unique, which reminded her of being in a cult and helped to motivate her, and sometimes her clients, to reclaim their independent identities:

It was sort of shocking in a way… it made me a little bit afraid because… it was almost like I felt like I was in a cult… Like when you think your thoughts are just thoughts and then you find out that your thoughts are like common…In fact, I have an eating disorder group… and I have this interview that I give out… and at the end they are all freaked out because they all have the exact same answers….I do this on purpose because I want them to realize that they are brainwashed a little bit. It’s like their brain is highjacked….And it’s kind of weird, but if people want to be ‘individuals’ and they want to be unique, they don’t like that very much and it kind of gives some people the motivation to fight against it.

Nicole also described a profound shift from a generic ED identity to a noteworthy recovered ED identity:

… My identity isn’t that I had anorexia, it’s that I recovered from anorexia. And I think that’s an important distinction because so many people find identity through
their eating disorder, and so holding that space of, actually, it’s more of a special and unique thing saying you’ve recovered from it.

Similarly, Bianca described the integral impact that her ED continues to have on her recovered identity:

….This was a huge experience in my life so it’s kind of like, if that didn’t happen I can’t even picture who I’d be. My understanding of my eating disorder and having that so formed my identity that it’s hard to figure out, you know, who I’d be.

Several participants also described soul-searching, especially as it pertains to the work they do with clients. Rose, for example, described that:

We can look at it in terms of [clients’] purpose. What is their purpose? Because I encourage, you know, lots of times to help them get out of their self-obsession, kind of being of service to other people in order to find out how much they matter…. and so doing some kind of volunteer work or something, that very often gets us into talking about their purpose on earth… I start to notice that we’re talking about meaning in their lives. What they want to do with their lives. You know, it’s kind of like, life goes on. I notice what we’re talking about in therapy--it’s no longer, you know, like ‘I look in the mirror and I can’t leave my house.’ It’s more about their job and their relationships.

II.B.2. Increased Personal Power

In addition to identity development and meaning-making, participants also described that recovery involved a reclaiming of their personal power and a strengthening of their voices. Cleo, for example, described that:
A fundamental part of our recovery is finding our voice again. In other words, our eating disorder was a way of speaking into what we otherwise couldn’t risk putting into words. So it’s our ability to say no, to say yes; to risk conflict and controversy; to see the blessing of conflict in connection, and how that deepens relationships.

Nicole also discussed the healing transition she experienced from “hiding” behind the shame and secrecy of her ED to feeling proud of, and speaking up about, her recovered status:

…I also feel like there’s so much shame with eating disorders…it’s this secret and the eating disorder thrives in secrecy and that shame. And so for me it’s definitely not something I’m ashamed of, it’s something that I’m proud to say, I’m recovered!

Bianca stated that, through recovery:

I found my voice and I found myself.

Similarly, Frankie described that:

More and more I feel like what’s the point of life if you don’t speak? If you don’t try to say what the truth is and try to make a difference? So I think I use that to bolster my courage if I do feel scared at times or if I do feel like, would I be ostracized, would I be less respected for people knowing this stuff?

Thus, an integral part of the participants’ recovery processes involved reconnecting with their personal power and using that power to advocate for themselves and their needs instead of utilizing the ED to communicate for them.

II.B.3. Congruency
All participants also described becoming more congruent and/or authentic through the process of recovery, which one participant, Cleo, described as “embodied”:

I say head, heart, guts. So belly, heart, head. If those things aren’t lined up and congruent, if you aren’t all there, fully present, our patients know it. When you’re in the presence of somebody who is fully embodied it doesn’t matter what they weigh. It doesn’t.

Similarly, Phoebe described that:

….The signs for me that I was recovered were sort of like congruency or an authenticness, like where I didn’t feel like I was living a double life or hiding things…And the same things I was thinking were the same things that were coming out of my mouth.

Further, when describing a mantra that helped her and her clients to heal, Nicole described:

…Truth without judgment, really teaching people how to be authentic and to be in a relationship with themselves authentically without judgment; telling the truth with oneself and other people.

In these ways, congruency and authenticity—in combination with meaning-making, identity development, and increased personal power—were essential in the recovery process to counter and heal from the shame, secrecy, and disconnection that drive EDs.

II.C. Social:

II.C.1. Reconnection & Risk

Because EDs thrive in secrecy and isolation, several participants described the need to reconnect socially, to learn how to trust again, and to risk the pain involved in
being in meaningful, authentic relationships. Phoebe, for example, described that recovery:

\[\text{…Helped in my relationships, and I kind of started to see other people as more of a resource. Like I called other people when I was feeling bad.}\]

Cleo also described the painful—yet imperative—risk involved in reconnecting:

\[\text{….Reopening my heart to grief-- that was the most profound shift I had. That’s what I had to come back to. A world in which I was existentially, fundamentally going to be devastated all over again and wake up and do it again. Wake up and do it again. And know that loss was as essential as loving. That’s the world I had to weigh myself back into.}\]

Thus, healing along the social domain required reconnecting with friends and family and being willing to accept the risk involved in trusting, loving, and being loved by others.

**II.D. Spiritual:**

**II.D.1. Connections Outside of Self, Creativity, & Movement**

All participants described the need to feel connected outside of themselves and their EDs, and/or to be nourished in creative or spiritual ways, which Ella fittingly termed “soul needs.” The ability to recognize one’s needs and to express oneself via a relationship with a higher power or through meaningful activities such as art, sports, yoga, cooking, or singing, for example, were identified as essential to replace the use of ED symptoms to express and soothe oneself, and to move away from the self-absorption that often accompanies EDs. Augusta, for example, expressed that:
If I were to write a prescription for recovery, and this is nothing new, it would be equal pieces of spirituality and movement and creativity and letting in all of these other energies, all these other ways of being nourished.

Similarly, Phoebe stated:

[Recovery involved]…having different experiences that kind of reconnected me with parts of life that weren’t part of my life any more…like nature.

Further, Rose described that:

I’m amazed at how, when people are really recovering, they often find something they’re going to-- they’re going to meditation, they’re going to maybe a church or something. They are finding something spiritual…. to keep them grounded. And it can take many forms, and I really do think sometimes artistic expression... just to get out of [the self-loathing nature of the ED] and to realize how much, I mean, joy you can bring to go tutor a child and read with them. I mean doing these kinds of things helps remind one that they can do things and that they can bring joy… I do think when you have a lot of those things it’s really hard to be so self-destructive.

II.D.2. Gratitude

The participants also described increased gratitude for their healthy bodies, for recovery, and for the ability to eat without guilt. Frankie, for example, described:

…I feel like I’ve been through a war with my body. I feel like we got out of the war. I’m just so appreciative and grateful to have this body working, you know? I’m also appreciative of the fact that I can eat something, like ice cream, and not feel worried in any way.
Similarly, Bianca described feeling:

…Really grateful I don’t have an eating disorder. I mean I really go, like I am so glad I have a good relationship with food. I just feel like, thank God I’m past that cause that sucked. And I look back thinking, I wasted a few good years of my life. And you can’t get those years back.

In this way, the participants’ gratitude for their health and ED recovery seems to strengthen their commitment to remain in recovery.

Rose also described the gratitude she feels towards her recovery for enabling her to do ED work:

I just get such joy… I really mean this-- I am truly honored to do this work. I mean it’s really amazing to be able to do it.

Similarly, Nicole described that:

Doing this work makes me much stronger in my recovery because I see the way [ED clients] are and the struggle that they go through and then at the end of the day I get to go home and I get to live my life.

Therefore, making connections outside of themselves, finding new creative and/or spiritual ways to express and nourish themselves, and experiencing gratitude for their physical health and newfound freedom were essential experiences in the recovery processes of the participants in this study.

II.E. Physical & Behavioral:

II.E.1. Medical Stability, Symptom Recovery, & Intuitive Eating

Several participants described that physical (i.e., medical and psychopharmacological stability) and symptom recovery were prerequisites for recovery
across other domains, which is directly related to the subcategory/property *beyond symptom recovery* (I.A.) previously described. For example, Cleo stated:

I see recovery as a series of processes that don’t necessarily happen in order but essentially require complete and absolute symptomatic recovery. And by that I mean proper weight restoration and the elimination of any purging or restrictive symptoms.

Similarly, Carolyn described that, when recovered:

> You are not engaging in *any* eating disorder behavior.

In addition to ED symptom recovery, many participants noted the need for normalized and balanced eating. Ella, for example, stated that:

> Full recovery means body acceptance and intuitive eating with no food rules.

Phoebe also described the importance of “intuitive eating”:

> I made a huge leap in my relationship with food and my body. It was because I learned the intuitive eating process. And so I had a whole new paradigm, something to think about food and how I eat, and when and what and how much and all that, which I needed. It was like an education on how to eat that I didn’t have, because before that I was just following a plan….It doesn’t really matter what foods you eat, that’s the whole thing. You’re going to get full differently; you’re just going to wait until you’re hungry. I tell [clients] it’s like a parking meter, like if you put seventy five cents in the parking meter you could park for forty-five minutes and if you put fifty cents in, you can park for half an hour.
> You’re going to be hungry and come back to put another quarter in. It’s the same thing.
Thus, in regard to the physical and behavioral dimensions of recovery, participants described the need to stabilize medically, to cease all ED behaviors, to let go of food rules, and to engage in intuitive, balanced eating.

**II.F. Emotional:**

**II.F.1. Distress Tolerance & Emotional Sobriety**

Many participants described the need to improve their management and tolerance of emotions. Rose, for example, discussed her difficulty tolerating distressing emotions and described healing from “emotional impulsiveness.” More specifically, she described learning about:

> The underlying need to fill a hole… This is a hard thing-- for me to learn to sit with those feelings and not, you know, numb them with addictive behavior. You know, we are so afraid of doing that, but once we start doing it, it’s like it’s not that bad.

Similarly, Augusta expressed the need to achieve “emotional sobriety,” which she described as the ability to:

> Be able to handle my emotions in a way that I can be serene and still speak up and do what I need to do to take care of myself and not have to resort to destructive behaviors…sobriety from getting lost in my emotions and feeling justified to act a certain way just because I’m angry.

Ella also described the need for “good emotional health” while Cleo discussed the need to “develop emotional skills and tolerance.” Further, Frankie described that, when recovered:
I slipped into gaining a little more weight and I was a little bothered by it, but I didn’t feel emotionally intense about it.

In sum, healing along the emotional dimension involved learning to both tolerate and manage emotions without the use of destructive behavior.

**III. Societal Context:**

**III.A. What is Normal in U.S. Society?**

Finally, all participants implicitly or explicitly questioned what constitutes “normal” eating behavior and weight/body consciousness in U.S. society. More specifically, they acknowledged that recovery from an ED in the U.S. does not mean an absence of body dissatisfaction or the absence of a desire to be physically fit:

I would separate out body image issues, which I believe we all (of industrialized nations) have to varying degrees regardless if we’ve ever had an eating disorder.

(Cleo)

A lot of us had been trained, you know, that recovery means you eat whatever you want and you don’t care about what body size you are. And especially here in XX, you know, realistic recovery is: if you want to be slim, you be slim. It’s the line you cross when you can’t control it. And when the behaviors are invading your life. So I think realistic recovery, you know, it’s ok to want to be in shape.

(Rose)

I mean I just think it’s a matter of degree from what I understand. It’s not, do you have it or don’t you have it? It’s like, is it in the way of your life?...I can’t tell
you how many women I go to lunch with who would never think of not ordering a salad. I’m not even talking about women with eating disorders…. And I don’t know, sometimes I’m like, well maybe they have eating disorders. It’s like, how do you define it? …Most of us worry about how we look and we’re socialized to worry about that. (Bianca)

I am a woman who lives in this society so if I’m going to act like everyday I wake up and look in a mirror and think, ‘wow I look fabulous’ (laugh), no, you know? (Nicole)

To me recovered means you are not engaging in eating disorder behavior. You’re not! When you’re recovered, now, you might have thoughts about it, you might feel fat, and some people say, ‘Oh well that’s still in recovery.’ I mean, you can’t expect more from the client being recovered than a normal woman in this world. (Carolyn)

Therefore, participants unanimously agreed that the definition of recovery cannot ignore the impact of American culture on body image. While healing, improved functioning, balance, and enhanced freedom occurred across each of the previously explored dimensions, this does not imply that the participants were immune to body dissatisfaction or a drive to be physically fit. Thus, these findings suggest that a realistic definition of recovery should not expect more from a recovered ED individual than is normal for individuals without ED histories in the U.S.

IV. Underdeveloped Categories:
IV.A. Aging and Letting Go

Some participants also described the influence of aging and reduced societal pressures to be thin as facilitating their recovery processes and their ability to “let go” (Bianca) of the drive for thinness:

I really think there might be something in the pressure of being a heterosexual woman and male attention…whereas I feel kind of freed up…I’m also getting older too. I’m now in my late 40’s so people aren’t looking at me as a sex object as much, if at all. (Frankie)

I don’t know, the consciousness is gone, you know? I do think there’s something to do with getting older. Like I have a child, I have a husband, and I have a career. You know? I have a life. (Rose)

Getting older gives you perspective…It’s kind of like, just everything is always shifting and changing, you know?…Like it’s all relative anyway. So it’s like…whatever you have an issue with now, wait ten years and you’ll realize how good you looked. So that kind of thing is coming with aging-- my own aging and my friends’ aging. And you just kind of get used to the idea that the quest for a perfect body or something, frankly it’s like you’re not going to get one…. It’s like a letting go. It’s like it doesn’t really matter, you know? I can safely say now that it doesn’t matter very much. (Bianca)
IV.B. Sexual Healing

Two participants shared a perspective that sexual healing is another imperative component of ED recovery. Cleo, for example, noted that:

Ironically, as many restricting anorexics are not sexual, I was. It wasn’t at all comfortable. I was very disassociated. And he would have never known the difference because he never knew me embodied. Because I never knew sex from an embodied place. So I didn’t have a frame of reference until some time later when I was actually with somebody where my whole heart showed up, did I know that my whole body came with me. So I think that’s vital. And I think for many of us until we’re in a real, you know velveteen rabbit kind of relationship, we don’t even know if we’re showing up sexually.

No other underdeveloped themes were noted by the analytic team related to the participants’ definition of ED recovery.

Classificatory Scheme 2: Recovered Clinicians’ Use of Personal Recovery in the Treatment of Eating Disorders

Findings related to recovered ED clinicians’ use of their personal recovery in the treatment of EDs include four overarching, interrelated categories (belief in recovery, authenticity, personal healing, and living it and saying it), which contain sub-concepts that elucidate the categories and the relationships between them. In short, the participants’ unwavering belief in ED recovery, which is derived from and continually influenced by their own healing experiences, serves as the foundation for both their implicit (i.e., “living it”) and explicit (i.e., “saying it”) uses of personal recovery in the treatment of clients with EDs. Further, authenticity, which tends to be both a goal and a
result of ED recovery, is an underlying and pervasive motivator for the participants’ use of personal recovery (see Figure 4.2). A fifth category including underdeveloped findings is also included.

For clarity, the overarching categories are denoted with Roman numerals; the properties are denoted with the same Roman numerals as the categories that they describe in addition to capital letters; and the dimensions are denoted with corresponding Roman numerals and capital letters in addition to Arabic numerals (see Table 4.2). With the exception of the underdeveloped concepts, all categories, properties, and dimensions were endorsed by a majority of the participants (6 or more). It should also be noted that because many of the concepts are interrelated, several of the citations are relevant to multiple categories and subcategories. Therefore, concepts that could not be fully separated from one another are described jointly (e.g., symbolize hope and motivating are described together as symbolize hope/motivating).

I. Belief in Recovery

All participants communicated an unwavering belief that recovery from EDs is possible, which stemmed directly from their personal experiences. Nicole, for example, described that:

The reason I became a therapist was because my recovery process was so kind of miraculous that I felt if I can do this knowing how intense my eating disorder was, and get better and not have to spend my life in treatment or at some low level of recovery, then I want to help other people because it’s possible…. I don’t say ‘I’m still in recovery or I’m still recovering or I’m in recovery.’ I say, ‘I am recovered from anorexia.’
Similarly, Phoebe stated:

I mean I don’t know if [clients] will recover, but I believe they can.

Further, participants described using their belief in recovery to empower and motivate their clients, and to serve as living, indisputable examples that recovery is possible:

I use it in a way to say, ‘you absolutely can be recovered. I was really bad. I was really messed up. I restricted my food to the point where I lost a ton of weight. I was freaked out about eating any grams of fat…I counted calories obsessively. I couldn’t watch a movie.’ And then I’ll say, ‘All that’s completely gone’ and then I’ll be a role model. (Carolyn)

I think I definitely can challenge [clients] using my own recovery because I’ve been there and done it and I know how hard it is. I know how scary it is. And I know how much strength it takes, but it is possible. (Ella)

If [clients] were asking ‘Can you get better? Do you believe you can get better?’ I’d say, ‘Well I do. I feel I have and I know other people have and I know you can too.’ (Frankie)

Families will say, ‘well we heard that recovery is not possible, that she’ll always have an eating disorder’ and I’ll say, ‘that’s not my experience. In fact, I had one and I consider myself fully recovered.’ (Bianca)

Thus, the participants’ personal healing experiences directly informed their unremitting belief that ED recovery is possible, which inspired hope in their clients while also helping
them to preserve their own hope as therapists throughout often long and arduous ED
treatment processes. For this reason belief in recovery is located at the center of the Use
of Recovery diagram (see Figure 4.2) and forms the foundation upon which all other
uses, functions, and techniques evolve.

II. Authenticity

In addition to an underlying belief that recovery is possible, the participants also
unanimously communicated that they tend to be most effective as therapists when they
use and embrace all parts of themselves, including their recovered status. Regardless of
whether they used their recovered status implicitly or explicitly, they always used it
authentically. For example, Phoebe stated:

I’m going to use whatever I have, whatever works….I’m just being myself and I
don’t have this therapist side of me that says all these certain things and then this
real side of me that says different things. I’m the same all the time.

Similarly, Cleo emphasized the need to be congruent and embodied (i.e., when one’s
“head, heart, and belly” are aligned and in sync) when working with ED clients:

If you’re a therapist who sits there completely disembodied and you’re operating
from the head up, I don’t care if you’re recovered or not, you are not going to
work well with these patients…If you can’t be down in the belly of your heart and
love and heal and help from that place, I don’t think we can help people get well.
If we aren’t whole then we can’t take them any further than where we’ve gotten.
Otherwise eating disorder patients will figure that out and they’ll either leave, or
they will stay because they know you won’t help them. And that is a really
dangerous spot.
Further, because authenticity is often both a goal and a result of ED recovery, the participants described the importance of modeling authenticity for their clients. For example, they stated:

I realize people respond best to the truth because they know when you are lying on some level and lying by omission…It’s not the need to know that I’ve had the same disorder, but that I have had issues with food and I have had those feelings and that shame-- that shame that I think all people with eating issues have about their body and their inability to handle food. So I find I use [personal recovery] a lot and I find that I don’t go into details but…I’m not a blank slate. (Rose)

As an eating disorder therapist you have to be willing to have a very authentic relationship with the person because that’s what’s missing in their life and you have to show them what that feels like, and how to do it. (Phoebe)

The participants also provided numerous examples demonstrating their authenticity throughout the therapeutic process. For example, Cleo stated:

I can tell one of my fat clients who has to recover back into a fat body, ‘I have no idea what it means to have to recover into a fat body. I give you that. I know what it’s like to recover back into a world that’s still going to judge me whatever my weight is, but I had the blessing of being able to recover as a thinner person in a weight-obsessed culture. So I don’t know that pain. I won’t even pretend to.’

Similarly, in reference to the sadness she feels when clients do not heal from EDs despite her wholehearted belief that recovery is possible, Nicole described that:
I think that I have to acknowledge that [sadness] in the room with clients sometimes. I have to say to them, you know, ‘I know you might not get better and that makes me sad….it’s your life.’ If I don’t acknowledge that I feel sad about that, they’re going to feel something from me and I’m not being authentic and so I have to put that out there and say, ‘This is what I feel. And yet I know I will support you in making the choices you want to make for your life…but it makes me feel sad.’

Frankie also described being transparent about her recovery with her ED clients:

I would be honest that there would be remnants of it a little bit when I was younger, like in my 30’s…At that time, if I gained weight I wasn’t as matter-of-fact as I am now. When I was under stress I would get into losing weight and maybe enjoy that a little too much…I would maybe say, ‘I think I probably have some tendencies still. But it doesn’t ruin my life. I don’t think about it. I can eat what I want.’ I would say something like that, not in a lot of depth, but just to give them hope. (Frankie)

Therefore, authenticity motivated and provided the foundation for the participants’ implicit and explicit uses of their personal recovery. More specifically, they described modeling authenticity in the ways that they presented themselves and related to their clients on an ongoing basis in addition to using intentional, authentic self-disclosure at times regarding their recovered status. For this reason, authenticity surrounds and infuses the entire Use of Recovery diagram (see Figure 4.2).

III. Personal Healing & Therapy Experiences

III.A. Positive & Negative Personal Therapy Experiences
When describing their own journeys to recovery, the participants often noted formative personal experiences in therapy, both positive and negative, that have informed their own work as ED therapists. For example, many participants described learning through their personal therapy experiences that it is essential to address behaviors directly with ED clients, and to avoid remaining distant and neutral in the therapeutic relationship. Cleo stated that:

The first treatment I sought was a disaster… So I walk into the analyst’s office my first year of graduate school. I walk in and I say to this man, ‘I believe I’ve been anorexic for the past four years, I need help, and this is the area that I want to go into.’ He folded his hands and he said nothing. And for I don’t know how many months, I watched that man fold his hands and say nothing. He basically was a hard core analyst-- I got no feedback. And I had the rare opportunity of speaking once where he was in the audience and I said, ‘Never sit silent in the face of an anorexic.’

Similarly, Rose described that:

For a while I had a real analytic therapist and I got out of it because I knew even though there’s a real value in that, insight is not going to get you far….It’s really important to not wait for the insight before doing behavioral things and challenging the thinking.

Further, Phoebe highlighted that a primary reason she was able to trust and connect with her ED therapist was because she was not distant and did not enforce rigid boundaries:

The first thing that was very helpful to me is that my therapist was recovered from an eating disorder…. The other thing I have to say that was helpful, and this is
very, very touchy too, is that the boundaries that my therapist had were not the typical boundaries. I was unreachable in that way…Like she did things with me. Like she we went on hikes and we picked flowers and we made beautiful things…And she ate with me. And I eat with my clients too. They need it….If you just sit there and talk about your feelings nothing will ever change…. You have to have a behavioral component with food and recovery or it’s not going to work. I mean you can sit there for years and discuss like their mother and their father, you know, and there will be all this insight but nothing will change.

Similarly, when describing her therapist and why she was helpful, Ella expressed that:

We built rapport really fast. I immediately felt like this was the only place I could let my eating disorder talk and get feedback and get challenged…She was so great in working with me on accepting my body and how she came to accept her body….She just kind of normalized my thoughts and she would help me not feel so guilty and critical.

Participants also described both positive and negative examples of their therapists’ uses of self-disclosure, which inform their own use of self-disclosure as therapists. Frankie, for example, described that:

I think that my first therapist… she, I don’t know, was cold and non-disclosing and I didn’t feel comfortable. And she didn’t feel comfortable with me. One appointment she said ‘I think I know somebody who could help you.’ ….And she recommended this person who also…had recovered from irritable bowel syndrome. She was open with me. And her self-disclosure and willingness to help me make the connection between my boyfriend dying and not knowing how
to handle my feelings-- restricting and trying to control and not knowing how to
manage sadness. All of a sudden that was the first time I learned about mind-body
connection-- through this therapist who was willing to say something about her
journey and recovering from that for her….I think that even shaped my views on
recovering clinicians and how helpful it can be.

Frankie also discussed how her therapist used self-disclosure therapeutically, which
relates to her personal use of self-disclosure with her own clients:

She was willing to answer questions. She didn’t overly talk about it, but first just
the mere fact that she had this and she got over it. It gave me hope…. She could
say, ‘I know. I really relate. And I did overcome it.’…. I couldn’t believe (a) that
I found anyone who had these symptoms, and (b) someone who overcame it, and
(c) she had some idea about her own journey and a path, which could help me
with mine. And that was the best thing with building trust. I mean I really trusted
her because of that… She didn’t talk about it a lot but she would answer questions
if I ever asked. She answered briefly and appropriately and was my first model of
really great use of self-disclosure.

Thus, participants’ recovery processes, including both positive and negative
personal experiences in therapy, directly impact their professional understanding of ED
treatment and of therapist self-disclosure. More specifically, based on personal therapy
experiences, the participants communicated that distance, rigid boundaries, and neutrality
can hinder both relationship-building and the effective treatment of EDs. On the contrary,
the clinicians in this study tend to favor transparency, use of self, and a more directive
therapeutic style to foster trust, reduce shame, and address ED behaviors directly.
Therefore, because the participants’ personal therapy and recovery experiences directly inform the work they do as ED clinicians, personal healing surrounds and infuses the entire Use of Recovery diagram along with authenticity (see Figure 4.2).

**IV. Living It & Saying It**

The participants used their personal recovery both implicitly (e.g., by using their insider knowledge to conceptualize EDs and to inform interventions) and explicitly (e.g., by disclosing their status as recovered ED clinicians and/or emphasizing that they “really get it” in order to build trust) depending on the context, the client’s needs, and their intent. For this reason, saying it comprises the permeable boundary of the inner triangle on the Use of Recovery diagram, which flows into and out of the infusive living it triangle (see Figure 4.2). Thus, “living it” and “saying it” are not intended to be dichotomized or hierarchical in nature; rather, they are closely related and mutually interactive. All participants “live” recovery; when and if they explicitly disclose and/or discuss their personal recovery, however, varies depending on context. Cleo, for example, described her philosophy regarding use of personal recovery:

> I have supervised people who are recovered and I said to them, ‘Whether you ever name it is actually not important to me. That you be it is vital…So if you are recovered in your ways of being a therapist, to me it doesn’t really matter whether you ever name it….I think to the degree that we are recovered, and inherent to that embodied-- embodied in our ways of being a therapist-- you never need to tell anybody. Because you are the recovery in action. You are by how you’re being, acting, feeling, holding yourself.

Similarly, Frankie stated that:
I mean I think I would say that I maybe only explicitly said it like 25% of the time. I think because everybody didn’t ask. I think some people just sensed the connection and that was enough.

When asked explicitly by her clients, however, Frankie tended to respond candidly to them after exploring the implications of her response. She described that they often “sensed” something, likely because they perceived that she was recovered:

I found that clients ask sometimes because they can sense something, like a connection. They would be like, ‘Have you ever been through this or something similar? Or did you ever have an eating disorder?’ Like they either would come right out and ask or they would hint around….I probably very rarely offered it if something weren’t asked of me along those lines. Because when would you say it? Just out of the blue?...If someone asked me I’d explore what would it mean for us, you know? I would say something like, ‘I can definitely answer that. I just want to explore with you a moment what would it be like if I were to answer it this way? Or if I can answer it that way? What would it mean for you if I were or if I weren’t?’ And so I did do a little exploring rather than just yes or no.

Several other participants also shared that their clients “sensed” that they might be recovered from an ED and/or purposefully sought services from them because they already knew the clinician’s status:

My first few sessions are really about just gathering information from them and I think where it comes out more is out in the milieu, over meals, on an outing, or in a group. I might mention that I’m recovered, but I don’t formally disclose the specifics…. I don’t have to say it every time-- they just know. (Ella)
They might already know so I kind of say, ‘I don’t know if you know already, but I have recovered from an eating disorder myself.’ Sometimes that’s pretty helpful for people… I’ve never ever had any client respond negatively to knowing that I had an eating disorder, ever… (Phoebe)

I’ve had very few patients frankly who didn’t [ask]. To be honest, very few haven’t. And it’s clinically meaningful to me if they don’t. And they may not ask for a long time, but they generally do…And I can only guess it’s because they know….My experience is, it’s a much more ‘out there’ phenomenon and I think people are educated to know that recovered people work in this field so they are kind of inclined to ask. (Cleo)

You know, [teenagers] come in to see me and … they’ll say, ‘I have an eating disorder. I understand you work with eating disorders.’ And I’ll usually say in the beginning, ‘Yea, you know, I had an eating disorder when I was younger.’ I say it almost because I’ve written about it. It’s kind of public knowledge. It’s like I’m just putting it out there that I understand to some extent. (Bianca)

I think that now I do often end up disclosing it, but I kind of wait for the timing and I often wait to see how forthcoming the person is going to be about their own behaviors. And if I find them really hesitant I might start, you know, but often they will ask me and I will tell them the truth. (Rose)
Therefore, participants noted that they tended to disclose their status candidly without going into details, either at the onset of counseling or when clients asked directly based on their own “sense” about the clinician. Further, because several participants are known locally or nationally for their status as recovered clinicians, their clients often have this knowledge prior to initiating therapy. In sum, this study suggests that the participants’ ED clients tend to know their status as recovered ED clinicians regardless of whether it is discussed explicitly. Following is a description of the specific uses and functions of the participants’ personal recovery.

\textit{IV.A. Serve as an Attainable Model of Recovery}

\textit{IV.A.1. Symbolize Hope/Motivating}

All participants described that their recovered status allowed them to serve as living, accessible, and indisputable examples that recovery is possible, which instilled hope in and motivated their clients, especially given the statistic that full recovery from EDs is rare. In this way, the participants used themselves as therapeutic tools and their recovery as a symbol of hope. For example, Phoebe described that:

It’s like this thing standing right in front of you that is recovered. So you can’t stay too long in the like, ‘nobody recovers because it is so difficult to recover.’ It is very easy to lose hope. That’s the reason why I didn’t get help for long because I really thought it was impossible, and I didn’t know anyone who had had an eating disorder.

Similarly, Rose described that:

I feel like I have gone through a lot of depression and negative things in my life and yet, here I have a child, I have a husband, I have a life that I really do enjoy.
It’s not perfect, but I like to hold out that it’s really possible to go from the depressed, hopeless person you are right there to having a life that’s meaningful to you.

Cleo also underscored her belief that:

Being in the presence of somebody who is further along in recovery is quite simply an experience of hope.

Further, Nicole described that:

I think that for whatever reason I can be a role model and people can say like, ‘Wow I really like her, not because she had an eating disorder, not because her body looks a certain way, but because she is whoever she is and she is recovered from this and if she can do that then I can do it too.’

Other participants also described their use of personal recovery as a testament that recovery is possible, especially during times of difficulty and hopelessness for ED clients:

This is a big challenge right now and it is really hard, but they know that I got through it and I think it helps them to think it’s possible. (Phoebe)

So I use it in a way to instill hope….I’ll eat French fries in front of them or ice cream and I’ll say, ‘I used to not be able to do this. If I can do that, you can do it too.’ (Carolyn)

Cleo also provided a powerful example of using insight and experience from her personal recovery to inspire hope in a despairing client:
I said, ‘I hope you would never settle for anything less than being able to go home to relax in the arms of somebody who loves you.’ She came back and burst into tears and said that is the most powerful thing you have said yet about being recovered. She wants to know that she is loveable. That is her existential crisis. So that’s what my recovery gave her. It wasn’t that I have a body that I like or whatever; it’s that I am risking being loved, which ironically was what my own recovery was about. (Cleo)

Further, Carolyn disclosed that clients often choose her ED treatment facilities because:

Knowing that there are recovered people gives them hope and encouragement.

In these ways, the participants’ status as recovered ED clinicians, quite simply, represented irrefutable possibility, which is perhaps the most powerful source of hope in existence.

**IV.A.2. Normalize ED Experiences, Reduce Shame, & Humanize Therapist**

In addition to instilling hope, all participants also discussed that their personal recovery functioned to normalize their clients’ experiences, reduce their shame, and/or humanize the therapists. For example, Phoebe described her sensitivity to shame and her ability to help reduce her clients’ shame based on her own ED experiences:

I think I’m more compassionate because I am so much more sensitive to the shame because I’ve had it… So I ask questions and I think I have a way of doing it so it’s a little less shame-based….If [clients] know, I think it’s easier for them to admit things…you know, they think that people aren’t going to understand and it sounds crazy and twisted… But it doesn’t sound crazy and twisted to me, you
know, I get it. So I think that that makes them feel less ashamed. And it just sort of speeds along the process.

Other participants also discussed their ability to relate to and reduce ED shame through their personal ED experience:

I mean I can definitely relate to the lying and the tricks and all that, and the secrecy and the shame. (Bianca)

I will use [personal recovery] with humor, like, ‘Yea, I remember going over to a relative’s house and, you know, all the bowls of candy were out and they were gone by the time I left.’ Like try to normalize it a little bit and sometimes it’s in the effort to, I feel like they are holding back on something and I want them to be more open… kind of like, ‘well I did that.’ (Rose)

Furthermore, several participants also discussed using their personal recovery in order to humanize themselves and to crystallize the attainable nature of recovery:

I think that if therapists are viewed as being idolized or seeming like perfect or something like that, especially in this population, especially being in a residential treatment center where I’m with them in their home-like environment because I’m eating meals with them…we have a different relationship and so I want to be someone who can be a role model in an attainable sense rather than like, ‘Oh, you know, good luck but you’ll never have this life.’ (Nicole)

…Sometimes people come in and they want to understand…They come in and they look at you and they go, ‘You haven’t had any problems. How can you
possibly relate to me? What’s your secret? What have you done? I want to do what you do.’….So I just have found that it’s important to say enough to let them know that I’m human and that where I am today may not be where I was ten years ago or twenty years ago and that…we are continually evolving and moving and growing, and that I have had my share of struggles. (Augusta)

In sum, personal recovery was used by the participants in order to show or convey that recovery is possible and attainable, and to normalize clients’ ED experiences while reducing their deep-seeded shame.

**IV.B. Facilitate Relationship-building**

**IV.B.1. Relate To/Validate ED Experiences & Build Trust**

All participants used their personal recovery, either implicitly or explicitly, as a “bonding tool” (Rose) in order to relate to and build trust with their (often untrusting) ED clients. Further, they conveyed ongoing understanding and compassion by empathizing with clients’ food and weight fears. Nicole, for example, shared that:

I’ll say, ‘I understand how scary that is to eat this…and let me tell you what I did,’ or just choosing a way to say, ‘I get it because I’ve been there. Look, it’s possible.’ So to not have to live in that place of fear, that place of uncertainty. Other participants also shared their use of personal recovery to compassionately relate to and relationship-build with clients:

The most effective method for me is to, you know, when a person is explaining something they are going through, just to say, ‘I understand. I understand this is part of the process. I understand.’ And I might say, ‘When we deal with things
like this’-- I might use an inclusive pronoun in order to let them know that I’m there with them without getting into specifics. (Augusta)

I realized because I had been through it, I knew what they were going through. And I just somehow really knew how to connect with them. I felt a connection, I felt compassion…. I just remember feeling in my heart such compassion as they were talking, and really understanding. I was really present with them in a way because it felt so familiar. (Frankie)

Further, based on her personal experiences as a client in therapy and as an ED clinician, Phoebe shared her perspective that:

People who have had an eating disorder can be excellent, excellent therapists. But it’s harder for the patient to trust, to have hope and to really feel like it’s really going to work. And when the therapist has recovered you sort of feel like the therapist fully understands, but at the same time provides this symbol of like, it’s possible.

Ella also described her ability to relate to and validate her clients’ ED experiences based on her own ED experiences:

I would say I use my recovery in 90% of my individual therapy and in groups in some way. Whether it’s just about the temperament of extreme perfectionism and anxiety and being highly self-critical or it’s about recovery and body acceptance and weight gain and freedom with food…. I think I can validate their experience in a way that maybe somebody who has never been there cannot.
Therefore, in addition to serving as attainable models of recovery, all participants also
described using their ED recovery to relate to, establish trust with, and convey ongoing
compassion and validation to their clients.

IV.B.2. Expanded Relationship Boundaries

Another relationship-building tactic discussed by many participants includes the
use of expanded relationship boundaries. More specifically, based on their personal
therapy experiences (see category III. Personal Healing) and their understanding of EDs,
the participants described being relational, directive in order to address ED behaviors,
and willing to self-disclose when and if appropriate in order to build trust. For example,
Phoebe articulated that:

I guess I would say that I am very transparent...no blank slate. I am in the
relationship, not just a transference tool. I also go to restaurants, go on walks, and
my style tends to be more directive than is typical. I think that having a more
authentic therapeutic relationship provides the trust needed so that my clients can
tolerate a more directive style that is often needed when treating eating disorders.
There is so much fear, resistance and mistrust-- something has to push hard to
penetrate through that and 'get in', convincing them to try, to risk, to do
something different. I often do that ‘new thing’ with them, depending on what
that is, of course. I would never violate the legal/ethical boundaries. I consider
what I do an expansion on the traditional boundaries that I personally find
limiting and not useful in this work.

Similarly, Rose described that:
I am interactive with my clients and a lot of times they seem to value that…and there again comes with some of the self-disclosure. I try to be careful with it, but, you know, I try to *use* it. A client with overt symptoms of any kind, I really think they need you to step in and not tell them what to do, but I always think of it as like I’m walking with them, I’m holding a flashlight, and I’m going to tell them what’s in front of them. (Rose)

Ella also described her use of self-disclosure and expanded boundaries with ED clients:

I think in terms of working with eating disorders my effectiveness is higher when there is more self-disclosure and I don’t have as fixed boundaries….I was trained to have really, really strict boundaries. If I were doing therapy with people that didn’t have eating disorders or I didn’t work in residential care, I think I would be more that way, and I think there’s a place where that’s really effective. But in terms of eating disorders, I think it's more effective to self-disclose my recovery.

Further, Carolyn described a specific example demonstrating her use of expanded boundaries when working with an ED client:

So I remember first having her bring dinner to the session, and then going out to dinner for a session…. And I think because I had been recovered I knew that it’s like talking about any phobia. If someone came to me and they had a phobia of snakes and I had recovered from a phobia of snakes and I knew that they needed to have an experience looking at snakes, getting used to them or whatever, why wouldn’t I do it? So I think that in some ways, [ED] therapists have thought about different things in terms of boundaries.
Therefore, several participants discussed the use of expanded, yet clinically and ethically appropriate, boundaries as an essential relationship-building technique. More specifically, they used purposeful self-disclosure about their own recovery in order to build trust while addressing behaviors directly within the context of a trusting relationship in order for treatment to be effective.

**IV.C. Native Language/Insider Information**

All participants emphasized a belief that personal ED experience is *not necessary* to be an effective ED therapist, but that it provides unique benefits. More specifically, based on their personal ED experiences, the participants described having an intuitive “ED sense” and an “in” to the ED world. For example, Cleo described that:

> It’s my native language. It can become another therapist’s fluent language.

Phoebe also stated that:

> It’s an easier road if you’ve had an eating disorder to treat other people with eating disorders.

Similarly, Frankie stated that “It’s way more automatic.” For example, when describing her previous experiences working with and feeling close to ED clients, she described an ability to know what and how to say things to advance clients’ recoveries:

> With my heart I felt for people. I felt sad for them. I felt hopeful for them…My emotions were with them for whatever they were going through. I think I knew how to say something that would bring them to the next place because I was right there with them. So I would know the thing to say or the question to ask to move them along a little bit.

Nicole also described using her ED “sense” as a therapist:
Just my knowing, definitely my intimate knowing of what those thoughts are so that I can more adequately come up with ways to counter eating disorder thoughts or I can really see, I can validate it sometimes for them when they feel like they are crazy because they think certain things or feel certain things. I can validate that I felt that too and I don’t any more.

IV.C.1. Increased Credibility

Many participants described using their recovered ED status to increase their credibility with ED clients. Nicole for example, described that:

I definitely think that it does make me more credible because I’m not someone who is just saying things and also because…I eat with them. So they see me eating ice cream, they see me eating chips, they see me eating things that are…fearful for them. They watch me eat it and can see that I’m ok with that and I do it, and so that definitely helps lessen the fear for them.

Similarly, Bianca described that her recovered status can help to increase clients’ confidence in the treatment suggestions that she makes:

I think it’s how I might use the insider information to help them. You know, to say, ‘Hey there’s this one particular thing I’m thinking might help you. What do you think of it?’ That gives them confidence.

Likewise, Rose explained that she may “mind-read” or name her clients’ ED behaviors before they disclose them in an effort to increase her credibility. For example, she described asking an adolescent client:

‘Do you just sit there in class and like count up all your calories during your math class?’ …I know those sort of things that help…It gives you a certain credibility
with a lot of clients and a certain sense of relief that they know you know what it is like [for example] to get up in the middle of the night and binge…I really get it.

Frankie also noted that:

I think being just maybe, a number of steps ahead, was sort of like a great place to be for helping people with eating disorders.

In sum, participants described using their insider ED knowledge to increase their credibility with ED clients who are often untrusting and afraid.

**IV.C.2. Leverage to Confront & Hold Clients Accountable**

All participants also explained that their insider ED knowledge gave them leverage to confront ED behaviors, hold their clients accountable, and/or view clients as capable of making positive choices and achieving recovery rather than viewing them as “victims” of their EDs. For example, Ella described that:

…Eating disorder behaviors are a choice that [clients] are making. And I feel like I can say that with my whole knowing because I’ve been there. And I know that it feels like it isn’t a choice sometimes, but it is….And so I think it can be challenging sometimes when there’s a lot of victimization or there is stuff that isn’t really owned and there isn’t a lot of accountability. I think as a recovered therapist that can be frustrating because I’ve been there.

Similarly, Nicole described that:

Our philosophy is that…eating disorders have a choice component, so once you’ve brought into consciousness and are aware of the eating disorder we want to help people see where their choices are in what behaviors they engage in or
don’t engage in. Like some force greater than you didn’t come down and put your running shoes on you and make you go running. You made that decision.

Further, several participants provided examples demonstrating how their insider ED knowledge provided them leverage to confront clients’ ED behaviors and voices. For example, participants described that:

I can make people a little more accountable because they know they kind of can’t fake it. They can’t trick me very easily, you know?...I can think of things, like through the eating disorder lens and so, like I’ll say…‘Ok you’re not supposed to be doing that, right?’ Let’s say they’re going to have like a veggie burger or something. Then I’ll say, ‘Ok this isn’t really going to be an effective challenge for you if you just don’t eat breakfast or you don’t you eat dinner because you’re compensating during this meal. You might as well not even do it if that’s your plan.’ They’ll look at me like, how’d you know that was my plan? (Phoebe)

[An ED client] had a 15 pound weight fluctuation. And I had asked her to increase her intake to two eggs a day. And so she said, ‘I quit eating the eggs because I gained 16 pounds in three days.’ I said, ‘Man those must have been highly caloric eggs.’ And I said, ‘Do you really think you can sit across from me and get away with…we both know you have 20% kidney function. We should be very worried about a 16 pound weight gain, not about the eggs.’ And I’m definitely using my leverage there…I said it just like that, with a definite sense of humor and with a ‘come on now. We have a major serious problem that has nothing to do with you eating two eggs a day.’ (Cleo)
When a client is sitting at the table at XX and some client is cutting up their food into bits and later in group they say, ‘Well YY really triggered me because she was cutting up her food.’ I always say, ‘That’s funny, she didn’t trigger me. So what does it say about you? She didn’t make you do anything. I mean what are you making of it? What are you saying to yourself about it? What does that mean to you? What do you want to get away with?’ (Carolyn)

‘Come on,’ I’ll say, ‘You know, don’t make it like it’s all pretty and perfect. We’re talking about throwing up here.’ (Rose)

In sum, the participants described using insider ED knowledge to “mindread,” to confront ED behaviors/patterns directly and with a sense of humor, and to hold clients accountable for the choices they make rather than viewing them as victims to their EDs.

**IV.C.3. ED Radar**

Participants also described having ED radar as a result of their personal experiences, which serves as a powerful therapeutic tool. More specifically, the participants’ ED radar helps them to spot ED behavior, be prepared for lies and deceit, and know what to expect throughout the difficult ED treatment process. For example, participants stated that:

There is the third channel and it’s the eating disorder channel. And those of us who have lived the experience, here’s what we could do: We can walk into a room and know just about immediately who’s got an eating disorder. We know the way they talk. We know the way they look at themselves. How they hold
their bodies. I can’t help that. So yea, you know, the same way that people who
are recovering from alcoholism tell me they can spot, what they call an alchy or a
junkie a mile away. Well I can’t. But I can definitely tell you in a room at a party
full of women who has body issues and who doesn’t. And so you can’t fool me as
well as I think other therapists can be fooled. (Cleo)

I do feel like I do know a lot of tricks. You know, I’m pretty savvy about eating
disorders just from having had one. (Bianca)

I think maybe there are some things that I didn’t need to be trained about. Like I
pretty much knew when I saw the first person with anorexia, I knew she was
going to lie. I didn’t get upset when I found out she had been lying in her food
journal-- I pretty much expected it. I knew that she wasn’t going to be all excited
when she gained weight…There were definitely things that I did not have to be
taught that helped me spot things…And it’s like AA says, ‘you can’t bullshit a
bullshitter,’ you know? On the other hand, I think you can get really good training
and learn that stuff. (Carolyn)

If I hadn’t gone through it, my radar wouldn’t be as sensitive as it is to sniffing it
out…. having sort of an implicit understanding of the spectrum of behaviors that
go with a certain diagnosis…well there’s an old AA saying, which is ‘if you spot
it, you got it.’ So I can own my stuff and if I spot it in other people, I can trust
that. (Augusta)
IV.C.4. Sounding Board for ED Voice

Several participants also described using their personal recovery and insider ED knowledge as a sounding board for clients’ ED voices. For example, they described “warning” clients about the dangers of EDs and being willing to confront clients’ ED voices directly. For example, given that many ED clients fear becoming fat as a result of recovery, Phoebe described using herself to confront this fear directly:

You don’t have to be fat to recover….They’ll say, ‘I just don’t believe that someone could just eat normally and be thin.’ And I will say, ‘Well do you believe that I’m lying to you when I tell you that I practice intuitive eating?’

Similarly, Bianca described using herself as a living symbol that you can be recovered without losing control of your body:

It’s like this leap of faith that, ‘Oh you can actually eat a couple of thousand calories a day and, you know, get to your normal weight.’

Moreover, when describing her personal experiences in therapy, Ella described that one of the most helpful aspects involved her therapist’s ability to serve as a sounding board for her ED voice:

She was great because even on a simple level, I would say something like, ‘You know, but I love French fries and I want to have French fries all the time.’ And she would say, ‘Well you could have French fries everyday for the rest of your life if you want and nothing is going to happen to you.’ And I would say, ‘Well do you eat French fries?’ and she would say, ‘Yes, and I eat Taco Bell…’. And so I could question her, like my eating disorder would fight her in a way that was so helpful because she won every time, because she really had the experience.
In a different example, Phoebe described using personal examples of the medical consequences of her ED in an effort to confront her clients’ faulty belief that they are invincible to long-term physical damage:

   I do talk sometimes about medical consequences because I want them to know what it’s like afterwards. Like they think they are not doing any damage, but they are. I tell them the consequences that I have now. And so just kind of to make it more real.

   In sum, all of the participants in this study described having insider ED knowledge as a result of their personal ED experiences, which served as one of their most powerful therapeutic tools in treating EDs. More specifically, they described using their insider ED knowledge in a variety of therapeutic ways, including increasing their credibility with distrusting clients, having specialized radar and leverage to both spot and confront clients’ ED behaviors, holding clients accountable for their choices and their ability to recover, and serving as a sounding board for clients’ ED voices in order to confront food and weight fears.

   **IV.D. Purposeful Use of Self-Disclosure**

   **IV.D.1. Less is More**

   All clients noted the importance of using self-disclosure cautiously and purposefully. More specifically, they discussed the importance of conveying that they “get it” and that recovery is possible without “binging on the details” (Cleo) or going “beyond the basics” (Frankie). For example, participants shared that:

   I don’t really talk about my own experience. I mean if I do, I only talk about the recovery part of it…to give them hope…. I never tell them how sick I was. I
never show them pictures, I never tell them anything about weight, I never engage in that kind of conversation. They don’t know any specifics about my eating disorder. (Phoebe)

I’m never graphic about my eating disorder….it’s more general, like ‘I get it.’… You know, I don’t think I’ve ever given any details. I might give a detail about a positive behavior like, something I found helpful…like I’ll tell people, ‘I find it completely helpful when I go to a restaurant, I do look at the menu and I say what do I want? And I order it.’….But I just try to talk to people about what helped me without talking about myself too much. I try to do it when it’s applicable. (Bianca)

I’ve just learned that sharing [details] hasn’t been as beneficial as one would think. Because I mean being empathic and saying, ‘I’m recovered’ is one thing, and I think for many people it gives them a sense of ‘Oh you get it, you know what it’s like.’ And what I’ve had to learn over the years is to then put a lid on it. (Augusta)

I think I found a way of not going into detail and explaining that the details can move us away. What was important was, ‘Yes, I do understand what you’re saying and I have gone through something like this.’ (Frankie)
What I do not do is, I don’t tell [clients], and I don’t let my therapists say how much weight they lost or specifics. Like how they purged or how many times…I don’t let the therapists give any tips away about being a better eating disorder person. (Carolyn)

Therefore, participants emphasized that “less is more” in the context of self-disclosure, and that their use of personal disclosure tends to be motivated largely by efforts to build trust and to communicate understanding and compassion. Further, their self-disclosure focuses on personal recovery rather than on the details of their EDs.

**IV.D.2. Avoid Inducing ED Competitiveness with Voyeuristic Details**

In addition to the theme *less is more*, several participants also discussed the importance of avoiding “voyeuristic” details (Ella), which can induce ED competitiveness. For example, Ella described that:

I’m definitely out with my recovery. I never talk specifics about my eating disorder or numbers or behavior so much because, what I tell the clients is, my feeling is that when they’re asking questions like that that are really specific, it feels more voyeuristic than helpful for their recovery.

Similarly, Cleo noted that:

I think it’s a mistake to share recovery from the comparison place that is experienced as competitive. So if I have a highly competitive patient, I don’t go around my recovery at all.

Likewise, Phoebe stated that:

I would never tell anybody the specifics because…I think it would be harmful if somebody was comparing themselves to me.
Participants also provided specific therapy examples demonstrating the competitive dynamics that ED details can induce. For example, Frankie shared that:

I also prepared myself that if [clients] were going to ask the follow-up questions, ‘Well what did you have and how long?’ I would say something like, ‘I don’t think telling you the details of it will be helpful because I think the details kind of get into dynamics of was mine worse than yours? Was yours worse than mine?…Or areas of difference, and that’s not as helpful as to know that I have had a similar experience. A way I can relate.’

Frankie also shared an example in which self-disclosure regarding personal recovery “backfired” because clients compared themselves to her and felt “less than.” She noted that they were:

Comparing themselves against me-- like I’m so great and they’re not because I recovered or I could recover…. I think just knowing the kind of client you have. I mean I think I would be able to detect that kind of client now to know not to say that with the sort of person who would always say that other people could do something they couldn’t. It wouldn’t be helpful.

In another example, Augusta described therapy experiences involving competitive ED dynamics that left her feeling vulnerable:

It’s just been a handful of clients but it’s almost like the moment they walked in, there’s a competitive thing going on…it doesn’t’ happen that often, but when it does I can feel it. And then I try to negate it and go, ‘No, no, no, come on.’ And then sure enough, we’ll get into treatment a ways and they want to know my story. And once they hear my story it’s as if, ‘Oh ok, now I’ve got the goods on
her’ and they move on….It did happen I think three or four times in kind of painful ways because they would leave and I would think, ‘I did it again. I can’t do that. I can’t make myself that vulnerable.’ ....And it’s weird because it shouldn’t matter. But it did matter in that I felt I’d given too much. And just having boundaries around that.

In sum, the majority of participants in this study discussed the importance of being aware of competitive ED dynamics and making efforts to avoid them. More specifically, they discussed the importance of avoiding voyeuristic details and of consistently being mindful of the when, why, how, and for whom of self-disclosure.

**IV.D.3. Client Benefit**

When discussing self-disclosure and use of personal recovery, all participants emphasized that a primary motive is client benefit. For example, participants described that:

> What we bring up in terms of self-disclosure needs to always be in the service of the patient in their recovery.  (Cleo)

> I didn’t launch it on anybody without a reason, and then I also always asked them, ‘What was that like for you to know that? Are you glad you know it? Are you not glad in any way?’ No one ever said there was a reason they weren’t glad.  (Frankie)

> I mean you have to know what to share and what not to share. And who to share it with and when.  (Carolyn)
I don’t have any hard and fast rules about self-disclosure other than I’m very aware that clients’ time is their time, it’s not about me. (Augusta)

Augusta also provided an example of a response she might give to clients when they ask personal questions to “keep the focus more on them”:

I’m happy to tell you about that, but I’m curious what you are looking for.

Carolyn described the benefit of self-disclosure when used purposefully and appropriately:

I feel like I would feel like I was keeping an inappropriate secret. You know, I’m not going to tell them about my sex life, there’s no reason for that. It’s not going to help them to heal. So it’s not about telling everything. It’s about if you have something that could really give someone hope, or give them an idea about a way to go about doing something different… or the consequences of stopping laxatives or any of those things, and you can share it. Why would you withhold it?

Therefore, all participants discussed their consideration of client benefit when deciding if, what, when, and how much to disclose.

IV.D.4. Avoid Imposing Personal ED Journeys & Alleviating Clients’ Pain

Participants also discussed the importance of avoiding imposing their personal healing journeys onto clients, over-generalizing their own experiences, and/or trying to alleviate clients’ pain. For example, Cleo described the importance of not using personal recovery if:
It’s narcissistically driven, if I’m being lazy, if I want my recovery to try to shortchange theirs. In other words, I think therapists can make the mistake that we can cheat people of learning the hard lessons just like parents do. Like go, ‘Honey I used drugs don’t do that.’

Augusta also emphasized the importance of acknowledging and owning the differences between her path to recovery and her clients’ paths. She described that when clients want her to teach them ‘how to get better,’ she responds:

…Well my path and your path are very different…but I can assure you if you keep on the path you will get better…You know, our bodies are wired to heal. And if you keep looking, if you keep working, you will get better.

Similarly, Bianca stated that:

I also usually say something like, ‘But everyone is very different, you know? I have some shared experiences, but I’m sure your experience is very different than mine.

Frankie also discussed the need to avoid “overgeneralizing your own experience,” and described an important risk of using personal recovery:

It could narrow your understanding…if somebody is too tied into their experience.

In another example, Carolyn discussed the importance of “wise judgment” when using self-disclosure as it pertains to personal recovery:

And in psychotherapy, people say, ‘Well, you know, you have to be careful because you shouldn’t put your own agenda onto the other person.’ And I agree. I don’t tell people how I got better or how much weight I lost or how many
laxatives I took. I don’t tell people that. But it’s the same thing as telling someone anything— you have to be careful when you use it, and use wise judgment.

Cleo also discussed the importance of pain in the ED recovery process and, more specifically, of relating to it as a clinician without trying to alleviate it. She poignantly articulated that:

I can’t take your pain away. I can tell you I shared it. And it was horrible for a long time. But I didn’t get to where I’m at without going through that, and you’re not either…. Pain’s function is to get your attention and to consider the need for change. If I take your pain away, I release you from any obligation to take care of yourself differently. I trust and respect you enough that you will find a way for your pain to inform your life. It’s not my job to take it away, it’s my job to help you negotiate it differently.

In sum, all participants highlighted the importance of using self-disclosure purposefully, thoughtfully, and for clients’ benefit. They emphasized their efforts to avoid inducing ED competitiveness, sharing voyeuristic ED details, and imposing one’s personal healing experiences onto clients. Finally, some participants also discussed the importance of pain in the ED healing process, and described their efforts to relate to clients’ pain without trying to spare them of it.

V. Underdeveloped Categories

V.A. Too Recovered?: Optimal Range for Working with EDs

Interestingly, three participants discussed a change in their motivation to work with EDs as they progressed deep into their personal recoveries. More specifically, they have found that the more removed they feel from their EDs, the more effort it takes to re-
enter the ED world. In other words, EDs can become more like a foreign language than a native language as they become a faded and distant experience of the past. For example, Frankie described that:

In my 30’s I definitely wasn’t where I am now in this, you know? And I was definitely recovered enough. In fact I think being closer to it… I think I was probably a better therapist for eating disorder clients at that stage. Because I still remembered what it felt like. I could remember the suffering. I could still relate to it a little bit, I had some hatred of my body sometimes. You know, I still had enough to make that connection. So it’s interesting, I find it harder to work with eating disorders at this stage because I’m too far away from it almost.

Frankie proceeded to describe the impact that distance and being “too far away from it” has on her current experiences treating EDs:

I have a little bit more impatience with it. I can judge it, I can say that’s superficial…Here’s someone who’s like beautiful sitting in front of me saying that she doesn’t look beautiful because she gained five pounds. I think that when I was closer to it I don’t remember ever feeling those judgments. I felt like I really understood the pain of it. Now I sometimes feel outside of it and I feel like it sounds monotonous. It sounds shallow. And I catch myself noticing that and I’m sure it shows a little in my presence. I try to bring myself into it again but it is an effort. It’s like the effort I guess of a therapist who never had one, or somewhere in the middle.

Similarly, Augusta noted that moving away from treating EDs symbolizes her progress in recovery. More specifically, she described that:
For me, that’s been the right course because if I had stayed just working with eating disorders that would have told me that I was stuck. …Other people have made a career of it and that’s fine. You know, that’s worked for them. For me, it’s like, you know what? I’ve had enough of this.

Bianca shared a similar sentiment:

And frankly right now, to be honest with you, I would prefer not to work with eating disorders…I’m known for eating disorders in my little community here, so I get a lot of referrals through that. But I love working with people who don’t have them because I find the actual management of behavior not terribly interesting at this point….. And sort of, you know, you just hear the eating disorder going, ‘You’re fat, you’re disgusting.’ It just all sounds the same after awhile. It becomes not as interesting.

Therefore, it is possible that there is an ideal window for using personal recovery in the treatment of EDs. More specifically, as some of the participants in this study achieved more distance from their personal ED experiences, treating EDs became less appealing and/or required more effort.

V.B. Greater Personal Healing

Several participants noted that they became stronger in, and more committed to, their recovery as a byproduct of their professional experiences treating EDs. For example, participants described that:

My recovery I think is positively affected by working with eating disorders. It is something I’m proud of and it’s part of my job. (Ella)
Doing this work makes me much stronger in my recovery…I choose to not deal with my issues through food and exercise and body, so I want no part of it.

(Nicole)

I’ve worked with really obese people and ironically there was a time during my recovery when I used to think, if I let myself go, I’d be 400 pounds. I always felt like I had this hunger and that I was always keeping a lid on it and that, you know, without too much provocation I could lose control and go way up. I think that was healing for me to work with obese women and realize that’s not going to happen to me….At least the women that I worked with, there was severe abuse or there was endocrine problems-- there were really good, compelling reasons why they were the size they were, and it wasn’t that they were out-of-control eating. And that was a good thing for me to learn because it helped open my world and…that little bit of fear that I had. It was like ‘Oh ok I can let go of that one.’ (Augusta)

Talking about it is always healing. (Frankie)

Therefore, several participants shared that they gained greater personal healing by treating EDs and/or using their personal recovery in the treatment process.

V.C. Fear of Judgment from Other Professionals

Another interesting finding relates to participants’ discomfort surrounding professionals’ judgment. More specifically, they disclosed experiences and fears about professionals’ judgment of their status as recovered clinicians and of their use of personal recovery in the treatment of EDs:
At XX the culture was not one of disclosure and that’s because it’s not a twelve step model…When we were there, there was an unspoken, or maybe it was spoken but not printed, belief that to talk about it would, you know, hurt you.

(Augusta)

I got the job and I started to hear rumors that some of the people hiring wouldn’t hire people if they knew you had had eating disorders. I heard things that you’re not supposed to say it. I became paranoid in a way that I hadn’t been…. I was like ‘Oh no, this is secret. Now I can’t tell anybody.’ I became more worried about it. (Frankie)

I was taken aside at major conferences and somebody said to me once, XX do you want to be known as a good therapist or do you want to be known as a former anorexic?...And I got freaked out and I cried, but really I said to myself, and it didn’t take long, why can’t I be both? (Carolyn)

I think that when I was in school I didn’t talk about it very much because I think I sensed that there I would somehow be judged. I think I worried I was going to be judged as someone who is screwed up or psychologically not as stable as someone who has never had these sort of issues. So it’s never been outward, like nobody’s ever directly said that or been that way, but I think the fear was still there. (Ella)
I didn’t have anybody until later in my career say, ‘Do not talk about this professionally-- you will be marginalized. The men in the field will never accept you. Don’t talk. Don’t tell.’ (Cleo)

But when I go like maybe to a conference or something like that, that’s usually when I will not say anything…. a lot of people don’t believe in the self-disclosure thing. And so I think that I’m aware of that and so I get a little bit more self-conscious about it when I’m in those big conferences where I don’t know the people personally. (Phoebe)

A few participants also hypothesized about why clinicians’ ED recovery may be stigmatized by non-recovered professionals. Frankie, for example, described that:

I think eating disorders are seen as pathological…the result of this belief is that you can never really recover. I would hear other clinicians say, the ones that maybe didn’t have eating disorders…they would be surmising that some therapists had an eating disorder and they shouldn’t work there. ‘They should never hire somebody who had an eating disorder because you never know if they really recovered. They could relapse.’ Or, you know, sort of treat it as this chronic, permanent condition, that you can never be healthy enough to treat other people.

Similarly, Bianca shared that:

I guess because no one really understands recovery from an eating disorder that well. Because, you know, you can’t be abstinent. I think maybe that’s part of it. Its like how do you prove you’re over it? But, you know, as therapists we don’t
have to prove we’re mentally healthy. Like how many therapists do you know that seem like they are completely mentally healthy?.... You know, just like the idea that someone is supposed to be free of problems coming into the field is just so strange.

Therefore, participants shared that although they never felt stigmatized by clients regarding their recovered ED status, they often felt judged by or fearful around other mental health professionals. More specifically, some participants had experiences suggesting that it is risky to disclose their recovered ED status to non-recovered professionals, potentially due to uncertainty in the field about the feasibility of ED recovery.

No other underdeveloped themes were noted by the analytic team related to the participants’ use of personal recovery in the treatment of EDs.
### Table 4.1

**Summary of Categories, Properties, & Dimensions Related to Participants’ Definition of Eating Disorder Recovery**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Properties</th>
<th>Dimensions</th>
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<tbody>
<tr>
<td>I. Individualized Process</td>
<td>I.A. Beyond Symptom Recovery</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>II.A.2. Body Acceptance</td>
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<tr>
<td></td>
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<td>II.A.3. Built-in Wake-up Call System</td>
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<tr>
<td></td>
<td>II.B. Existential</td>
<td>II.A.4. Freed Mental Space</td>
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<td></td>
<td>II.C. Social</td>
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<tr>
<td></td>
<td>II.D. Spiritual</td>
<td>II.B.1. Meaning-making &amp; Identity Development</td>
</tr>
<tr>
<td></td>
<td>II.E. Physical &amp; Behavioral</td>
<td>II.B.2. Increased Personal Power</td>
</tr>
<tr>
<td></td>
<td>II.F. Emotional</td>
<td>II.B.3. Congruency</td>
</tr>
<tr>
<td>III. Societal Context</td>
<td>III.A. What is “Normal” in U.S. Society?</td>
<td></td>
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<tr>
<td>IV. Underdeveloped Categories</td>
<td>IV.A. Aging &amp; Letting Go</td>
<td></td>
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<td></td>
<td>IV.B. Sexual Healing</td>
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Table 4.2

*Summary of Categories, Properties, & Dimensions Related to Participants’ Use of Personal Recovery in the Treatment of Eating Disorders*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Properties</th>
<th>Dimensions</th>
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<tbody>
<tr>
<td>I. Belief in Recovery</td>
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<tr>
<td>II. Authenticity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III. Personal Healing &amp; Therapy Experiences</td>
<td>III.A. Positive &amp; Negative Personal Therapy Experiences</td>
<td></td>
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<tr>
<td>IV. Living It &amp; Saying It</td>
<td>IV.A. Serve as an Attainable Model of Recovery</td>
<td>IV.A.1. Symbolize Hope/Motivating</td>
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<tr>
<td></td>
<td></td>
<td>IV.A.2. Normalize ED Experiences, Reduce Shame, &amp; Humanize Therapist</td>
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<td></td>
<td>IV.B. Facilitate Relationship-building</td>
<td>IV.B.1. Relate To/Validate ED Experiences &amp; Build Trust</td>
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<tr>
<td></td>
<td>IV.C. Native Language/Insider Information</td>
<td>IV.B.2. Expanded Relationship Boundaries</td>
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<tr>
<td></td>
<td>IV.D. Purposeful Use of Self-Disclosure</td>
<td></td>
</tr>
<tr>
<td>V. Underdeveloped Categories</td>
<td>V.A. Too Recovered?: Optimal Range for Working with EDs</td>
<td>IV.C.1. Increased Credibility</td>
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<tr>
<td></td>
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<td>IV.C.2. Leverage to Confront &amp; Hold Clients Accountable</td>
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<td></td>
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<td>IV.C.3. ED Radar</td>
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<td>IV.C.4. Sounding Board for ED Voice</td>
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<td>IV.D.1. Less is More</td>
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<tr>
<td></td>
<td></td>
<td>IV.D.2. Avoid Inducing ED Competitiveness</td>
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<td></td>
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<td>IV.D.3. Client Benefit</td>
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<td>IV.D.4. Avoid Imposing Personal ED Journeys &amp; Alleviating Clients’ Pain</td>
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Figure 4.1. Recovered Clinicians’ Definition of Eating Disorder Recovery
Figure 4.2. Clinicians’ Use of Personal Recovery in the Treatment of Eating Disorders
CHAPTER 5
Discussion

Summary

The limited estimates available (Barbarich, 2002; Bloomgarden, Gerstein, & Moss, 2003; Costin & Johnson, 2002) indicate that the prevalence of eating disorders (EDs) among professionals who treat EDs is significantly higher than the prevalence of EDs in community samples. Despite this indication, little is known about how “recovery” is defined or how recovered clinicians use their personal recovery in the treatment of EDs.

The present study contributes to this largely underdeveloped body of literature by providing an in-depth examination of a sample of nine clinicians’ understanding and use of their personal recovery in the treatment of eating disorders. More specifically, this study used a feminist research orientation (Striegel-Moore, 1994) and the Corbin/Strauss (2008) approach to qualitative analysis to develop classificatory schemes and accompanying diagrams related to recovered clinicians’ (a) definition of ED recovery and (b) uses of their recovery in the treatment of eating disorders.

The data collection and analysis procedures were recursive in nature and included seven processes, which often occurred simultaneously rather than sequentially. The research processes included researcher reflexivity and consensus coding; concurrent data collection and analysis; immersion in the data; microanalysis; general analysis; theoretical sampling and comparative analysis; and the integration of findings (see
Chapter III for a detailed description of each process). In short, the Corbin/Strauss (2008) method is based on identifying significant concepts in the data and exploring their relationships through an intensive and reflective coding process, which entails interacting with, asking questions about, and making comparisons between the data. Because the current study was one of the first examinations of recovered ED professionals’ understanding and use of their personal recovery in the treatment of EDs, the researchers aimed to achieve an in-depth exploration of each phenomenon rather than a theoretical explanation or interpretation. Therefore, this study aimed to contribute to the current empirical literature by providing a classificatory framework for each phenomenon (i.e., the organization of data into discrete categories/themes according to their descriptions, properties, and dimensions), which could serve as precursors to future theories on the topics at hand.

The current study utilized a team approach to analysis to reduce the influence of individual bias while stimulating multiple analytic perspectives. The research team was comprised of three women: the primary researcher (a third-year Italian American doctoral student in counseling psychology who has a personal history of BN), a third-year South Asian Indian doctoral student in counseling psychology who has struggled with body image dissatisfaction and sub-clinical disordered eating due to her inability to meet the dominant culture’s standards for “thin White women”, and a master’s level White counselor who has never struggled with disordered eating or significantly impaired body image. All three researchers identified with a feminist theoretical orientation and had previous training and experience conducting qualitative research. The team initially met to reflect upon their relevant experiences and biases related to the topic under study, and
then met biweekly throughout the data analysis stages of the research process to consensus code, discuss analytic reflections, and identify themes. Because two distinct phenomena were studied, the researchers analyzed each one separately.

In sum, the present study aimed to:

(a) serve as one of the first studies to examine recovery from the perspective of recovered ED clinicians;

(b) contribute to the lack of literature relating to recovered clinicians’ uses of their personal recovery in the provision of ED treatment; and

(c) apply the unique lens of a counseling-psychologist-in-training’s strengths-based and feminist perspective to a topic that is typically approached from a deficit-based, disease-oriented framework.

Following is a discussion of the major findings and conclusions drawn from the current study, their implications for practice and training, and recommendations for future research.

Conclusions

The current study produced findings in the form of two distinct classificatory schemes with accompanying diagrams, which resulted from the research team’s analysis of the transcribed interviews with recovered ED clinicians. Team memos/reflections, the researchers’ codebooks, and feedback from the participants (i.e., member checks of the two classificatory schemes and the accompanying figures) informed the findings.

Classificatory Scheme 1: Recovered Clinicians’ Definition of Eating Disorder Recovery

Findings related to the definition of ED recovery through the lens of recovered ED clinicians included three overarching, interrelated categories (individualized process;
towards balance, freedom, and embodiment across multiple dimensions; and societal context), each containing sub-concepts (i.e., properties and dimensions) that elucidate the categories and the relationships between them. More specifically, findings revealed that recovery is an individualized and multidimensional process towards balance, freedom, and embodiment (i.e., being authentically and fully expressed), which is perpetually influenced by societal standards and messages (see Figure 4.1). Results also included a fourth category of underdeveloped findings, which included aging and letting go and sexual healing.

These findings suggest that recovery is an individualized and multidimensional process beyond the symptom abatement of food, weight, and body behaviors and preoccupations as described in the DSM-IV-TR (APA, 2000). Therefore, the current findings support a multidimensional definition of recovery that includes healing along psychological, existential, social, spiritual, physical and behavioral, and emotional dimensions. Although no consensus on criteria for recovery from EDs exists in the current empirical literature (Kordy et al., 2002; Noordenbos & Seubring, 2006), these findings are most closely aligned with the feminist literature’s conceptualization of recovery, which tends to capture the complexity of healing beyond food, body, and weight concerns (Fallon, Katzman, & Wooley, 1994). Peters and Fallon (1994), for example, proposed that “recovery is a multidimensional process and involves a progression of changes in relationship to self, body, family, and culture” (Peters & Fallon, 1994, p. 352) and, further, that it entails “a personal awakening to secrets, alienation, and powerlessness” (p. 353).
Further, the current findings support the findings of Peters’ (1990) qualitative study, which include three multidimensional continua of recovery from BN: “denial to reality” (e.g., accepting that BN is a problem rather than a solution; accepting and experiencing feelings rather than avoiding them), “alienation to connection” (e.g., disclosing one’s experiences with BN, exposing one’s shame-based secrets, reconnecting with one’s sexuality and interpersonal relationships), and “passivity to personal power” (e.g., increasing commitment to treatment and changing one’s attitude towards problematic cultural standards of female thinness from compliance to outrage) (cited in Peters & Fallon, 1994). Thus, the current study’s conceptualization of ED recovery is closely aligned with Peters’ (1990) conceptualization.

The current study’s findings are also consistent with several of Bowlby’s (2008) dissertation findings, which include six themes regarding clinicians’ personal recovery from EDs. More specifically, Bowlby’s (2008) non-linear process and multifaceted themes are consistent with the current study’s findings related to ED recovery as a multidimensional process; understanding and valuing the self is consistent with the current study’s findings related to increased personal power and voice; de-identification with the illness is consistent with the current study’s findings related to connection outside of self; purpose and meaning in life is consistent with the current study’s findings related to spirituality, meaning-making, and identity development; and developing meaningful relationships is consistent with the current study’s findings related to reconnection and risk. The current study’s findings also support Bowlby’s finding that EDs serve as a functional coping tool in response to difficult life experiences or circumstances. Bowlby’s (2008) dissertation is the only previous study that could be
found examining recovered ED clinicians’ perspectives and experiences related to their personal recovery.

The current findings further support Cockell and colleagues’ (2004) findings related to factors that help individuals to maintain change post-discharge from ED treatment. Cockell et al.’s (2004) findings included maintaining ongoing connections with both professionals and family/friends, which is consistent with the social dimension of healing in the current study; applying cognitive strategies and affective skills, which is consistent with the psychological and emotional dimensions of healing in the current study; and focusing on experiences beyond the ED, which is consistent with the spiritual dimension of healing in the current study.

One of the unique findings of the current study related to recovered clinicians’ definition of recovery suggests that ED recovery signifies the ongoing ability to (a) recognize imbalance and then (b) make subsequent personal and life changes to restore balance, which leads to enhanced comfort, harmony, and empowerment along multiple dimensions of functioning— a concept that the researchers of the current study termed “freedom/embodiment.” More specifically, the category freedom/embodiment signifies first, freedom from ED mind, body, and soul torment (i.e., freedom) and, second, the intentional use of that freedom to be authentically, healthily, and “fully expressed” (Augusta) psychologically, existentially, socially, spiritually, physically/behaviorally, and emotionally (i.e., embodiment). In this way, freedom/embodiment is aspirational and requires ongoing efforts to maintain balance and congruence in the face of life’s inevitable personal, familial, environmental, and societal triggers. Therefore, the current findings suggest that ED recovery involves the ability to respond differently to personal
vulnerabilities, body image concerns, and environmental triggers rather than an absence of them.

The concept *freedom/embodiment* is directly related to references in the ED literature to “disembodiment,” which Hutchinson (1994) describes as the treatment of one’s body “as if it were an object separate from the self” (p. 155). More specifically, Hutchinson (1994) maintains that healing from body image disturbances involves moving from “disembodied,” or the objectification of one’s body, to “embodied,” the integration of body and self in such a way that one’s body is experienced “as a reference point for being in the world” (p. 155). Further, Hutchinson (1994) describes that the “body awareness” that results from being embodied is distinct from “body hatred and body narcissism,” and that it helps one to “perceive changes that signal emotional shifts” (p. 155). Thus, Hutchinson’s conceptualization of embodied is similar to the current study’s findings that recovery from EDs includes: (a) freedom from ED torment and (b) congruence between body, mind, and soul resulting in the ongoing ability to recognize signs of imbalance.

The current study’s findings additionally suggest that *freedom/embodiment* includes the ability to take action to restore balance across multiple dimensions of functioning in order to work towards being fully and authentically expressed, which is related to Satir et al.’s (1991) discussion of “congruence” as the choice to be aware of and fully value the many dimensions of oneself (and others) and to Maslow’s (1943) concept of self-actualization. Further, because achieving balance across dimensions is relative to the individual and her perpetually evolving life context, the current findings
suggest that the ED healing and ongoing maintenance processes are unique to each individual.

Finally, one of the most pronounced findings in the current study related to recovered clinicians’ definition of ED recovery suggests that realistic recovery in U.S. society does not entail an absence of body dissatisfaction or the absence of a desire to be physically fit. The participants in this study unanimously agreed that the definition of recovery cannot ignore the impact of American culture on body image. This finding is consistent with Root’s (1990) finding that the most commonly endorsed definition of recovery by individuals who were recovered from BN was, “I am recovered, but I still struggle with food, weight, and/or body image” (as opposed to the other two options, which included, “I am recovered; I no longer struggle with food, weight, and/or body image” or “I will never be completely over my eating disorder; I will always struggle with an eating disorder”) (p. 399). This finding suggests that the notion “I am recovered but still struggle with food, weight, and/or body image” in some capacity may be the most realistic expectation of recovery for both professionals and for clients, and may even be normative (Root, 1990).

This finding is also consistent with other studies suggesting that ED recovery is a dynamic process rather than a static state, and that it tends to involve residual preoccupations with food, body image, perfectionism, and/or weight (D’Abundo & Chally, 2004; Jones et al., 2005; Srinivasagam et al., 1995; Stein et al., 2002). Pettersen and Rosenvinge (2002) also warn against “the fallacy of ‘supernormalism’ in measuring recovery” given that unrealistic expectations can “exacerbate negative perfectionism” among individuals recovering from EDs (p. 70). Thus, these findings suggest that a
realistic definition of recovery should not expect more from a recovered ED individual than is normal for a woman who has never had an ED in U.S. society.

Classificatory Scheme 2: Recovered Clinicians’ Use of Personal Recovery in the Treatment of Eating Disorders

Findings related to recovered ED clinicians’ use of their personal recovery in the treatment of EDs included four overarching, interrelated categories (belief in recovery; authenticity; personal healing; and living it and saying it), which contain sub-concepts that elucidate the categories and the relationships between them. In short, the participants’ unwavering belief in ED recovery, which is derived from and continually influenced by their own healing experiences, serves as the foundation for both their implicit (i.e., “living it”) and explicit (i.e., “saying it”) uses of personal recovery in the treatment of clients with EDs. Further, authenticity, which tends to be both a goal and a result of ED recovery, is an underlying and pervasive motivator for the participants’ use of personal recovery (see Figure 4.2). Results also included a fifth category of underdeveloped findings, which include, too recovered?: optimal range for working with EDs; greater personal healing; and fear of judgment from other professionals.

The current findings suggest that the clinicians in this study use their personal recovery in a variety of implicit and explicit ways, many of which have broad therapeutic relevance and have been discussed extensively in previous psychological and theoretical literature that is not specific to EDs. These uses include instilling hope (e.g., Alcoholics Anonymous, 1955; Yalom, 1981; Yalom & Leszcz, 2005); reducing shame (e.g., Kaufman, 1992); providing empathic understanding (e.g., Rogers, 1975; Teyber, 2006);
modeling authenticity, transparency, and genuineness (e.g., Rogers, 1951); and, in doing so, providing corrective emotional experiences (Teyber, 2006).

In addition to the aforementioned uses of personal ED recovery that apply to a variety of clinical concerns, the participants in this study also used their personal recovery in ways that may be unique to EDs and other types of addictive behavior. For example, the participants in this study used their recovered status to symbolize an attainable model of recovery from a disorder in which full recovery is rare, and to communicate that “if I can do this, so can you.” This is similar to AA’s model as a “mutual-help fellowship whose members share ‘their experience, strength, and hope that they may solve their common problem and help others to recover from alcoholism’” (McIntire, 2000, p. 1). This finding also supports White’s (2000b) proposal that recovered counselors in addiction treatment have the unique ability to use their personal experiences to inspire hope, and Costin and Johnson’s (2002) observation that recovered clinicians provide “light at the end of the tunnel” (p. 297) by serving as living examples that recovery is possible.

Further, the participants used their recovered ED status to establish credibility with distrusting clients; as radar to detect ED thoughts, behaviors, and dishonesty; and as leverage to confront clients’ disordered thoughts and/or behaviors while holding them accountable for positive change. These findings are consistent with one of AA’s premises related to the idea that “you can’t bullshit a bullshitter” (An Irish Friend of Bill, 2008) and with Bowlby’s (2008) finding related to recovered ED clinicians’ therapeutic leverage with ED clients. They also support White’s (2000b) assertions that recovered counselors in addiction treatment have the unique benefit of insider knowledge of the
addiction derived from lived experience and an awareness and willingness to be more confrontational with early recovery addicts than non-recovered clinicians. Finally, these findings support Costin and Johnson’s (2002) observations that, due to their shared personal experiences with EDs, recovered clinicians have increased leverage to confront patients’ hopelessness and tend to be less ambivalent than non-recovered staff members to do so. Therefore, these findings suggest that recovered clinicians have leverage to directly or indirectly communicate “been there, done that. If I can do it, so can you.” (Costin & Johnson, 2002, p. 298).

The current findings further support the judicious use of self-disclosure (Maroda, 2009) regarding one’s recovered status and/or personal experiences in recovery when it is beneficial for the client, and the use of authentic therapeutic responses (Costin, 2009). More specifically, the participants in this study used their personal recovery to expand traditional relationship boundaries with clients by being more directive when addressing ED behaviors, by engaging in non-traditional therapy activities with clients such as eating, and by being transparent and “in the relationship” rather than serving as a neutral “countertransference tool” (Phoebe). These findings support Baldwin’s (2000) and Satir’s (2000) promotion of the positive use of self in therapy and, further, the use of interpersonal connection and the therapeutic relationship as “the heart of effective clinical practice” (Maine, Davis, & Shure, 2009, p. xxii; Teyber 2006) with EDs. These findings also support the use of self-disclosure in the context of a Relational Therapy (RT) approach to ED treatment as described by Tantillo (2004) in order to promote empathy and validation, to foster universality by moving from “me” to “we”, to normalize clients’ experiences, to promote trust and understanding, and to empower clients by sharing
similar experiences. Finally, these findings support Costin and Johnson’s (2002) observations that recovered clinicians tend to have a noteworthy ability to avoid getting stuck in the complicated dynamics underlying EDs at the expense of the direct treatment of ED symptoms.

Interestingly, similar to the finding in Classificatory Scheme 1 that being authentic and embodied (or operating with one’s “heart, head, and belly” in sync as described by Cleo) is an integral component of the participants’ definition of ED recovery, they also discussed the importance of using their embodied, authentic presence therapeutically to model body acceptance, congruency, and balance. This is consistent with the Satir Model’s (Satir et al., 1991) promotion of congruence for both therapists and clients, which involves “harmony within oneself, with others, and with the world” (Lum, 2002, p. 191). This finding is also directly aligned with Costin’s (2009) discussion of “the embodied therapist”:

Ideally, female therapists can serve as positive, healthy role models for their eating-disordered clients by demonstrating self-acceptance, care, and love for their bodies. It is healing for clients to see females who are comfortable with their bodies, living a life free from restrictive dieting or other disordered behaviors, thoughts, and desires. (p. 182)

This finding supports Costin’s (2009) conclusion that “the therapist’s embodied experience can be one of personal joy as well as a useful tool in the efforts to help clients navigate recovery” (pp. 191-192).

In addition to the therapeutic advantages of using personal ED recovery, the current findings also highlight various risk factors of using personal recovery in the
treatment of EDs, including the risk of experiencing countertransference and
overgeneralizing personal experiences; trying to spare clients of their pain or expedite
their recovery processes; becoming more invested in the client’s recovery than the client;
and being uniquely vulnerable to disappointment, frustration, and burnout when clients
do not recover due to the therapist’s personal experiences verifying that recovery is
possible. This is consistent with both Johnston et al.’s finding (2005) and White’s
(2000b) discussion that professional helpers who are in personal recovery have an
increased risk of overextending themselves and/or over-relating to clients. It is also
consistent with Costin and Johnson’s (2002) observations that recovered staff members
have an increased risk for countertransference issues, such as becoming narrow-minded
about how recovery occurs for clients based on their own processes of recovery. In other
words, the “been there, done that” approach can sometimes impede clients’ processes by
preventing them from finding their own path to recovery (Costin & Johnson, 2002).

The current findings also support the notion that “less is more” when it comes to
self-disclosure (Maroda, 2009) with ED clients about one’s personal ED experiences in
order to avoid inducing what the researchers termed “ED competitiveness.” In other
words, communicating that the participants had “been there and done that” was more
useful and effective than discussing the details of their EDs, which could be triggering
and countertherapeutic for clients. This is consistent with Costin’s (2009) suggestion to
avoid talking about the details of one’s illness with clients: “It is the process of getting
through something, not the specific details of the problem, from which clients can
benefit” (p. 189). Previous literature discussing the dynamics of ED competitiveness
within the context of the therapeutic relationship could not be found, which suggests that this may be a unique finding of the current study.

Further, the clinicians in this study used their personal experiences in therapy, both positive and negative, to inform their clinical work and uses of self-disclosure as therapists. More specifically, the clinicians in this study reported acquiring increased self-awareness, balance, empathy, and patience as a result of their personal healing processes, which directly and positively impacted their work as therapists. This finding supports the notion that personal therapy can be helpful for clinicians both personally and professionally (Macran et al., 1999) and, further, that a “wound in the helper may contribute to the helper’s own wholeness” (Miller & Baldwin, 2000, p. 256).

Finally, an important finding of the current study relates to the participants’ experiences and fears related to judgment of their recovered status from the professional community. This is consistent with White’s (2000b) discussion in the History of Recovered People as Wounded Healers of the vulnerability of professional helpers who are in personal recovery to “interprofessional conflicts” related to differing views about the nature of addiction and recovery (p. 19). Johnston et al. (2005) also highlight the debated issue of the mental health of practitioners working in healthcare professions and, further, that “eating disorders in particular have often been singled out as conditions that may significantly interfere with the sufferer’s fitness to practice in a healthcare profession” (p. 301). Thus, clinicians who are recovered from EDs (and likely other mental disorders) may be vulnerable to stigmatization among the non-recovered professional community.
**Implications**

*Clinical Practice*

The current study was one of the first to examine recovered ED clinicians’ understanding and uses of their personal recovery in the treatment of EDs. The present findings contribute to the literature on use of self in clinical practice, and suggest that clinicians’ implicit and explicit uses of personal ED recovery provide several unique advantages throughout the treatment process in the perception of recovered clinicians. Most notably, these include relationship- and trust-building assets such as the ability to expose and reduce ED shame based on shared experiences; access to insider information based on lived ED experiences; increased credibility with ED clients who tend to be distrusting and fearful of relenting control; and leverage to hold clients accountable for making choices that support recovery based on the therapists’ personal experiences verifying that ED freedom is possible.

Furthermore, the recovered clinicians’ unwavering belief that recovery from EDs is possible, which stemmed from their personal healing experiences, served the dual function of (a) helping them to maintain hope for and patience with their clients throughout often long and arduous treatment processes, and (b) representing irrefutable, living examples that ED freedom is *possible*, which is arguably the greatest source of hope and motivation available to clients suffering from a similar illness. The Use of Recovery diagram (see Figure 4.2) provides a framework for the therapeutic use of personal ED recovery in the treatment of EDs, which may also be applicable to the use of other types of personal recovery in the treatment of various psychological disorders.
Despite the aforementioned perceived advantages of recovered clinicians’ uses and functions of personal recovery in the treatment of EDs, the participants also unanimously suggested that personal recovery is not necessary to be an effective ED counselor. They emphasized, for example, that being recovered from an eating disorder does not make a clinician “better or worse across the board” (Frankie). Therefore, these findings support White’s (2000b) conclusion that ultimately, “a personal history of recovery from addiction does not, in and of itself, qualify or disqualify one as an effective facilitator of recovery for others” (p. 19).

The current findings also have implications for ED conceptualization and treatment. More specifically, the participants’ understanding and treatment of their clients’ EDs were directly informed by their personal experiences with recovery, which importantly suggest that EDs serve purposes beyond a drive for thinness and, therefore, that recovery requires healing beyond the abatement of DSM symptoms. The Definition of ED Recovery diagram (see Figure 4.1) provides a framework for conceptualizing and treating EDs multidimensionally, which includes psychological, existential, social, spiritual, physical/behavioral, and emotional dimensions of healing. Given that no consensus on criteria for recovery from EDs exists in the current empirical literature (Kordy et al., 2002; Noordenbos & Seubring, 2006), the ED Recovery Diagram and framework contribute to this void and may provide both researchers and clinicians with a useful model of recovery that is uniquely informed by the personal healing and professional treatment experiences of recovered ED clinicians.

The current findings have additional diagnostic implications related to EDs. For example, while the present findings suggest that recovery from EDs requires healing
across multiple dimensions, they also suggest that realistic recovery does not require an absence of body dissatisfaction due to the pervasive influence of U.S. societal standards and media on body image. More specifically, while healing, improved functioning, balance, and enhanced freedom occurred across each of the six dimensions of healing for the participants in this study, this does not imply that they were immune to body dissatisfaction or a drive to be physically fit. As Costin (2009) eloquently describes, “while body image disturbance is central to the diagnoses of eating disorders, it also is a normative experience for women today” (p. 181). Thus, these findings suggest that the definition of recovery should not expect more from a recovered ED individual than a woman without a history of an ED in U.S. society.

Further, findings from this study suggest that realistic recovery represents the ability to respond differently to personal vulnerabilities, body image concerns, and environmental triggers rather than an absence of them. Therefore, an attainable and worthwhile goal of ED treatment may include helping clients to (a) interpret ED triggers as signals to pay attention to the “body of their life” (Cleo) rather than to their body parts (i.e., to recognize when and where they are imbalanced), and (b) to respond differently to these triggers by restoring balance across the relevant dimensions of functioning. The current findings also suggest that making connections outside of oneself, such as becoming spiritually connected, participating in hobbies, and engaging in healthy movement, is an essential component of the ED treatment and recovery process. Additionally, the participants’ experiences both recovering from and treating EDs collectively suggest that a directive, relational, and embodied approach to treating EDs is
essential. For example, Cleo highlighted the importance of being an embodied ED therapist:

If you’re a therapist who sits there completely disembodied and you’re operating from the head up...you are not going to work well with these patients...If you can’t be down in the belly of your heart and love and heal and help from that place, I don’t think we can help people get well. If we aren’t whole then we can’t take them any further than where we’ve gotten. Otherwise eating disorder patients will figure that out and they’ll either leave, or they will stay because they know you won’t help them. And that is a really dangerous spot.

Finally, it is important to note that the participants in this study felt that their work as ED clinicians strengthened, rather than threatened, their recoveries, which refutes the notion that mental health professionals who are personally recovered are significantly more vulnerable to relapse. Although this can be the case, the results of this study suggest that the opposite may also be true—a recovered status may also serve as a protective factor when treating EDs. Further, the findings of this study suggest that “wounded healers” (White, 2000a; White, 2000b) who have successfully tended to their wounds can serve as effective and powerful therapists. As Kreinheder (1980) describes in his personal recount after suffering from severe rheumatoid arthritis:

When you become ill, it is as if you have been chosen or elected, not as one to be limited and crippled, but as one to be healed. The disease always carries its own cure and also the cure for your whole personality. If you take it as your own and you stay with this new experience, with the pain and the fear and all the
accompanying images, you will be healed to a wholeness far beyond your previous so-called health. (p. 15 as cited in Miller & Baldwin, 2000, p. 256)

The current study suggests that this newfound “wholeness” can have a positive impact on recovering and/or recovered healers’ professional work.

Training

The current findings have important implications for training. Perhaps most importantly, they highlight the need for ED specific training and supervision, especially in regard to use of personal recovery in the treatment of EDs. The finding that participants had experiences and/or fears related to judgment by the professional community further suggests that clinical supervisors may be part of this feared community, which may impact clinicians-in-training’s comfort and level of vulnerability in supervision. Therefore, recovered clinicians would benefit from supervisors who view their recovered status as a strength and a resilience factor rather than as a deficit or a risk factor. The facilitation of a safe space in supervision would also help recovered clinicians to voice their personal struggles/triggers, countertransference reactions, and dilemmas related to self-disclosure, which the current findings suggest are all areas of relevance and importance when using personal ED recovery in clinical practice.

The current findings also have implications for, and lend support to, the use of self model in therapy (Baldwin, 2000) and in supervision (Wells & Pringle, 2004). More specifically, they suggest that the judicious use of one’s authentic and whole self, including one’s recovered status, may enhance the clinician’s confidence and comfort conducting effective therapy. Further, it seems that the guiding principles and underlying dynamics of Wells and Pringle’s (2004) use of self supervision model closely parallel the
current participants’ experiences and motives for using personal recovery with ED clients. For example, Wells and Pringle describe that the Use of Self Supervision Model: …Places the supervisory relationship, the person of the supervisor, the person of the therapist, and the therapy relationship at the center of focus…Use of self supervision encompasses much more than self-disclosure, but the issues of self-disclosure and exposure to the self are central to its expression. Such a supervisory approach thus requires risk-taking for the purposes of learning and furthering the supervisory action. Both supervisor and supervisee enter a collaborative process based on the valuing of mutuality or learning from each other, the process of co-creating meaning, and corrective or facilitative relating. (p. 1)

Therefore, the findings of this study imply that the use of self supervision model may be especially applicable and useful when working with recovered clinicians. In particular, the supervisor-supervisee dynamics in the use of self supervision framework can serve as a model of, and preparation for, the clinician-client dynamics that are relevant to the use of personal recovery in clinical practice.

Further, given that the majority of participants in this study used their personal therapy experiences, both positive and negative, to inform their current uses of self-disclosure and personal recovery as therapists, this finding supports the notion of “taking the journey inward” and suggests that mandated and/or voluntary personal therapy experiences can benefit trainees and professionals in their roles as therapists.
Limitations

The current study was one of the first to provide an in-depth examination of recovered ED clinicians’ understanding and use of their own recovery in the treatment of EDs. Despite the unique strengths of this study, there are several noted limitations. First, the current sample was notably homogenous in regard to class, race, sexual orientation, and gender. It is important to note, however, that generalization is not the intent of a qualitative study; rather, the goal is to gain new knowledge by conducting an in-depth examination of a particular phenomenon. Further, because qualitative researchers aim to discover variables rather than control them, the quality and depth of analysis is more important than the size of the sample (Corbin & Strauss, 2008).

Second, while the current study was exploratory in nature and was designed to provide only a preliminary conceptual understanding of recovered ED clinicians’ definition and use of their personal recovery in the treatment of EDs, the depth of information gleaned from each participant was limited to a demographic survey and one semi-structured interview that was informed by the concepts derived from previous interviews (i.e., theoretical sampling). Therefore, it might have been helpful to conduct follow-up interviews with participants and/or to triangulate data collection by using multiple sources of information (e.g., interviews with the family members or clients of participants), and thereby achieve thicker and richer descriptions of the phenomena under study. As Corbin and Strauss (2008) note, however, although a qualitative researcher can collect data forever and continue to find new properties and dimensions, “eventually a researcher has to say this concept is sufficiently well developed for purposes of this
research and accept what has not been covered as one of the limitations of the study” (p. 149).

Similarly, the findings of the present study are limited to descriptive classificatory schemes that are grounded in the data, and therefore do not provide interpretative theories of the phenomena under investigation. Although the current study thoroughly analyzed and developed properties and dimensions related to each phenomenon under investigation, it did not analyze context and process, which are necessary for theory development as described by Corbin & Strauss (2008).

Finally, although the primary researcher’s status as a recovered ED clinician was a unique strength of the current study because it facilitated relationship-building and trust with the participants, helped to prevent the objectification of their experiences, and aided in data analysis, it is also possible that my shared status inadvertently skewed my understanding of the participants’ experiences. The use of two additional data analysts who did not have personal histories of EDs were included in the research team to minimize this threat by providing a forum for continual consideration and comparison of both insider and outsider perspectives. As Corbin and Strauss note, qualitative findings are always “a product of data plus what the researcher brings to analysis” (p. 33).

Therefore, in qualitative research:

‘Credibility’ indicates that findings are trustworthy and believable in that they reflect participants’, researchers’, and readers’ experiences with a phenomenon but at the same time the explanation is only one of many ‘plausible’ interpretations possible from data. (p. 302)
Future Directions

The current study highlighted several areas of research that warrant attention. Perhaps most notably, the current findings suggest that, in the perceptions of recovered clinicians, the implicit and explicit uses of their personal recovery in the treatment of EDs provide several unique benefits to the therapeutic process; further research is necessary, however, to investigate the effectiveness of this practice on treatment outcomes and in the perception of clients. In other words, while the current study provides a preliminary understanding of clinicians’ uses of personal recovery, additional research is needed to study the effectiveness of those uses. A potentially rich method of studying this may include a combination of quantitative and qualitative methodologies investigating a diverse sample of clients’ experiences and recovery rates with recovered versus non-recovered clinicians. For example, how does the clinician’s use of personal recovery impact treatment in the perspective of ED clients? Are certain uses more or less effective than others? What positive and/or negative effects do various uses of personal recovery have on clients? What are the effects on treatment processes and outcomes? Are clinicians who have recovered from AN, BN, or EDNOS differentially effective when treating clients with AN, BN, or EDNOS? In other words, does the type of ED that a clinician has recovered from impact her effectiveness treating that particular disorder more or less than her effectiveness treating other types of EDs?

Furthermore, the current study provides two conceptual schemes related to recovered ED clinicians’ definition and use of personal recovery in the treatment of EDs, and additional research is needed to investigate each framework’s clinical utility. More specifically, additional information is needed to determine whether the Use of ED
Recovery framework (see Figure 4.2) is applicable to the therapeutic use of other types of personal recovery, such as recovery from PTSD, depression, alcohol and drug addiction, and/or anxiety. Moreover, research is needed to investigate which uses of personal recovery in the current study are unique to ED treatment and which are more generally applicable to other mental health disorders. In regard to ED recovery, research is needed to evaluate how the Definition of ED Recovery framework (see Figure 4.1) compares to other recovered and more diverse (in regard to race, ethnicity, culture, SES, sexual orientation, and gender, for example) individuals’ understanding of their personal ED recovery. Further, how useful is the framework in informing treatment providers’ conceptualizations of ED treatment and recovery?

An additional interesting area of investigation resulting from the current study relates to the question of what is “recovered enough” versus “too recovered” to provide ED treatment. Several participants described that treating EDs became less appealing and required more effort as they progressed in their recoveries and gained substantial distance from their EDs. Therefore, it is possible that the experience of feeling “too recovered” may be related to clinician burnout and/or that there is an ideal window for using personal recovery, which requires being recovered enough to be an effective treatment provider, but not too recovered that one loses her ED radar, leverage, and compassion. One of the participants, Frankie, illuminates this hypothesis, which may inform research in this area:

Recovered enough could be this ideal place where you’re five years out, or a few years out, or have low grade symptoms a little bit where you understand the whole thing enough to help [clients] make connections between their emotions
and their eating and how it all works, and you feel passion about it and you want to read about it. Now I can barely get myself to read things about it. It’s like I’m too recovered….I have to put a lot of effort in to feel that level of compassion and just to think about what I can do to help them move and grow.

Similarly, future research can help to illuminate how clinicians can measure “recovered enough” from EDs and other mental disorders in themselves or in supervisees and, further, how similar, different, or effective “wounded healers” who have tended to their wounds are as therapists in comparison to those who have not engaged in personal therapy or adequately resolved their personal issues.

It is also important to further investigate how recovered clinicians can determine “what to share and what not to share, and who to share it with and when” (Carolyn). Although the current study provides useful information regarding clinicians’ intentions and uses of personal recovery, the findings do not explain how the clinicians become savvy in the “what, when, why, and how” of self-disclosure and use of personal recovery.

Moreover, an interesting finding of the current study relates to the potential for inducing “ED competitiveness” within the context of the therapeutic relationship by over-disclosing ED details. Given that previous literature discussing the dynamics of ED competitiveness within the context of the therapeutic relationship could not be found, this seems to be a unique finding of the current study that warrants further investigation. The current findings are also limited in regard to information regarding recovered clinicians’ risks of relapse. While several of the participants in this study communicated that their work as ED clinicians strengthened, rather than threatened, their recoveries, further
research is needed in order to determine recovered ED clinicians’ level of risk for relapse due to the intensity and nature of ED clinical work.

Furthermore, because the current study was limited to a homogenous sample of White, predominantly middle-class, heterosexual women, further research is needed to study similar research questions with more diverse participants. For example, how does gender and racial/ethnic identity impact one’s personal use of recovery? How do sexual orientation, SES, and racial/ethnic identity – and the potentially different perceived pressures and standards of thinness based on these identities – impact individuals’ experiences of and recovery from EDs? Is body dissatisfaction also a “normal” developmental experience for women who do not identify with the majority culture and sexual orientation?

Research is also needed to further study the concept of “supernormalism” (Pettersen & Rosenvinge, 2002, p. 70) as it applies to diagnostic and recovery criteria for EDs. More specifically, the current findings suggest that body dissatisfaction may be a “normal” experience in U.S. society and therefore should not be included in the diagnostic criteria from EDs. Additional research is necessary, however, in order to study the extent to which body dissatisfaction is a “normal” experience for all women in U.S. society, especially those who do not identify with the dominant culture, race, or sexual orientation. As Cleo states:

To the degree that it’s part of the diagnostic criteria that we have a disturbance in the way we experience our weight or shape, I have no idea if my experience of my body as a recovered woman is any better or different than those who never had an eating disorder.
Further research is needed in order to achieve clarity in this area and to adjust the DSM diagnostic criteria for EDs accordingly.

Interestingly, the current findings also suggest that the experience of being embodied, or fully expressed and congruent between “heart, head and belly” (Cleo) that can result from ED recovery may be a unique experience to those who have been disembodied. In other words, it is possible that a person cannot experience, or know to experience, embodiment without first having been disembodied (i.e., the experience of treating one’s body as an object that is separate from one’s self). Frankie, for example, described that:

I feel like I’ve been through a war with my body. I feel like we got out of the war. I’m just so appreciative and grateful to have this body working, you know?...I think that someone who has never been through that is still a little more harsh with themselves. I don’t know that they’re as grateful for their ability to eat and feel good and not be worried. They don’t notice the absence of a stressor about it…. I just don’t know that people sit around appreciating or feeling compassion for their bodies.

Additional research is necessary to examine the experiences of, and conditions for, embodiment. For example, how is embodiment (and, conversely, disembodiment) experienced? How does a person become embodied? How does a person maintain embodiment?

Another important area of study that warrants attention is the professional stigma associated with the use of personal recovery in the treatment of EDs and other mental disorders. More specifically, how do non-recovered professionals view recovered
professionals’ use of personal recovery in the treatment of various mental disorders? How does this perception vary depending on the disorder from which the treatment provider has recovered? Frankie stimulates helpful thinking in this area that may have implications for research directions:

I think there’s such a pressure for psychology to be this science that when therapists admit they ever have problems, it’s almost like diminishing them as though we’re not good practitioners instead of looking at it like, the human element can also coincide with science and there can actually be synergy. But I think that we have this pressure to be this kind of hard science and empirically supported and where does this fit in? Is there empirical support that therapists who have recovered or who are in recovery are good clinicians or better than others? I mean that’s hard stuff to prove, hard to do research on.

Further research in this area is necessary in order to better understand and reduce the stigma attached to the use of personal recovery among professional clinicians.

Lastly, the current study highlights the importance and helpfulness of using qualitative methods to facilitate a deeper understanding of phenomena that may be more difficult to access with traditional quantitative methods. Furthermore, this study underscores the advantages of using oneself—and one’s shared identity with participants—as a powerful research instrument when utilized in the context of a team approach to data analysis. More specifically, the primary researcher’s shared identity with the participants facilitated relationship-building and trust, helped to prevent the objectification of their experiences, and, consequently, contributed to creating a safe space in which they felt comfortable disclosing personal and deep information related to
their understanding and uses of their own ED recovery. Further, the primary researcher’s identity as a recovered ED clinician in collaboration with the identities of two researchers without histories of EDs greatly enhanced the analytic process by providing a forum for continual consideration of both insider and outsider perspectives. Thus, the current study supports Corbin and Strauss’ (2008) view that the researchers’ relevant experience to the topic under study is as an asset to the analytic process:

Background, knowledge, and experience not only enable us to be more sensitive to the concepts in the data, they also enable us to see connections between concepts….we have to have some background, either through immersion in the data or through personal experience, in order to know [that] what we are ‘seeing’ in data is significant and to be able to discern important connections between concepts. (p. 34)

In addition to positively impacting the data collection and analytic processes, the primary researcher’s shared status with the participants also provided personal benefits. More specifically, I, the primary researcher, learned from the participants’ wisdom, I derived strength and comfort from our shared experiences, and, consequently, I gained greater personal healing and professional development as a recovered ED clinician. Through this methodologically, personally, and interpersonally rich research process, both the participants and I were provided the exceptional opportunity to mutually influence and grow from each other. For these reasons, the present study supports the use of the researcher’s personal identity—and more specifically, her or his shared identity with the participants—in pursuit of both methodologically and personally significant research.
**Closing Reflections**

My personal experiences recovering from an ED, my professional experiences treating EDs, and my developing identity as a feminist counseling psychologist directly impacted my choice of, interest in, and commitment to this research topic. More specifically, my strengths-based perspective, which is rooted in and supported by counseling psychology’s core values, informed my belief that clinicians’ recovered status is a valuable resilience factor and a potentially powerful therapeutic tool rather than a deficit, and therefore enabled me to pursue this topic openly and proactively. Further, my feminist theoretical orientation informed my belief that use of self is a valuable clinical and research instrument and that a shared identity with the participants could facilitate meaningful interpersonal connections and rich data collection when combined with ongoing self-reflection and research team collaboration. Finally, my commitment to self-growth and use of myself as an instrument in both research and therapy are reflected in my choice of qualitative research methodology to study a topic relevant to use of self in clinical practice.

I am grateful to have had the opportunity to use my personal experiences, professional identity, and simultaneous vulnerability and strength as a recovered clinician to complete this dissertation. As I reflect on the participants’ tremendous experiences and insights, I continue to feel moved and inspired by their strength, openness, and courage. In addition to helping me gain greater self-awareness and personal healing, I hope to also channel what I have learned from the resilient women in this study into my work with others in pursuit of ED recovery. In closing, I move forward from this dissertation with gratitude and a renewed hope and belief that:
Recovered people, with all their assets and vulnerabilities, [can] enter relationships with their clients with an unshakeable belief that there is hope for permanent recovery from addiction [and other psychological disorders], the best evidence of which lies within their own transformed lives. (White, 2000b, p. 21)
REFERENCES


Feminist perspectives on eating disorders (pp. 152-168). New York: Guilford Press.


treatment of eating disorders are necessary 'ingredients' in the recovery process?-


APPENDIX A
Recruitment Flyer

**Seeking Eating Disorder Clinicians to Participate in a Qualitative Study Who:**

1) Are currently employed as a master’s or doctoral level mental health clinician for eating disorders

2) Have met the criteria for an eating disorder at any time in your life

   AND

3) No longer meet the criteria for an eating disorder at the time of recruitment for this study as indicated by normal weight and the absence of binging, purging, and other compensatory behaviors for at least one year

The purpose of this study is to understand how recovered eating disorder clinicians both understand and use their own recovery in the provision of eating disorder treatment.

*Participation in this study includes:*

(a) Partaking in one individual interview (45-90 minutes, either by phone or in person at a time that is convenient to you)

   AND

(b) Completion of a short demographic questionnaire (5-10 minutes in length)
All participants will be entered into a raffle for a $50 Visa Gift Card at the conclusion of the interview process. Please note that participation in the research is not required in order to enter the raffle.

All the information provided by participants in this study will be confidential. Please contact the primary researcher, Alessandra Urbano, for more information at urbanoa@uga.edu

This study has been approved by the University of Georgia’s Institutional Review Board (#2009-10936-0) and is under the direct supervision of Dr. Delgado-Romero.
APPENDIX B

IRB Consent Form

The University of Georgia

College of Education

Department of Counseling and Human Development Services

Dear Participant,

You are requested to participate in a research study entitled “Clinicians’ Understanding and Use of Their Personal Recovery in the Treatment of Eating Disorders” that seeks to examine your experiences as a recovered eating disorder clinician providing treatment to individuals with eating disorders. Your participation would include completing one short demographic form (approximately 10 minutes in length), partaking in one interview (45-90 minutes in length) about your understanding and use of your personal recovery in the treatment of eating disorders, and participating in a short follow-up in which you would be asked to check the accuracy of your interview after it has been transcribed (5-20 minutes in length depending on how closely you review the transcribed interview). This is voluntary study, and you may refuse to participate or stop your participation altogether at any time without penalty or loss of benefits to which you are otherwise entitled.

If you volunteer to participate in this study, the researcher will contact you to arrange either a phone or in-person interview scheduled at a time and place that are convenient for you. The interview will be audiotaped and later transcribed. All participants will be entered into a raffle for a $50 Visa Gift Card at the conclusion of the interview process. Participation in the research is not required, however, in order to enter the raffle. It is possible that you may feel emotional discomfort in answering some of the interview questions. You may skip any questions that you do not wish to answer. You may also discontinue participation at any time without penalty. You may ask to have any information that can be identified as yours returned to you, removed from the research records, or destroyed. If you experience any distress as a result of participation in this research, you may contact the researcher for assistance and resources. Your participation will provide you an empowering opportunity to share your valuable experiences and may increase mental health professionals’ understanding of both eating disorder recovery and treatment. Your participation will also help to provide a deeper understanding of recovered clinicians’ understanding and use of their personal recovery in the treatment of eating disorders.

Your responses will be confidential. If you agree to participate in this study, you will select a pseudonym, which will be used in place of your name throughout the study. Therefore, no identifying information will be used. The audiotape(s) and your original contact information will be locked away securely and will be destroyed within six months after the interview has been conducted. If you have any questions, you may contact the researcher at 203.671.6831 or the researcher’s advisor, Dr. Delgado-Romero, at 706.542.1812.
Sincerely,

Alessandra Urbano, M.A.
Department of Counseling and Human Development Services
University of Georgia
203.671.6831
urbanoa@uga.edu

I have read and understand the above statements. I, _________________________, agree to take part in this research study, which is being conducted by Alessandra Urbano, a doctoral student at The University of Georgia UNDER THE ADVISEMENT OF DR. DELGADO-ROMERO. My questions have been answered and I have received another copy of this form.

_________________________________
Participant Signature/Date

Please sign both copies, keep one and return one to the researcher.
APPENDIX C

Demographic Questionnaire

________________________________________________________

Demographic Survey

Selected Pseudonym ________________________

Current Age ______________________________

Race _________________________________

Ethnicity _______________________________

Gender ________________________________

Current Height _______ Weight _______

Highest Level of Education _____________

Work Setting _________________________
(e.g., residential eating disorder treatment center, outpatient treatment center, private practice etc)

Length of Time Working at Current Setting________________________________________

Job Title _________________________________________________________________

Brief Job Description _______________________________________________________

Personal History with Eating Disorder(s):

Type of Eating Disorder(s) that you have met the criteria for at any point in your life: ________________________________

Age at Time of Diagnosis: ________________________________

Duration of Eating Disorder(s): ________________________________

Type of Treatment Received, if any: ________________________________
Amount of Time in Treatment, if applicable: ____________________________

Number of Relapses, if any: _________________________________________

Length of Time in Recovery (as evidenced by normal weight, the absence of binging, purging, and other compensatory behaviors, and no longer meeting the criteria for any of the *DSM-IV* eating disorders): __________________________________

Is your employer aware of your eating disorder history?
_______________________________________________________________
APPENDIX D

Semi-Structured Interview Questions

Part I: Recovery (First review the recovery section of the demographic survey with participant)

When were you first diagnosed with an eating disorder?
  What was your diagnosis?
  What type of treatment did you receive, if any?
  For how long?
  Did you ever relapse?

How long have you been “recovered”?

How do you define and understand recovered?

  *Follow up:* What does recovery look and feel like for you?
  (in regard to both cognitions and behaviors)

Is there anything related to your understanding of ED recovery that we have not talked about that you would like to talk about?

Part 2: Experiences treating ED clients as a recovered clinician

How long have you been providing treatment to individuals with eating disorders?

What type of treatment do you provide (e.g., individual, group, CBT, DBT, interpersonal etc)?
  Primary Theoretical Orientation:

Does your employer know about your status as a recovered ED clinician?

Do your clients/patients typically know about your status as a recovered ED clinician?

  *Follow-up:* What impacts whether or not you disclose this information?

How does your status as a recovered ED clinician impact the way you treat ED individuals (regardless of your clients’ awareness of your status)?
  (e.g., your understanding of eating disorders, your attitude towards treatment, your treatment conceptualization etc.)
How do you use your personal recovery in the treatment of eating disorders?
(e.g., personal disclosures, use of self as source of hope, use of self as leverage to hold clients’ accountable, etc.)

How have your experiences been providing treatment to ED individuals with regard to:
Perceived effectiveness:
Strengths:
Challenges:
Triggers:
Workplace Support:
Supervision:

How do you think your experiences providing treatment to ED individuals would be different if you were not a recovered clinician?

Is there anything else that sticks out to you related to your understanding and use of your personal recovery in the treatment of eating disorders that we have not yet talked about?
APPENDIX E

Example of a Codebook

Codebook: Cleo

How do clinicians who have recovered from eating disorders (i.e., recovered clinicians) understand and define their recovery?

- Beyond symptom recovery (63-64)
- American norm for body image vs. recovered ED body image norm? (93)
- NOT recovered body image (93)
  - Body image issues are inevitable (229)
  - Difference is that recovered people can translate it into the “body of life issue” that feeling fat is otherwise speaking to (230)...awareness of what to do with body consciousness (240)
- Held to higher standard (107)
- Recovery is a Process (139)
  - Abstinence from symptoms (117)
  - Psychological—reopening heart to grief (151); emotional tolerance
  - Temperamental
  - Spiritual
  - Finding voice
  - Sexuality (384, 446)
- Triggers
  - Losing weight (290, 327)

What are recovered clinicians’ experiences treating eating disorders?
How do clinicians use their own recovery in the treatment of eating disorders?

- Types of uses:
  - Disclose when therapist loses weight (302)
  - When it’s for client and not the therapist (636)
  - Embody recovery by being, acting, feeling, holding yourself (816)
  - Confront behaviors and irrationalities (978)
- Risks:
  - Cheat people in learning hard lessons (639)
  - Can’t take pain away (652)
  - Inducing competitiveness (722)
  - “Binging on details” (805)
- Benefits:
  - Ability to relate to pain (672)
- Insider knowledge
  - Never sit silent in the face of an anorexic (611)
- Symbolize hope (756)
- Leverage to confront behaviors and irrationalities (978)
- Native language vs. learned language (1018)

- Use these concepts to inform subsequent interviews
  - Question: What is “normal” body dissatisfaction for women in American society? How does this differ for participants who have recovered from an ED?
APPENDIX F

Example of a Team Memo

March 12, 2010: Team Memo

Analytic thoughts and questions related to Phoebe, Ella, Bianca, Rose, CC, and Nicole

• Recovery
  o Integrated (rose)—beyond multidimensional?
  o Recycling through stages with new coping skills—not a linear process

• Expanded boundaries—self-disclosure

• ED “lens”-- Different conceptualization of EDs—they serve a purpose/communicate something (more than a set of behaviors and thoughts directed at a drive for thinness)
  VERSUS
• Insider knowledge-- on one side there’s sensitivity and compassion, on the other there’s accountability and radar (phoebe)
  o Are ED lens and insider knowledge two different constructs/concepts?

• Modeling of personal recovery experience-- is this a parallel process?
  o Therapist’s self disclosure
  o Understanding ED as serving a purpose (after understanding the purpose of therapist’s own ED) (ella, bianca)
  o Belief that recovery is possible (phoebe, ella, nicole)—more than hope
  o Truthful with self-- therefore clients need to be truthful with themselves, “although your truth will be different than mine” (rose)
  o Humanizing
  o Not repeating the underlying dynamics of the disorder (shame, secrecy)-- CC

• Leverage to use:
  o Humor (rose, Bianca)—no judgment
  o Language—“we”

• Expediency and effectiveness
• Hope vs. possibility—(pheobe, ella, nicole); possibility is greater than hope; it’s knowing that recovery can happen rather than hoping that it can happen
  o Unique to those who have recovered

• New identity development—full life and full belly
  o Creativity and connection outside of self—leads to greater connection and balance to new parts of self (balance); less ED head space

• Unconditional ED positive regard—mirrors Rogers’ Unconditional positive regard

• Gratitude/celebratory

• Ideal window to treat EDs—too much distance vs. too much closeness???

• Parallel process—interviewer self-disclosed just as therapist does with clients (Frankie, Bianca commented) -- how does this impact data collection process?

SYSTEMIC ISSUE
  ▪ Stigma attached to disclosure and use of self among scientific field of psychology
  ▪ Psychodynamic inheritance
  ▪ Fear of being judged by other professionals rather than by clients—interesting for future study

QUESTIONS:
  • Is “normal” different re: body discomfort (e.g., guilt after eating, discomfort sitting with fullness) vs. body dissatisfaction (feeling unattractive; comparing self to unattainable standards of societal beauty)
    o What is normal for women in American society? For recovered ED women?
    o How is normal defined?
    o Different for el vs. uma. Vs. alessandra (e.g., is exercise healthy or unhealthy for recovered ED individuals?)

  • More effective vs. more natural
    o How much is it stated or implied in the transcripts that recovered ED professionals are more effective?
      ▪ Eleanor and Uma think this is implied
      ▪ Alessandra thinks the participants are communicating that they have advantages without implying they are more effective
    o Do ED therapists draw more energy from ED clients to prevent burnout?

FUTURE STUDY:
  ▪ Disembodied vs. dissatisfaction—what is normal?
    o Are the triggers different? I’m not being heard, I’m in pain vs. unattainable American standards
• Do recovered ED clinicians experience increased body consciousness/discomfort during tough times and increased body gratitude during embodied times than what is typically “normal”?

CONSIDER in subsequent data collection and analysis:
• More effective vs. more natural—different meanings
• What is the role of increased “effectiveness” of recovered ED professionals in each transcript?