ABSTRACT

OVERCOMING AN EATING DISORDER: A NARRATIVE APPROACH TO LONG-TERM RECOVERY

by Jill Anne Matusek

Using the framework of narrative psychology, this study portrays women’s experience of long-term recovery from anorexia and compulsive overeating through performance based texts. This study aims to understand from an experiential perspective how recovered women make sense of their transition to wellness by presenting thick descriptions of the self-identified epiphanies and turning points contributing to their recovery. Using a qualitative method of semi-structured interviewing and an interpretive biographical method to understand each woman’s narrative, the texts are interpreted using the concept of personal positioning in relation to cultural master narratives. Viewing recovery as a process of re-storying the life story, the findings suggest that long-term recovery from an eating disorder involves spiritual commitment and purposeful engagement with communities larger than the self.
OVERCOMING AN EATING DISORDER: A NARRATIVE APPROACH TO LONG-TERM RECOVERY

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Introduction

Despite the considerable strides made in understanding the short-term treatment outcome of eating disorders in recent years, our knowledge of what constitutes full or long-term recovery from these life-threatening disorders remains largely inconclusive. Current attempts to draw connections among the array of women who have successfully combated these problems (or given up this lifestyle choice) have largely consisted of outcome studies or a few qualitative reports focused on individual accounts of personal insight and key turning points (Hardin, 2003). A third front has been the influx of personal memoirs dedicated to recounting personal struggles with anorexia nervosa (AN), bulimia nervosa (BN), or compulsive overeating (CO) (Bullitt-Jonas, 1998; DePree, 2004; Hornbacher, 1998; Liu, 1979; MacLeod, 1981; O’Neill, 1992; Rio & Rio, 2003). These accounts chronicle the grip the eating disorder has had on the individual’s life, but tend to gloss over the protagonists’ re-emergence from the long and painful journey of disturbed eating to healing and wellness (e.g., Hornbacher, 1998; O’Neill, 1992; Way, 1993).

Findings in the qualitative and personal memoir literature vary from stories of full recovery imbued with hope (Bullitt-Jonas, 1998; Hall, 1993; O’Neill, 1992) to stories of containment in which women never return to typical eating, but rather manage the chronic cycle of disordered eating and temporary remission of symptoms (D’Abundo & Chally, 2004; Hornbacher, 1998). Outcome studies, on the other hand, strive to assess both recovery and the effectiveness of different treatments. Collectively, these studies tend to reach vastly different conclusions based on the methods of assessment, length of follow-up, and the particular measures used. Generally the outcome literature focuses on physiological symptoms and whether or not a particular mode of therapy (e.g., cognitive behavioral therapy versus interpersonal therapy) has greater success reducing physiological symptoms rather than examining what long-term recovery actually entails. For instance, in one of the more comprehensive assessments of recovery via treatment outcome, Strober and colleagues (1997) found 76% of anorectics free of the physical symptoms of their disorder at 10-15 year follow-up. Alternatively, Deter and Herzog (1994) found the recovery rate for anorectics to be 54% when based on physical symptoms alone, but 41% when including psychological functioning at 12 year follow-up. However, if recovery from AN is solely based on weight restoration and the reinstatement of menses (or as in the case of BN, the cessation of binging and purging) then these recovery rates should be interpreted with caution because recovery from physical
symptoms is simply not enough (Richards et al., 2000). In addition to physical factors, a meaningful construct of recovery should incorporate the psychological and psychosocial factors along with the client’s subjective experience of how these changes have occurred over time (Redenbach & Lawler, 2003). Ultimately these recovery rates leave us with a superficial and diminished account of the actual experience of recovery.

Defining and Describing Recovery from an Eating Disorder

The conceptualization of what constitutes recovery from an eating disorder is complicated by differing definitions and criteria along with methodological differences across studies (Field et al., 1997; Richards et al., 2000). The wide variability of reported recovery rates for eating disorders (from 13% to 77%) illustrates the diverging viewpoints within the field (Jarman & Walsh, 1999; Keel & Mitchell, 1997; Strober, Freeman, & Morrell, 1997). Although recovery rates fluctuate depending on the definition and criterion, research clearly indicates that long-term recovery is typically achieved over the course of many years (Pettersen & Rosenvinge, 2002; Strober et al., 1997). Illustrating the lengthy duration of recovery, Lamoureux and Bottorff (2005) report women recovering within as few as three years to as many as 24 years, with Herzog and colleagues (1999) reporting an average of 7 to 10 years for achieving long-term recovery. One way this lengthy span of recovery can be partly understood is through individual differences and partly from diverging definitions and dimensions of recovery, such as, “I’m completely symptom-free” versus “I lapse on occasion, but my thoughts and behaviors are predominately different from when I was in the throws of my eating disorder.”

Recovery, as I currently conceptualize it, is the evolution towards accepting oneself and one’s body while relinquishing destructive behaviors and dysfunctional attitudes about food, weight, and body shape. This evolutionary process of self-acceptance and shift in focus from the self to something larger than the self fundamentally differs from the central focus and struggle with food, weight, and body image during the height of the eating disorder; although the difference need not be absolute. Recovery is not linear or fixed; rather it very well may be a life-long process. I present my starting point and position upfront to acknowledge that I am not an impartial observer, but someone who has worked with this population for two years in residential and outpatient settings with formulated beliefs about how eating disorders and recovery operate. Since it is customary for qualitative researchers undertaking an interpretive approach to state their position, I offer my viewpoint on recovery fully recognizing that “all inquiry reflects the
standpoint of the inquirer” (Denzin, 2001, p. 3). However, I acknowledge that this conceptualization does not adequately capture the multi-dimensional construct of recovery, and there is still much to learn about how the process of recovery unfolds. Moreover, I recognize that my conceptions are framed in the context of traditional psychology, medicine, and psychiatry—the very discourses that operated and defined the milieu I worked in.

Despite or maybe because of my traditional roots in inpatient units, I believe that an important starting point to stress is that recovery from an eating disorder comprises much more than freedom from the eating disorder’s rules, rituals, and symptoms. Ultimately, recovery from an eating disorder eludes a neat, concise definition. Perhaps the phenomenon can more readily be described by what it is not—that is merely maintaining a healthy weight and presenting the absence of medical complications as the dominant viewpoint of medicine and psychology suggests in the DSM-IV (American Psychiatric Association, 1994). Whereas weight restoration or weight maintenance constitutes a critical piece of the recovery process, this factor alone is truly a crude estimator of health and wellness. A rich conceptualization of recovery calls for an inclusion of the duration of improvement along with psychological aspects such as reduction in fears of fat, food, and body image disturbance. Additionally, a broadened construct of recovery should include psychosocial components such as social contacts, social, educational, and/or occupational adjustment (Manz, Deter, & Herzog, 1992; Noordenbos, 1992). In fact, eating disorders are often extremely isolating given the individual’s preoccupation with the disorder and strict adherence to the eating disorder’s rules and rituals. Women with eating disorders frequently find themselves with a very restricted range of options and choices for social development (Nielsen & Bara-Carril, 2003). The isolating nature of eating disorders bolsters the reasoning for including this variable to the study of long-term recovery, but the difficulty in evaluating psychosocial criteria accounts for its frequent exclusion in outcome studies and a majority of the literature. Correspondingly research suggests that sexual adjustment should be considered an indicator of recovery since women’s relationship to their bodies and bodily appetites for food and sex work in tandem (Richter, 2001). Furthermore, many women with eating disorders experience guilt and shame related to their bodies and sexuality (Richards, Hardman, & Berrett, 2007). Lastly, integrating a phenomenological exploration of the client’s individual subjective experience of change can provide a more robust portrait of recovery.

Direction of the Current Study
Given that a satisfying definition and description of the process of recovery and the endpoint/outcome of recovery continues to elude researchers (Jarman & Walsh, 1999; Noordenbos & Seubring, 2006), the current study attempts to understand and present women’s experience of recovery through an alternative approach—performative writing through performance based texts. Performative writing consists of storytelling by presenting the women’s own words with some artistic license on the researcher’s part in the form of performance based texts. Performance based texts often take the form of short stories, poetry, diary entries, dramatic monologues, and fictional personal letters (Denzin, 1997). The rationale for choosing a performative writing approach over another methodology (e.g., questionnaires or grounded theory) is to allow the reader to engage with and learn from the turning point moments in the women’s narratives which serve as justification for their individual recoveries. Naturally, the performance texts will not include all of the above listed domains of long-term recovery because the focus on the most crucial turning point moments will differ from woman to woman and will not necessarily encompass all of the domains (e.g., psychological, social, sexual). Rather the presentation of performance texts allows the recovered women’s lived experience to be brought to life for the reader. By highlighting and illustrating the ambiguous, nonlinear, and bodily process of the women’s subjective accounts of recovery, this study strives both to move the reader and to clarify the processes underlying long-term recovery. In effect, the presented performance texts offer the possibility of narrative enrichment, which Scheibe (1986) describes as the process of rendering a range of mysterious activities understandable that were previously puzzling.

The primary research questions this study addresses are the following: how is recovery from an eating disorder experienced by recovering/recovered women? How does it occur? What are the patterns that emerge across the differing accounts? What is it that these women ultimately needed in order to recover? Instead of focusing solely on the medical aspects of the disorders as others have done, this study examines the topic through a process-oriented qualitative approach grounding the work in the study of lived experience by studying the particular biographical moments that connect these women to the larger American public culture and its social institutions—the very same institutions that may have contributed to their problems with food and body image in the first place, such as the patriarchy or the media-saturated consumerism of the Western world (Denzin, 1997).
**Studying Recovery through Qualitative Methodology**

The advantage of using a qualitative approach is that it allows the researcher to understand in depth the client’s views on formative and responsible processes in their healing and improvement. Studying recovery through qualitative methodology also allows access to autobiographical, personal experience and subsequent meaning making out of these experiences. Moreover, attending to recovery qualitatively invites reflexive co-construction between the women interviewed and myself.

Recent attempts to elucidate the underlying processes of recovery through qualitative perspectives reveal that acknowledgement of the eating disorder as a problem often marks the beginning of the recovery process (Goldkopf-Woodtke, 2001; Peters & Fallon, 1994; Pettersen & Rosenvinge, 2002; Woodside, Kohn, & Kerr, 1998). In other words, being sick of “being sick,” an epiphany, or a turning point in viewing the behavior as problematic and necessary to change registers as a catalyst in the motivation for recovery. A variety of models gleaned from qualitative, client-perspective studies delineate middle and final stages toward self and body acceptance, refusal to let food dominate one’s life, feeling a sense of purpose, and developing an identity outside of the eating disordered persona (Keski-Rahkonen & Tozzi, 2005; Lamoureux & Bottorff, 2005; Pettersen & Rosenvinge, 2002; Reindl, 2001).

However, other accounts in the literature often find that recovery is not so neatly ordered. For example, Garrett’s phenomenological study (1998) suggests that recovery is not a final endpoint or achievement but rather an elastic concept including the fluctuation of advances and setbacks. It is fluid, constantly moving, never finished or an entirely complete journey with an “infinite number of variations” and “its fine details are different for every person” (Garrett, 1998, p. 42). Moreover, Garrett’s participants collectively spoke of recovery from AN, BN, and CO as a shift towards reconnection with themselves, nature, and others. Spirituality, in a variety of conventional and unconventional forms, emerged as a recurring theme in the journey towards improvement and reconnection (Garrett, 1998). Meanwhile, D’Abundo and Chally (2004) concluded that ultimate freedom from an eating disorder is unlikely; rather women tend to live with a milder form of their eating disorder for the rest of their lives. This study hopes to contribute to the literature by examining recovered women’s stories in terms of how they position themselves relative to the master narrative of the thin beauty ideal for women, i.e., thoughts and beliefs surrounding the preference and necessity for unrealistically thin female
bodies (Rodin, Silberstein, & Striegel-Moore, 1985; Stice, Schupak-Neuberg, Shaw, & Stein, 1994; Tiggemann, 2002) and the medical model’s master narrative of recovery from a disease of the mind and body (Chavez & Insel, 2007; Wilson, 2005; Wilson, Grilo, & Vitousek, 2007).

**Narratives and Recovery**

Although recent studies have attempted to answer similar research questions through grounded theory (Cockell, Zaitsoff, & Geller, 2004; D’Abundo & Chally, 2004; Lamoureux & Bottorff, 2005; Pettersen & Rosenvinge, 2002; Sharkey-Orgnero, 1999; Weaver, Wuest, & Ciliska, 2005), case study (Matoff & Matoff, 2001; Woodside et al., 1998), or textual analysis of internet chat room discussions (Keski-Rahkonen & Tozzi, 2005; Walstrom, 1996), the present study examines the topic through a narrative approach aiming to capture and present the women’s recovery experience through storytelling and performance based texts (Denzin, 1997). The argument for using narratives as the primary mode of collecting and interpreting data originates from the tenet that “speakers construct events through narrative rather than simply referring to events” (Mishler, 1995, p. 90-102 as cited in Chase, 2005, p. 656). The study of narratives “allows for a systematic study of personal experience and meaning of the events from the perspective of the active subject” (Riessman, 1993, p. 70). Because recovery in itself is a process of re-storying and reconstructing past experiences along with re-authoring how a life story will unfold in the future, eliciting personal narratives inherently makes sense. Narratives, by their very nature, retrospectively make meaning. The power of telling stories stems from their “ability to effect healing” through the medium of revealing the self as social beings to others (Garrett, 1998). Narrative accounts offer a richer and fuller portrait of recovery than a mere chronology or the sum of questionnaire scales (Chase, 2005). Through narratives I hope to understand not only what happened, but also to learn about the emotions, thoughts, interpretations, and why the accounts were shared in the particular ways that they were told (Riessman, 1993).

To clarify, there are two approaches to studying narratives summarized by Polkinghorne (1995) which are the analysis of narratives and narrative analysis. The analysis of narratives subjects the collected stories to an analysis of concepts from a pre-existing theory such as psychoanalysis or by inductively deriving concepts and conclusions from the stories themselves. In contrast, narrative analysis collects events and happenings and synthesizes them into a story or multiple stories (Polkinghorne, 1995, p. 12). This project uses the active approach of narrative
analysis and performative writing in order to attend to recovery stories that are often individualistic, messy, and incomplete. Performative writing includes the presentation of women’s experiences through a variety of formats such as short stories, poetry, and personal letters among many others. Just as recovery is constantly shifting and evolving, performance texts grant the flexibility for the individual’s meaning to be preserved and reflected upon and if done correctly move the reader by the evocative nature of the story (Denzin, 1997; Tillmann-Healy, 1996). Performative writing attempts to elucidate the present which makes this approach a suitable vehicle for understanding recovery because recovery concerns the present and future life of the individual. Moreover it mirrors the lived experience and “allows the reader to re-experience the events in question, coming to see the truth of the narrative that contains them” (Denzin, 1997, p. 267). Ultimately this study is concerned with the truth being produced through narrative. The performance texts “offer an imaginative truth as valid as the truth of literature; a poetic, if not an empirical truth” (Garrett, 1998, p. 36). Presenting evocative texts allows the recovery stories to be felt and sensed by the reader. The goal of moving the reader to feel and sense the experience of recovery may be for catharsis, reflection, or to move the reader to action. Evocative writing strives to bring the experience vividly to life so that the reader can reflect upon it and experience it themselves. All in all the strong connections between the body and the bodily experience of recovery from an eating disorder warrant a performative approach.

Previous Narrative Studies on Recovery from Eating Disorders

The relative scarcity of recovered women’s voices in the scholarly clinical research literature is quite remarkable given the metaphor of silencing and denying the self associated with eating disordered behavior (Saukko, 2000). For this reason, and the general importance of personal narratives for feminist theory and research, this study uses narrative methodology to answer the research questions. After an extensive literature review of previous narrative studies on eating disorders to date, there have been at least three studies addressing this line of research from a narrative perspective, one on anorexia (a blanket term for all eating disorders) by Catherine Garrett (1998), an Australian sociologist, and one on bulimia by Shelia Reindl (2001), an American psychologist. The third study conducted by two Australian nurses, Redenbach and Lawler (2003) focused on both AN and BN. All three of these studies provided a nuanced and complex portrait of recovery from an eating disorder. In the first study, Garrett concluded that eating disorders are “an extreme form of desire; a spiritual craving expressed through the body”
Furthermore, Garrett (1998) likened recovery to an abandonment of food/weight obsessions, a firm resolve to never again starve, binge, and purge, and no longer feeling cut off from oneself and others. In the second, Reindl (2001) concluded that overcoming bulimia involved coming to terms with the core sense of shame associated with needing and wanting, experiencing a sense of enoughness, recognizing and listening to bodily sensations, and learning to tolerate emotional distress. In the third, Redenbach and Lawler (2003) discovered that among their entire sample (N = 5) recovery occurred without formal treatment and that self-determination and self-acceptance promoted the women’s recovery from anorexia and bulimia.

Each of these narrative studies came to fairly different conclusions, which may be due to focusing on one versus all forms of eating pathology or a testimony to cultural, methodological, and/or disciplinary differences. Although many of the authors’ conclusions resonate with me as both a clinician and researcher, I wondered if their conclusions would apply to my participants. Would I find similar stories of recovery or substantive differences? Moreover, I wondered what impact their personal struggles with an eating disorder had on their data collection/write up, and how mine would fundamentally differ with having no such prior history.

Since no one study in this nascent domain can be considered definitive, the current study sought further knowledge on how women recover from an eating disorder. Although some researchers still question whether or not women actually do recover from an eating disorder, the more relevant question for this study was: how do women recover from an eating disorder? To do this, I interviewed women relatively far along in the recovery process to understand the motivations and progression recovery takes with the expectation that they had the words to describe the process without being bound by the conventions of traditional medical and psychological discourses as some younger recovered women might have been.

**Master Narratives and Positioning**

By incorporating an analysis of how these women’s narratives compare to the dominant master narrative of recovering from an eating disorder, i.e., recovering from a disease of the mind and body through pharmaceutical and/or psychological interventions, I explore in the discussion section how my participants position themselves and their experience of recovery in relation to the discourses of traditional psychiatry and psychology. To do this, I applied the concepts of positioning and master narratives. Thorne and McLean (2003) define positioning as “the social and emotional stances that individuals take vis-à-vis real or imagined others” (p. 171).
Elaborating further, Thorne and McLean explain that master narratives are those constructions upheld by people whom “have cultural authority, such as parents, teachers, doctors, or valued peers” (2003, p. 172). Master narratives are those culturally dominant narratives or positions that are regarded as the appropriate ways to experience and behave in the world (Mishler, 1995; Thorne & McLean, 2003). Within these delineated narratives of how the world is or ought to be there are concealed patterns of domination and submission that include and privilege some but deliberately exclude others. This project studies how women position themselves and their story of recovery in relation to the master narratives of the thin beauty ideal for women and recovery from a mental and physical illness.

Because the dominant master narrative of recuperating from an ailment of the mind and body frames people’s perceptions of recovery, this socially constructed dominant story does not necessarily include or fit every woman’s individual experience. All narratives were welcomed in the research interviews, including traditional master narratives and more subversive counternarratives that challenge the status quo. Alternative narratives and discourses were heard and examined in relation to the existing feminist, spiritual, and politically active literature on eating disorders (Bordo, 1993; Kraatz, 2006; Maisel, Epston, & Borden, 2004; Orbach, 1986; Peters & Fallon, 1994) and the master narrative of what is considered best practice within the field of clinical psychology (Wilson, 2005; Wilson et al., 2007). Part of the intention and methodological focus of interviewing women relatively far along in their recovery was guided by the expectation that this cohort would have examined some of the taken-for-granted assumptions underlying the master narratives of how women should look in American culture and how recovery from a mental illness such as AN, BN, or CO occurs. From a methodological standpoint it made sense to interview women well into their recovery because of the higher likelihood that this subset of recovered women would have tighter and more coherent narratives. This assumption was based on the knowledge that women with eating disorders experience a high incidence of relapse (60%) and a number of repeated hospitalizations (Gary, 2001). Given this information it seemed likely that long-term recovered women would frame their discourse of recovery separate from the medical model and those with a more complete recovery would have more coherent and tightly constructed narratives. In other words, they might resist and subvert the master narratives by repositioning their experience within a counternarrative or by finding an alternative discourse altogether.
Based on my review of the literature I deduced that some of these alternative discourses would be framed by feminist and culturally informed perspectives on eating disorders (Bordo, 1993; Lelwica, 1999). Bordo (1993) clarifies what these perspectives have to offer in relation to the dominant views of the medical model of eating pathology in her three part thesis. First of all, it questions the label of AN, BN, and CO as diseases of the brain; “instead it emphasizes the learned, addictive dimensions of the disorders” (Bordo, 1993, p. 54). Second, the feminist and cultural paradigms “reconstruct the role of culture, especially gender as central to these struggles” (Bordo, 1993, p. 54). This focus on gender is important because even though men are affected by eating disorders, for every one male sufferer there are still nine women (Maisel et al., 2004). Thirdly, this paradigm “shifts factors viewed as individual dysfunction by the medical model to ones of social causes” (Bordo, 1993, p. 54). Presenting and reading the narratives of recovered women under this theoretical lens naturally complimented this study’s aims and narrative methodological approach because feminist and cultural critiques are strongly committed to taking the perceptions of women seriously instead of discounting their experiences as psychopathological distortions caused by mental illness. Through feminist and cultural critiques researchers and clinicians are given the opportunity to read these stories as part of a larger story of societal problems. Hopefully, such an approach will extend our understanding of recovery and contribute to the current body of literature attempting to understand this phenomenon.

Bordo (1993) offers in her socio-cultural analysis an explanation of how the manifestation of eating disorders in our current cultural climate reflects society’s ills. She argues that our historical disdain for the body, fear of losing control of our bodies, and the meaning behind our contemporary beauty ideals map onto three axes for understanding eating disorders culturally. The first axis, the dualist axis, refers to the tendency to split the material and bodily experiences from the mental and spiritual realms. In the case of eating disorders, women experience their bodies as alien or not self/not me. The corporeal body is viewed as a confining limitation and enemy that threatens all and any attempts at control. The anorectic’s or bulimic’s answer to the competing agendas of the mind/body split is to gain control of the body by becoming disconnected and unaware of its distractions by ceasing to experience hunger and desire. Achieving a thin body or non-body is the closest thing to attaining “absolute purity,
hyperintellectuality, and transcendence of the flesh” (Bordo, 1993, p. 147). The second axis, the control axis, refers to contemporary culture’s obsession with controlling the unruly body. In eating disordered individuals, their identification is with the mind (or will), ideals of spiritual perfection, and fantasies of absolute control. Fundamentally the pursuit of self-denial is an end onto itself steeped in the belief of the purity it bestows. A sense of accomplishment results from the anorectic’s achievement of bodily control. In the third axis, gender/power, femaleness is associated with voracious appetites (for food and sex) and with wanting and needing too much emotionally whereas maleness is associated with higher intellectuality, greater spirituality, and more strength of will (Bordo, 1993, p. 160). The attempt to achieve the thin body or non-body strives to attain all of the mental/spiritual elements associated with maleness by whitling away all of the excessive neediness and fleshiness associated with the female body.

In addition to feminist and cultural critiques, the present study contributes to the existing body of literature regarding the role of spirituality in recovery from eating disorders. Coupled with the aforementioned theoretical lenses, this study strives for a more concerted examination of the disconnection from the body, self, imagination, and the sacred by primarily focusing on the avenue of reconnection to these aspects through recovery. To this end I inquired about dreams, the imagination, and other creative outlets as they relate to processes of recovery. By attending to and inquiring about the spiritual, political, and imaginative, this study strives to acknowledge the multi-dimensional facets of eating problems that many recovery studies overlook.

**Spirituality and Eating Disorders**

Recent scholarship examining the relationship between eating disorders, recovery, and spirituality has found growing evidence that women who have recovered from eating disorders believe that spirituality was an important factor in their healing and recovery (Garrett, 1996; Garrett, 1997; Garrett, 1998; Hall & Cohn, 1992; Hsu, Crisp, & Callender, 1992; Jersild, 2001; Liu, 2007; Mitchell, Erlander, Pyle, & Fletcher, 1990; Morgan, Marsden, & Lacey, 2000; Rorty, Yager, & Rossotto, 1993; Ryerson, 2005; Smith, Richards, Fischer, & Hardman, 2003). Prior to reviewing these survey, interview, case, and correlational studies I will define what I mean by spirituality. Pargament (1999) defined spirituality as “a search for the sacred” (p. 12). Agreeing with this definition, references to ‘spiritual’ or ‘spirituality’ in the current study also encompass “all of the invisible phenomena associated with thoughts and feelings of enlightenment; vision, harmony with truth; transcendence; and oneness with God, nature, or the universe” (cf. James,
Spirituality, in all of the previously cited and current researchers’ terms, incorporates more than traditional notions of a Higher Power, a moral code to live a good life by, and the intangible truths of the world in which we live. In this study, references to spirituality also include connections (or reconnections) to a meaning or purpose greater than oneself, be it through the natural world, animal kingdom, interpersonal relationships, or political engagement. Put most broadly, spiritual should not be equated with ‘religious’ which Pargament (1999) defines as “the search for significance in ways related to the sacred” (p. 12). Although spiritual matters invariably include theological references to God or a Higher Power and the ultimate meaning or purpose of human life, these religious constructions do not automatically discount other spiritual constructions that are not religious in nature. For some the spiritual is inherently tied up with the theological or religious, whereas for others the avenue towards meaning and understanding the ultimate questions of life will be through alternative explanations, no less spiritual than their counterparts’ more theologically oriented explanations.

As mentioned earlier a brief review of the eating disorders literature regarding the relationship between spirituality and recovery demonstrates that “perceptual, emotional, and spiritual relationship experiences have great long-term impact on healing, change, and recovery” (Richards et al., 2007, p. ix). For instance, Mitchell et al. (1990) reported in their follow-up study of women with BN that

the single most common write-in answer as to what factors had been helpful in their recovery had to do with religion in the form of faith, pastoral counseling, or prayer.

Since we had not inquired about this systematically, we were somewhat surprised by the number of these responses and decided this should be explored further (p. 589).

Further inquiry led Mitchell et al. (1990) to conclude that spiritual issues are important to many women’s recovery from bulimia. Echoing Mitchell and colleagues’ (1990) findings, Jersild (2001) depicted case examples of patients who described their faith in God as most helpful in their recovery from their eating disorder. Similarly, Morgan et al. (2000) provided case examples where Christian beliefs provided containment for maladaptive behaviors and negative affect through a sense of belonging to a religious community.

In Liu’s (2007) book on long-term recovery from eating disorders she found spirituality and activism to be crucial for women’s sustained recovery. Among the 30 women she interviewed, she found that by “cultivating self-transcendence through prayer, meditation, art, music, and religious studies” many women “found sources of meaning beyond material
possessions” (Liu, 2007, p. 64). The women in Liu’s book further described “returning to health to become more connected with the world at large by [socially and/or psychologically] relocating to a different kind of community or culture” (Liu, 2007, p. 85).

In Hall and Cohn’s (1992) follow-up survey of 366 recovered bulimic women, 59% of the respondents identified “spiritual pursuits” as being very helpful in their recovery. Hsu and colleagues (1992) conducted six interviews with recovered anorexic women to find out what they regarded as helpful in their recovery. One woman reported that her religious beliefs and faith in God was instrumental in her recovery from anorexia. Since Hsu et al. (1992) did not inquire about spirituality or religious beliefs in their interviews, it is unclear whether or not it played a part in the others’ recovery. In Ryerson’s (2005) book of seven case examples one recovered bulimic woman attributes her recovery to surrendering to God’s will. In Rorty et al.’s (1993) interviewing of 40 recovered bulimic women, many women found the spiritual aspects of 12-step programs to be an important component of their healing process. In Garrett’s (1996, 1997, 1998) interviews of 32 recovered eating disorder patients she found that “recovery requires an experience of something (a material reality and/or an energy) beyond the self” be it called “spirituality, love, God, or nature” (Garrett, 1996, p. 1493). Although a variety of other survey studies and case reports have pointed to the importance of attending to spiritual issues in recovery from eating disorders, Smith and colleagues’ (2003) correlational study found that improvements in spiritual well-being were significantly correlated with positive gains in overall psychological functioning and attitudes about eating and body image.

A more theoretical argument supporting the relationship between spirituality, eating disorders, and recovery is found in Starving for Salvation: The Spiritual Dimensions of Eating Problems among American Girls and Women (Lelwica, 1999). The connections among these three topics becomes exceedingly clear in Lelwica’s compelling argument that women in distress previously turned to the principles and customs of their religious traditions to help them make sense of their lives and create a sense of purpose in relation to the greater cosmos. But in today’s postmodern world where traditional religion steadily loses its clout, girls and women still find themselves in need of a “network of meaningful symbols, beliefs, stories, and rituals” to ground themselves in and make sense of their experiences (Lelwica, 1999, p. 7). According to Emmett (1985), women’s devotion to exercise and weight control have filled this void and become their “small ‘g’ gods,” filling the space previously occupied with a larger sense of purpose or
connection to a Higher Power. Instead of turning to organized religion to meet these needs, women are coming to understand what it means to be female in American culture through the “media-saturated and consumer-oriented culture’s secular salvation myth of female slenderness” (a.k.a. the thin-ideal) by curbing and controlling bodily appetites and appearances (Lelwica, 1999, p. 7). Such attitudes, beliefs, and practices are so ubiquitous that even most so-called “normal” and “healthy” women in our culture regularly use diet products, no calorie, sugar-free, fat-free foods, and specialized exercise equipment to shed excess unwanted flesh. Yielding considerable control over its followers, this powerful media-inspired cultural myth promises salvation and happiness through achieving the ideal weight and by attaining the perfect body fat percentage.

Through Lelwica’s examination of the historical shift from a predominantly religious-oriented culture to a secular, profit-driven, media-saturated one, she delineates how similar the “obsessive, ritualizing, ascetic, and devotional aspects of anorexia and bulimia resemble features of traditional Christianity” (1999, p. 7). Much like Garrett, her analysis of religion, gender, and culture suggests that eating problems point to spiritual hungers for a sense of meaning and wholeness that women embody through their mastery of the flesh which is most strikingly apparent in women with full-blown eating disorders. In addition to the body of literature supporting the influence of religious and spiritual matters in recovery from eating disorders already reviewed, Maisel et al. (2004) speak of the role spirituality plays in assisting women to reclaim their lives from AN, BN, and CO. They argue that spirituality can “profoundly link a person to herself and the world around her” after an eating disorder has “cut a person off from herself and disengaged her from the world” (Maisel et al., 2004, p. 173). Maisel and colleagues’ (2004) argument supports the broader empirical evidence that spiritual practices promote physical and emotional healing beyond the realm of eating disorders (Benson, 1996; Borysenko & Borysenko, 1994; Richards et al., 1997).

Based on recent work supporting spiritual and/or political alternative discourses for achieving recovery (Garrett, 1998; Hall & Cohn, 1992; Hsu et al., 1992; Lelwica, 1999; Lewis, 2001; Maisel et al., 2004; Mitchell et al., 1990; Richards et al., 2007; Rorty et al., 1993), this project listened for rich stories of recovery instead of simply determining whether or not these women are completely free from their physical symptoms.

Method
Participants

I interviewed a total of eight women who self-identify as “recovered from an eating disorder” and now consider themselves to be fully recovered or well into the process of recovery. My faculty advisor, Roger Knudson, interviewed some of these women together with me. All of the participants ranged in age from 18 to 55 years old. Because I sought women far along in the process of recovery and many women with diagnosable eating disorders years ago would have gone undiagnosed by a health professional, this research was not limited to those who have been clinically diagnosed with an eating disorder. Moreover, due to the fact that medical records are not obtainable and many women hide their eating disorder and/or never seek treatment for it, this study relied on the participants’ self-reported incidence of an eating disorder. Participation was limited to women who identified having an eating disorder at some earlier point in their lifetime, but do not currently struggle with their eating disorder to the extent they did in the past. None of the participants was currently in treatment for their eating disorder.

This written report focuses on three participants: Heidi, Pamela, and Virginia. These three were selected among the eight participants because their narratives were more complete, coherent, convincing, and exceptional. From a methodological standpoint Hillman (1986) advocates studying the exceptional cases over the more typical cases. Hillman’s argument for studying fewer exemplary cases over a larger number of typical cases suggests that any number of typical cases does not equal one exemplary or exceptional case. By focusing on fewer more exceptional narratives instead of a larger quantity of impoverished narratives, understanding of the phenomenon is enriched. The narratives shared by Heidi, Pamela, and Virginia were richer, more coherent, and more tightly woven compared to the other women’s narratives. Each of these three women has spent considerable time thinking through her recovery, and these three women were more articulate in sharing their accounts than the other five women I interviewed. To guard against the critique that I selectively chose these three women because their stories meshed with what I hoped to find or that these three stories are simply the base rate of finding spiritual or communal elements among a sample of recovered women, it is important to note that spiritual and communal elements emerged in the excluded participants’ stories. For example, a major part of Frances’ recovery had to do with rescuing cats and reconnecting with her self and the world through relating with the animal kingdom. Another example of community engagement emerged in Jenna’s story where returning as a recovery speaker to her treatment
center and being interviewed by a local paper on her recovery story gave back to the community of women currently struggling with eating disorders. Each of the five excluded stories offered valuable information; however the three selected stories were simply better examples and clearer illustrations of long-term recovery from an eating disorder. Profiles of Heidi’s, Pamela’s, and Virginia’s current life circumstances and status regarding food, exercise, and body image are included below for the reader to assess their level of recovery (see Appendix A for thumbnail sketches of the other five participants not presented in this written report). All three of the women opted to retain their true first names and requested that I disguise any potentially identifying information (with the exception of Virginia who was not concerned with disguising potentially identifying information).

Heidi, 45, works as nurse. She is married with two young children. Her struggle with anorexia began at 15. Her starting weight was 153 pounds, and her lowest weight was 103 pounds at 5’8.” She was nearly hospitalized, but never received any counseling at the time. Her recovery began at 16 when she had a glimpse of her true form in the bathroom mirror but has spanned the course of many years. She is currently very active in her church community and teaches a 7th and 8th grade girls Sunday school class.

Pamela, 24, is a social work student working on her masters. She is in a committed relationship with her boyfriend, and they are in the process of adopting two foster children. Her struggles with weight began in high school when she decided to become anorexic to get out of an unbearable home situation. She identifies the onset of anorexia at age 16, and her lowest weight was 85 pounds at 5’6.” Her recovery began after she entered an eating disorder residential program at 17 and continued when she found feminism at 19. Pamela does not currently engage in any form of regular exercise other than occasional yoga. She reports the absence of any eating disordered behaviors and characterizes her current caloric intake as healthy, vegetarian, and calorically lower than average. Currently she weighs 115 lbs. at 5’6.”

Virginia, 55, works as a massage therapist. She is divorced with one daughter and one grandchild. She developed an over-concern with her weight and shape around age 12 when she began binge eating. She was at her heaviest weight of 192 pounds at 5’6” and 15 years of age. Until age 40 she cycled between periods of binge eating and restricting. During periods of restriction she used laxatives and fasted. Her weight fluctuated between 117 lbs., her lowest weight, and 160 pounds. She identifies her recovery as a mental shift that occurred at age 40 fueled by spirituality. In the past 15 years she has shifted her compulsive energy into thrift store clothes shopping instead of food. Today she weighs 140 pounds at 5’6.” She exercises four times a week including cardio circuit strength training, yoga, walking, and dancing. Meditation is her most important practice, which she does daily.

Procedure
I interviewed women who self-selected in response to advertisements in the *Oxford Press, Dayton Daily News, Hamilton Journal,* and *Fairfield Echo* newspapers. Recruitment also extended to flyers posted around campus, the Women’s Center electronic newsletter, and postings on national eating disorders websites.

After obtaining informed consent, participants partook in informal semi-structured interviews about their experiences of recovery, how they define this phenomenon, and what meaning it has in their lives. Due to the sensitive nature of the topic, participants were given the option to review the interview guide prior to the interview; however none of them chose to do so. Participants were also invited to review the transcription and the researcher’s interpretations in a post-analysis follow-up interview to allow the women the opportunity to clarify, contribute, and/or correct my readings of their stories. Virginia was the only one who did this in person while Heidi and Pamela opted to do this via email. The interviews lasted one hour each, and every participant was interviewed over the course of one to three separate occasions depending on time constraints and the amount of information shared.

Data collection was guided by the general prompt: “I’d like to hear the story of how you gave up your eating disorder (or for participants who identified themselves as recovering: what do you think the process of recovery will involve?”). I used the attached interview questions (Appendix B) as a guide, but allowed for the flexibility of going in the direction the interviewee indicated. These interviews were framed by broad questions and supplemented by probing clarifying questions (e.g., Can you tell me more about that? What was the experience like for you?). Regarding the place of spiritual or community engagement, these topics were not imposed upon the participants of this study. If not brought up on their own accord, I inquired if any particular spiritual, philosophical, or political beliefs influenced their recovery or how they think about their own femininity in our current American culture. Notably Heidi, Pamela, and Virginia all brought up spirituality, activism, and community involvement on their own accord without being prompted by the interviewers. The fact that these three women described spiritual and community engagement in their recovery stories without any initial prompting from the interviewers suggests that these three accounts emerged spontaneously and are consistent with the studies reviewed above that place spiritual and communal dimensions as central to recovery.

I audio-taped the interviews and transcribed them in their entirety. These transcripts are my primary data. Under the guidance of Denzin’s framework of interpretive interactionism
the women’s accounts of their private troubles with an eating disorder and the turning point moments (or epiphanies) that led to recovery were read and analyzed in relation to the public issues, policies, and institutions that have been created to address this very personal problem. This approach compliments this study’s aims and research questions because eating disorders, like alcoholism, are personal matters with structures like treatment centers and outpatient therapy programs in place to deal with them. Yet there is a disconnection between the efficacy of these applied programs and a meaningful understanding of what recovery from eating disorders actually entails. Through this project’s examination of how women actively experience their eating disorder and recovery, I strove to better understand the phenomenon of recovery by specifically attending to their turning point moments. This project’s biographical, interpretive method focused on understanding and extracting meaning from interpreting the biographical, interactional, and historical accounts that speak of turning point moments in women’s recovery from anorexia and compulsive overeating (Denzin, 2001; Hardin, 2003). The focus on turning point moments attempts to draw the reader into the texture of the experience and the power that these epiphanal moments held for the individual women. While some of the surrounding context is lost without the fuller account, the heart of the story resides in the epiphanic turning point moments. Bear in mind the presented performance texts and interpretations offered are one set of interpretations; they are not claiming to be the interpretation.

The undistilled, raw accounts gathered from the interviews allowed for a dialogical exploration (between interviewer and interviewee) of the associations, contradictions, and omissions of their stories without imposing tidy premature conclusions. Emersion in and comprehension of these interview data afforded me the opportunity to actively engage with these stories, “discerning what phenomena are experienced as helpful in the process of recovering; how such phenomena are experienced as helpful; and how these phenomena interact with one another in real, lived experience” (Reindl, 2001, p. 299). Collaborating with the participants to make sense out of their experience, creating a space for their voices to be heard, and writing their stories with them and for them truly fostered increased understanding of recovery.

**Approach to Understanding and Reading the Narratives**

All of the narrative accounts were read as texts embedded within the larger master narratives of control, Western culture, capitalism, desire, gender, and power. Women’s personal
recovery stories were read alongside the larger-scale master narratives that shaped their eating
disorder and subsequent experience of recovery. The storied approach to narrative taken in the
current study read or re-read these stories in relation to the larger master narratives they are
embedded within and re-position against. This approach “reflexively embeds the reader (and
analyst) in the text’s multiple material and historical realities” (Denzin, 1997, p. 233). In order
to achieve this, the co-constructions of the participants’ personal turning point moments (of their
fuller recovery narratives) are presented as performance texts and interpreted in the discussion
section using concepts originating from Garrett (1998) and Lelwica’s (1999) argument for
attaining recovery through spiritual practices, Bordo’s (1993) feminist reading of women being
forced into dominant master narratives, and Lelwica’s (1999) recovery model of changing
individual consciousness through community engagement.

Using Denzin’s (1997) model to read and write about narrative in a storied way, I first
obtained accounts of recovered women’s words and experiences. Secondly, I located the
participant’s experiences in theoretical terms and within the socio-historical forces shaping her
everyday biographical life and more particularly her tale of recovery in the discussion section.
Lastly, I discuss the individual women’s experiences of recovery within the concepts of re-
positioning or creating an alternative discourse to live a meaningful and fulfilling life as a
woman in today’s contemporary American culture.

Performance Texts

More than two decades later I realized that recovery was in many ways more
complicated than the eating disorder itself (Liu, 2007, p. 23)

The performance texts presented below invite the reader’s active participation and
interpretation. The stories primarily consist of the women’s own words from the interview
transcripts and sparingly include my own. I attempted to remain true to the women’s original
account but took some artistic and creative liberty in presenting their stories. Most of the words
in the performance texts are the participants’ words, but I gave myself permission to juxtapose
parts of the interview that did not originally follow side by side. All of the presented
performance texts were shared with the original storyteller who was given the opportunity to
revise the text to fit her experience. None of the women chose to further alter the performance
texts.
In spite of the fact that all of the presented performance texts are only a part of a larger story, each one remains true to the described ephiphanal turning point moments of the women’s respective recoveries. The parts of the stories presented were selected because they speak to these critical junctures or turning point moments. In order to show and avoid telling the reader how the performance texts should be read, the performance texts are presented without interruption. The purpose of presenting the stories in this format is to evoke empathic, emotional understanding of the core of the experience without interpreting the story for the reader. A discussion of how I read and understand the full transcribed accounts follows the presentation of the performance texts.

Heidi’s Story: Revelation in the Mirror

“For we walk by faith, not by sight” 2 Corinthians 5:7

The presentation of the following fictional letter written from Heidi to her adolescent daughter on her confirmation retreat day was inspired by my own moving experience of receiving spirit day letters from my family on my confirmation retreat day 12 years ago. Many of my peers and I found our parents sharing very personal parts of themselves and saying things they normally wouldn’t say in daily casual conversation in the format of a spirit day letter which was intended to show how much they cared, loved, and supported the adolescent about to be confirmed in the church. Confirmation is one of the seven sacraments in the Roman Catholic Church that seals you with the gift of the Holy Spirit and initiates you into adulthood in the eyes of the Church. Unlike the sacrament of baptism, confirmation is the time when the child becomes an adult in the church by choosing the faith as their own, not something that is passed down to them from their parents as in the sacrament of baptism. It is a renewal of the baptismal vows as an adult and a public confirmation and statement of taking on the Catholic faith as your own. A new confirmation name is taken as a symbol of the renewal and rebirth of the child becoming an adult in the eyes of the Church.

Dear Libby,

I’m writing this to you so you can understand what I went through and how I emerged from my struggles with food, shape, and weight. It is my fervent prayer and hope that you never experience or go through what I did, but as you reflect and read all of these letters on this day of your confirmation retreat, I hope you can understand how the hand of God and the church community touched and changed my life. Realize that this is truly your decision to decide as an adult whether or not you truly want to embrace this faith as your own. Weigh and discern your decision carefully. Don’t just decide to be confirmed merely because you were born into this faith, it was passed on to you, or because it’s what is expected of you.
Speaking to you as an adult, mother, friend, and woman I want to explain how He knows every part of our history—that little girl, the woman, and everything in between. The best way I know how to talk about this is to go way back, back to the summer of 1977. Now I realize it must be hard for you to think of your mom as being a little bit older than you are now, but at the age of 15, I gradually became less and less comfortable in my own skin. I remember thinking I was ugly, goofy, and no boy would ever pay attention to me. So I put myself on a diet. Before long that diet turned into something more, and the false promises of being thin and becoming thinner had me believing that happiness was almost within my grasp. It just barely escaped me. It would be mine if I could only lose a few more pounds…then I’d really be happy, truly happy. Then I might feel better about myself, boys would notice me, and all of those feelings that sat in the pit of my stomach would go away. If only I was a thin person, then I’d truly have no problems.

You know what I’ve learned? Well, a lot of things actually. Well first of all, thin people have problems too. And while losing weight seemed to be the ultimate answer for all of my problems, guess what? It was never enough. Granted, it felt good for a little while. But I still had problems, and I had low self-esteem even at my lowest weight. What’s really sad is that I felt fat the whole time. I never felt thin enough, and I could never be satisfied or attain that elusive promise of happiness. Well, not through dieting and starving myself anyway. I learned this lesson the hard way. But I was lucky really. At least I was able to get myself out of it.

I guess I really shouldn’t say that I got myself out of it. That’s a little presumptuous and not exactly how it happened. The doctors really didn’t know what to do with me or even what I had at the time. At one point they thought I had leukemia, but once they ruled that out the doctor told me if I didn’t gain weight he would put me in the hospital. Now I probably should have been more scared, but I just thought that everyone was OVER-REACTING. What they saw wasn’t my experience. Sure they were entitled to their opinions, but it just wasn’t what I saw. I kept seeing FAT, FAT, FAT!

Now you’re probably going to laugh, but the real turning point in my recovery from anorexia happened in the most unlikely place—the master bathroom at grandma and grandpa’s house. I remember it vividly. I was stepping into the shower one morning. Just like any other day, I walked past the mirror that hung over the sink. As I walked over to pick up the fluffy terry-cloth towel for after my shower, I happened to glance over and see my naked body
reflected in the big mirror. It was me, but it was not the me I’d been seeing for the past few months. In that instant, a flash really, I saw what everyone else had been seeing and harping about all this time. I saw for the first time, and the only time, as others saw me—emaciated. I looked hollow and frail. I saw myself and I thought, “Oh my goodness is that me?” And then it was gone. It wasn’t anything that lasted. It was in a flash really, but it jarred something in me and made me willing to listen a little bit to what other people were saying. That glimpse of myself in the mirror may have saved me. It really was a revelation of sorts. Looking back now, many years into my recovery, I see that really as a gift from God. For in that moment He granted me the grace to see me as I truly was. Momentarily the blinders were lifted from my eyes. What I saw scared me. It really scared me. But I’m thankful for that fleeting moment. It very well may have saved my life because it opened me up and allowed me to really hear what others were saying.

It was really just the beginning of my recovery that is continuing to this day. Eating used to be the central thing in my life, and now it is not the central thing in my life anymore. Now it’s just a carpetbag that I carry around with me. My family, my friends, my faith, and my church are really the focus now. I’ve been so enriched by finding this community of believers. I have something to hang on to. I have something that is never going away. When I was receptive and open to His will I found great comfort and strength in ministering to other young women struggling with disordered eating and poor body image. You probably don’t remember this, because you were quite small when I first began teaching Sunday school to 7th and 8th grade girls. By helping girls who struggle with the same thing that I went through I have found complete meaning for myself, and I have everything I need in my relationship with God, my family, and the church community. I feel like God has been taking care of me the whole time—just as He’s been taking care of you the whole time. I hope you can realize that and see how much He’s carried you through your life up until now and will continue to do so. Love,
Mom
Pamela’s Story: Finding Our Voices

*Jill: What advice would you give someone struggling to conquer an eating disorder?*  
*Pamela: I would definitely tell them to become some part of a community of women.*
Pamela presented her difficulty with anorexia as a volitional decision she made as a last resort to get out of her family’s unbearable, emotionally abusive home environment. Inspired by all that she learned from school health classes she opted to take matters into her own hands since none of the trusted adults she turned to (such as her teachers, school counselors, and children’s services) listened or did anything about what was going on in her home. Pamela figured that these same people would be forced to respond if she was physically ill from all of her emotional pain. However, she recognizes that what initially began as a volitional act soon took control of her even after she went to live with an aunt and uncle. A key turning point in her recovery process was reconnecting with people and beginning to have trusting relationships with them. Furthermore, finding feminism and getting connected to a community of women in college moved her recovery forward. The name of the group she found at her college’s Women’s Center, Finding Our Voices, captures her experience of how she not only found her voice, but also found healing through relational connections to individuals and to a larger community of women.

**Finding Our Voices**

*I went to Renfrew for one week  
To jumpstart my recovery.

The feminist, woman-identified environment there  
Was a tremendous source of support for me.

To this day I never felt as nurtured,  
Whole,  
Or secure  
Anywhere  
As I did at Renfrew.  
When you’re only there for a week  
I wonder,  
“How can I carry that with me  
Through years of recovery?”

It had such an impact on me.

It was very woman-identified  
With women  
Of all ages  
From little girls,  
To middle aged,  
And elderly women.  
And everybody  
Really listened.

A woman my mom’s age  
Would be talking and remember something
From my story and ask me to talk.
They would all listen and be responsive to what
I said.

Everybody there
Treated each other
Like an equal
Which was critical
Since I had so many issues
With adults not listening to me.
It made a big difference.
That sense of community
Just felt wonderful
Because there were so many women there.
And it taught me how women can interact
In a healthy and supportive
Loving way.

People really listened to me at Renfrew
But the most long-lasting thing for me
Was the sense of community.
The supportive women
Taught me what healthy relationships are like
And how they are not.

I felt real awe & admiration
Toward the recovering women there
Like it would be disrespectful
Not to try my hardest to get better.
The social pressure stayed with me
Long after I left Renfrew.

I developed a respect for my body
And a loathing for eating disorders
When I saw how many women
It hurt.
I guess I felt
A spiritual, moral obligation to get better.
I have great admiration and humility
For all the women I’ve met struggling with eating disorders.
I started with emptiness
But got filled up with love
By thinking about others.

I found a very similar kind of thing
At the Women’s Center in college—
That wonderful sense of community
And that physical space
Where you could hang out.
You could tell everybody
About a bad day you had.
They were my surrogate moms or sisters.
I just loved it there;
It felt like coming home.

So that’s where I learned about feminist theory,
And I became a politically active feminist
In my junior year in college
When a feminist philosophy professor
Helped me make a big intellectual connection
Between feminist models of thinking in relation to children & maternity.

I’ve carried that with me into my work as social worker.
I wouldn’t be nearly as effective working with women in poverty
If I hadn’t had personal and professional relationships with other feminists.
I see these women as my sisters.

The security of these relationships
Also gave me a sense of what
I wanted and needed
In relationships with other women.
And then there’s my boyfriend and partner
Who was pivotal in my growth throughout my recovery.
That relationship truly jump-started and furthered my recovery.

I see my recovery from anorexia
As a kind of parallel to feminism.
When I was anorexic
I didn’t have any sense of empowerment
Or feeling good about myself.

Yet the more I grew into a strong person
Into a loved and secure person
Into a feminist
Into an intellectual
And the more I’ve become comfortable with my flaws, fears, and emotional weaknesses
The more I’ve recovered.

Virginia’s Story: The Last Big Vestige of Shadow

Virginia: I’m so much happier, but it wasn’t until I was 40 that it clicked in my head.
Roger: So how did that happen?
Virginia: Spirituality. I've never not been a seeker...and meditation

The dramatic monologue presented below attempts to illustrate and integrate the turning point moments of Virginia’s 54 year old narrative. Virginia started off her narrative in 1953 when she was diagnosed with the last surge of polio before the vaccine became readily available. Like an undercurrent throughout her life, the story of her eating disorder and recovery contains memories from second grade, middle school, high school, college, young adulthood, and her current life as an activist, writer, and small business owner.

The last big vestige of shadow hung like a pall, enveloping and engulfing me. It had always been there in some form. The shadow I’m referring to is the power my eating disorder held over me. To me, my eating disorder was in my head. It was guilt. Shame. I learned from a very early age to supplant my nervousness, my anxiety, my embarrassment, and my sadness with eating. In many ways the deck was already stacked against me. Growing up I lived next door to a homemade ice cream parlor, and my family was very dysfunctional about how we used food. My parents and grandparents were farmers, and they eventually became diabetic and overweight cooking everything with lard and butter. But I rebelled against that. In this case it was a good rebellion. I returned to the earth and became a vegetarian and a great flower-child much later.

But before the hippie movement, what was instrumental in developing my eating disorder and first starting to lose weight was when I had my second polio operation at age 12. I was overweight and the doctor wanted to put on me on a 1000 calorie diet. And I remember this little snarl-like interlude we had. I was teasing with him and said, “Well, why don’t you just make it 800?” And he crossed it out on the chart and made it 800 calories. And I started losing weight; that was the first time I felt empowered. It was life changing. I started binging shortly after that. Now I dieted and overate before age 12, but going on this rigid diet was a real turning point. Prior to this and as early as second grade I can remember having this ritual where I would cocoon up on the couch and soothe myself by eating canned plums in a thick, heavy syrup. But it was after the second polio operation and being put on this rigid diet that the binging really started. There was a lot of shame associated with the fact that I ate beyond being full and was sneaking food. It was almost a sinful feeling. I didn’t feel sinful about having had polio, but the eating until I was overly full…that was all by my choice and doing. I knew it was a seeming weakness that I would overeat—a weakness of willpower actually.

I was ashamed of it. I continued to lose weight, but I was ruled by it. I was ruled by whether I followed through on what I said I was going to do and ruled by my weight. It was real
cyclical. I did extreme things like fasting and laxatives. I did whatever diet was going on, and I always lost weight. I was always in control for a little while. And I did all of this until I was 40 years old. Nobody knew—not my sister—no one. Well my husband knew about the laxatives, but he didn’t know that I was really binging. It was my struggle—always very, very internal. I see that now. At the time I felt like I had my life in pretty good balance…except for this. And when I got that under control then I would be okay. And that’s kind of true only I really did it the other way. I got okay and then it became a non-issue.

It wasn’t until it finally all clicked in my head that my recovery got underway. But what I say cured me was this big realization and how to achieve it. What I finally realized at 40 was that dieting takes energy, and the resistance to dieting takes energy. If you focus on weight you’ve got weight. If you focus on a problem you’ve got a problem. At last I realized I should focus on what I want, which is not the body. It’s balance. So I figured if I returned to the most basic denominator, then I’d cure my obsession. I realized earlier that it wasn’t about food because once I had my weight “under control” that compulsive energy would take over in another way like wanting to shop compulsively. If it’s a resistance thing that is, if you think you’re making yourself be that way, it takes too much energy and human beings can’t sustain it because we ebb and flow. So I began trying to achieve balance instead of weight—thinking of balance. So I realized that meditation and visualization needed to be important factors. So I do that and yoga…when in doubt meditate. That means quiet your mind because I need balance no matter what, and the world is not balanced. If we can’t balance the world, we can only balance ourselves.

I think I finally believed I was balanced because I started focusing on a different thing. I finally stopped focusing on weight. That was what made the shift happen. That took a lot of reading and understanding which made me realize that people in college are way too young to take philosophy. I mean those were older people who came to those realizations, and that’s why they came to them because they lived those long, full lives. I think it’s the same way in this; you have to have the wisdom of experience and working at yourself. But I’m always working on myself and still am to this day.

I’m so much happier now that I finally “got it” thanks to practicing meditation and believing that I could bring into being what I wanted. I think if you meditate long enough it sneaks up and gets you. It may feel like all of a sudden, but actually it was something you’ve
been working on for a long time. It slowly chips away at you or you at it, but finally there’s a paradigm shift. That’s exactly what it was…it’s a whole belief system. I nudged a belief system and turned it into a different thing. I finally believed I was not overweight. It was like the last big vestige of shadow. Although I say that somewhat arrogantly because I’m sure that I have other shadows to contend with, but this one doesn’t have any power over me anymore.

I identify with my eating disorder because it helped; whatever that really was about. Whatever our issues are in life I think they’re only a metaphor for what we’re learning spiritually about ourselves. So someone else might take a similar lesson and learn from it in a totally different way. But I value it so I don’t want to compartmentalize it; I don’t want to freeze it or myself in time. So I see it as something I went through, and I wasn’t a victim if I was learning something from it.

Now I teach this to people and I have a four-step program I call the Healthy Habit Technique. I primarily teach people who come to me through my massage practice, through workshops, seminars, and people I reach through my email list and the book I wrote. Activism is really where I’m at now. I am an energy addict, and I’d rather use my energy for the greater good. I do think it’s for the greater good to share joy because it feels so much better when you feel empowered, when you feel a part of a community. It is such a charge; it’s like bubbles inside. It’s effervescent, so I love that feeling and the joy I get from imparting information to people.

Discussion

As previously noted what follows is my own reading and interpretation of the presented performance texts. My understanding of the stories is framed by some of the previous work reviewed and by the larger stories the individual women shared with me. Keeping in mind the ideas informing the current study’s narrative perspective, what emerged from these accounts is that overcoming an eating disorder requires attendance to all parts of the human being, that is, mental, emotional, physical, social, and spiritual components. Although all three women reported cognitive, emotional, and physical changes as they progressed through their recovery, the core components of their recovery stories emerged in the forms of social activism and deepening spiritual commitment. The findings of the current study support previous work which indicated the importance of community involvement, political activism, and spiritual/religious engagement in long-term recovery from eating disorders (Garrett, 1998; Kraatz, 2006; Lelwica,
1999; Liu, 2007; Morgan et al., 2000). These findings not only support past work, but also attend to components of recovery that are often neglected in the literature (Kroll & Sheenan, 1989; Mitchell et al., 1990; Richards et al., 1997; Richards et al., 2007). The pertinent relevance of the spiritual and social components to recovery for these three women suggest that long-term recovery from an eating disorder requires something more than solid relationships, good nutritional counseling, and psychotherapy. Rather it involves real purposeful engagement with countercultural communities and some form of spiritual and/or religious practice that is larger than the self. For some recovered women this may be achieved through connecting with other anti-anorexia or anti-bulimia supporters and contributing to the online archives (www.narrativeapproaches.com) of resisting pro-anorexic/bulimic acts and beliefs (Epston, Morris, & Maisel, 1995; Madigan & Goldner, 1998; Maisel et al., 2004; Zimmerman & Dickerson, 1994). But for my participants it occurred in the form of teaching evangelical Sunday school, activism in a college campus women’s center, feminism, social work, guest lecturing, and book writing.

Spiritually and Socially Active Community-Based Recoveries

For each of the women presented in the current study, recovery includes involvement in some cause or community greater than themselves. For Heidi, who never received any psychological counseling when active in her eating disorder, her faith in God and the ongoing support of a religious church community helped her achieve lasting recovery from anorexia. By giving back to the community through teaching 7th and 8th grade girls Sunday school, Heidi has found working with this cohort rewarding and reparative since she strongly identifies with girls struggling at this formative age. Interestingly, Heidi does not have a 7th or 8th grader, and she did not particularly enjoy teaching when she previously taught her children’s Sunday school classes. Since there was a need for a 7th and 8th grade girls teacher, Heidi prayed on the matter and came to the conclusion that she should do it. Heidi now reflects that she was called to teach this group and has been teaching this age group ever since. Being attuned to picking up on and helping other young women who are struggling with nascent eating disorders has been important for Heidi’s own healing. She “wants to be there when a 7th or 8th grade girl is going through the same thing. I want to pick up a cue; I want to see it. I want to be used in that way.” In our conversations Heidi related a story where her “antenna for spotting eating disorders” helped a friend’s daughter with bulimia and cutting disclose her struggles and begin seeking help.
For Pamela, she credited inpatient treatment as the crucial starting point of her recovery, but realized that her brief time at Renfrew, a residential eating disorders clinic, was only the beginning of her recovery. It was through finding feminism, getting connected to a community of women in college, and later finding her calling to work with underserved women and children that Pamela has been able to sustain her long-term recovery from anorexia. When Pamela was “really struggling or feeling really bad” she “would pray” but it was not to a specific entity. Pamela explained her spiritual construal “as karma, some kind of god or goddess, or the energy exchanged between people—call it love, compassion, or karmic energy.” In addition to prayer, Pamela would play the piano “over and over again and feel extremely mentally and physically calm. I think a lot of psychological, emotional, and spiritual healing happened while I was playing the piano. I unloaded a lot of emotion during that time.” Pamela “described it [her recovery] spiritually” in the sense “that I started out with emptiness, and I got filled up with love and good things, by thinking about others.”

In Virginia’s case, recovery from compulsive overeating directly stemmed from Zen and Christian spiritual beliefs. For Virginia, healing came through meditation, practicing yoga, and reading philosophical, esoteric works that made connections between the mind, body, and spirit. According to Virginia, activism and spirituality cured her compulsion to binge eat and diet restrictively. Through teaching workshops, writing books and daily email tips, along with teaching clients in her massage practice about stress, healthy eating, and their bodies, Virginia has found “giving back to be quite cathartic and a real charge of energy.”

Even though these three women spoke of the relevance of spiritual aspects to their individual recoveries, this was by no means the entire story for any of the women. The content of the performance texts primarily focused on the turning point moments that each woman described as pivotal to the recovery process. For Heidi and Virginia, spiritual commitment was most salient, although their community involvement certainly played a central role in their respective recoveries. For Pamela, her community involvement and political standpoint superseded her spirituality, even though she expressed the importance of spirituality in her story. For each of these women the spiritual and social components of their recoveries differed in the form it presented itself, in the intensity, and the perceived order of relevance. Additional components such as emotional healing, refusing to perseverate on destructive thoughts about weight and shape, interpersonal relationships, improvements in relational styles, psychotherapy,
nutritional counseling, countercultural community involvement, and political action also emerged in one or more of the accounts as helpful in achieving recovery. Ultimately all of the elements contributing to Heidi’s, Pamela’s, and Virginia’s recoveries evolved and unfolded over time. As each of these women went through various recovery experiences, they found that these areas or experiences often needed to be addressed and re-addressed.

Recovery as a Process

“My recovery is not a one year, two year recovery. My recovery is continuing to this day.” (Heidi)

Each of the recovered women actively spoke of recovery as a process. For Heidi, her journey into anorexia and her emergence from it has been “an exploration of trying to find my way and getting to a place where I realize I am not the sum total of my weight, but rather what I contribute to relationships and my other talents and gifts.” In addition to Heidi, the other two women spoke of their eating disorder recovery as a process that served a purpose and lead to greater self-understanding and awareness. For example, Pamela acknowledges that her anorexia communicated to others how much emotional pain and turmoil she was in as a teenager. Learning how to have healthier relationships and how to be noticed and heard without visibly conveying her pain through her emaciated body, Pamela has since learned how to express herself and have her needs met without wreaking havoc on her corporal body. As for Virginia, she described her eating disorder and recovery as “a necessary lesson or metaphor for the struggles in [her] life.” She “values the experience and does not try to compartmentalize or deny it.” Rather, Virginia tries to honor her experience and the lessons she learned. Talking with me and helping me with my research was one way she could “give back” while simultaneously receiving many benefits and insight related to understanding her own personal experience.

These findings reproduce Garrett’s (1998) findings that recovered women “saw anorexia and recovery as a necessary step in their personal evolution or a necessary mechanism for coping with otherwise unbearable pain” (p. 61). Similar to Pamela and Virginia, Heidi “does not feel like I’ve had a bum deal. It’s just something that happened and it’s a part of me.” She likened her anorexia to “a weird uncle that used to live close by, but now only stops by for occasional visits.” For Heidi the process of coming to truly believe that there was more to her than her weight and appearance and that people could love her just the way she is, has been a continual process. To consider their recoveries complete or finished would deny Heidi’s, Pamela’s, and
Virginia’s dynamic experience of their recoveries continuing to this day. Although Pamela considered herself “done with anorexia” and talked about how “I got better,” she also identified as still recovering in our conversations. In our interview Pamela endorsed thinking about her recovery as hardly complete but rather in flux “moving two steps forward, then one step back.”

Political and Spiritual Recoveries

In each of the women’s stories there is a real shift or movement away from the eating disorder to a new and different way of living or being in the world. To leave the worlds of anorexia and compulsive overeating, Heidi, Pamela, and Virginia actively sought alternative ways to make sense of the world and find value in life beyond the prison of their eating disorder. According to Lelwica (1999), this personal, social, and spiritual transition occurs in one or more of the following ways: “(1) the development of a critical and embodied awareness; (2) participation in countercultural communities; and/or (3) commitment to ongoing spiritual growth and vision” (p. 129). In my interviews with Pamela and Virginia, both women clearly endorsed liberal and countercultural beliefs which stemmed from spending a fair amount of time critiquing the dominant cultural systems that disenfranchise women. Furthermore, all three women actively participate in countercultural communities (e.g., Pamela’s participation and creation of a feminist group at her college, and Virginia’s participation in the hippie, organic health, and New Age movements). Although Heidi’s involvement with her Christian church community would not be considered by most as countercultural, her evangelical, charismatic church can be considered countercultural relative to the Presbyterian Church she grew up within her family of origin. Through living a faith-filled life of stewardship and service to others in our current consumer-oriented society, Heidi defies cultural norms and expectations of how to life a good life. Furthermore, West (1988) suggests that re-visioning and finding a place for women in traditionally male dominated religious institutions can be seen as a kind of radical spiritual practice and cultural criticism. Nonetheless, Heidi framed her recovery through an ongoing commitment to spiritual growth instead of a firm commitment to cultural criticism for the sake of such awareness per se.

Yet another way to understand each of these women’s recovery stories relates to Bordo’s (1993) dualist, control, and gender/power axes for understanding the rise of eating disorders in American culture. In many ways long-term recovery from eating disorders can be understood by revisiting the cultural forces that initially contributed to the development of eating disorders in
the first place. During an eating disorder the focus is on whittling away the feminine body and cultivating the will, intellect, and spirituality associated with the masculine whereas during long-term recovery the gender/power axis is turned upside down. For these three women long-term recovery entailed re-claiming the feminine body and spirit through joining together and finding solidarity among a community of women and a renewal (or discovery) of spiritual practices.

All three of the women looking back over the course of their long-term recoveries identified non-standard markers responsible for their recovery in hindsight. For Heidi (29 years in recovery), she regarded the revelation in the mirror “as a present from God” after the fact, not when it happened at age 16. Heidi attributed her recovery to her adult conversion experience and renewed faith in God opposed to receiving formal treatment, which certainly diverges from the standards in the literature for treating and recovering from anorexia (Chavez & Insel, 2007; Wilson, 2005; Wilson et al., 2007). Pamela (6 years in recovery) recognized that her politically active feminist stance was not conceived as a marker of recovery until the end of college at age 21. For Pamela, feminist theory and philosophy helped her make essential links between her viewpoints on children, maternity, motherhood, career, and her life in general. Through this alternative way of conceiving her place in the world, Pamela was able to channel that “social pressure from the Renfrew Center to develop a respect for my body, a desire to be healthy, and to incite a real fear and loathing for eating disorders.” Once Pamela saw “how many women it hurt” she developed “a spiritual and moral obligation to get better.” Virginia (15 years in recovery) described herself as “always being a seeker and nudging a spiritual belief system over the course of many years.” She described the “click in her head at age 40” as fueled by spirituality and fully recognized this at the time it happened and in the past 15 years that have ensued. The ways these three women have storied their experiences in relation to the master narratives of the thin-ideal (Rodin et al., 1985; Stice et al., 1994; Tiggemann, 2002) and traditional recovery from an eating disorder are discussed in further detail below.

Master Narrative Positioning and Recovery from Eating Disorders

As mentioned earlier, master narratives are those “culturally valued positions” that help individuals define their personal experiences in relation to the larger culturally dominant stories (Thorne & McLean, 2003, p. 171). Positioning the self in relation to these stories can be defined as the “social and emotional stances individuals take vis-à-vis real or imagined others” (Thorne & McLean, 2003, p. 171). In regards to master narrative positioning this concept includes
people’s perception of their own role(s) or place(s) relative to the culture’s master narratives. My three participants positioned themselves rather differently to the two cultural master narratives prescribing (1) how women should look in American culture (i.e., the thin-ideal) and (2) how women with eating disorders should (or typically) recover from a mental and physical illness. The following section describes the individual women’s positioning and re-positioning relative to these two master narratives.

Heidi’s Position Relative to the Thin-Ideal Master Narrative. Heidi admitted to fully endorsing the culturally prescribed belief that women should be thin and beautiful at all costs and that their worth is inherently tied up in whether or not they achieve this so called thin-ideal (Rodin et al., 1985; Stice et al., 1994; Tiggemann, 2002). Heidi endorsed this master narrative prior to and during her anorexia. She owned up to still endorsing the beliefs of this master narrative to some extent today (e.g., she worried that I might perceive her as being too heavy to be a recovered anorectic). Today, the main difference is that while she feels ashamed that old college friends may perceive her as “having let myself go,” she refuses to do sit-ups underwater to “get rid of the fluff around the middle.” However, Heidi divulged that adhering to the culture’s thin-ideal is not as encompassing as it once was in her life. She admitted to “giving food and body image more attention than they deserve but it definitely is not the driving force anymore. But it is definitely still there.” Heidi’s way out of the thin-ideal master narrative was through religion. She asserted that “my faith changed it. I think my faith took over the driving force and replaced it. I feel like God has been taking care of me the whole time. He was trying to get my attention back then in the bathroom. When I finally looked away from the world and I saw Him, my life was radically changed.”

Pamela’s Position Relative to the Thin-Ideal Master Narrative. Pamela strategically positioned herself outside of the master narrative of the thin-ideal (i.e., that all women should strive for an unrealistically thin and svelte body type). In the way Pamela told her story, her anorexia “was never about being skinny,” neither in the throes of it nor in hindsight. For Pamela it was “not important to be skinny; it was about the willpower to eat little and keep exercising” to the envy, surprise, and consternation of all those around her. Fundamentally, for Pamela, her anorexia was tied up in getting her parents and authorities to hear her through her eating disorder. Yet she admitted that once it was beyond her control it was very much tied to aspects of the thin-ideal. She discussed the “very traditional feminine identity” she had during her
anorexia that included “never going out in public without lipstick on and always having to have a cute outfit on before anybody could see me.” Pamela described her extremely liberal feminist ideology as being “the dead opposite now.” Her identity and personality were “watery” during her anorexia but became more solidified as she adopted feminism. Currently, Pamela positions herself in opposition to the thin-ideal master narrative and finds “the big strong man and little, beautiful, frail female thing very unattractive to me now.” She described her feminist belief system as being antithetical to the thin-ideal master narrative and depicted her relationship with her fiancée as being “a radically liberal feminist couple.”

*Virginia’s Position Relative to the Thin-Ideal Master Narrative.* During her eating disorder Virginia positioned herself within the thin-ideal master narrative “like any normal woman in our society, I was always preoccupied with having those ten more pounds to lose or that last little bit more to lose.” Through her spiritual practices and social activism, Virginia has since repositioned her self outside of this master narrative “by changing my focus, practicing visualization, and no longer believing that I have weight to lose.” Instead of positioning herself in opposition to the thin-ideal master narrative, Virginia has stepped outside and endorsed an entirely different belief system that “focuses on balance” and “frees me from the trap of obsessing about my weight.”

*Participant Positioning Relative to the Recovery Master Narrative.* All three of these women recovered from an eating disorder in ways that are divergent from the master narrative of recovery from an eating disorder, i.e., seeking psychological, nutritional, and medical treatment for a disease of the mind and body. I use the term “disease” here full-well recognizing that the master narrative supports and uses the terms “disease” or “illness.” The term can also be considered as “a cultural artifact, defined and redefined over time” (Brumburg, 2000, p. 3).

According to the master narrative of how one recovers from an eating disorder, these women’s recoveries do not follow the typical storyline of receiving medical, psychological, and nutritional services to cure their mental and physical illness. Pamela is the only one out of the three women who actually received standard or “best practice” care for her eating disorder (Wilson, 2005; Wilson et al., 2007). However, Pamela’s brief foray into psychotherapy and medical/nutritional monitoring at Renfrew was clearly not the cure for her anorexia according to her. Rather it was a pivotal starting point in facilitating her recovery. Notably Heidi and Virginia achieved lasting recovery without treatment from psychological and nutritional professionals. Despite the fact
that medical doctors intervened at some level with both Heidi and Virginia, neither credited her doctor with starting or furthering her recovery. In fact all three of the women’s stories support findings (Ben-Tovim et al. 2001; Redenbach & Lawler, 2003; Woods, 2004) that women can recover from eating disorders without any formal treatment.

All three women had varying viewpoints and positions in relation to the master narrative of requiring the health care system to prompt and aid their recovery from an eating disorder. Heidi and Virginia did not find psychological or nutritional counseling to be necessary to overcome their eating disorders. Both Heidi and Virginia found recovery possible without formal treatment. Interestingly both of these women subscribe to an addiction model of eating pathology. Virginia regards eating disorders as being fueled by addiction and control. She found her way out of this vicious cycle of addiction and controlling her food intake by realizing that she could “change [her] desires to be healthy and think about getting sweetness from a pear instead of chocolate.” Virginia shifted her “desires and thinking of food as energy” from previously thinking of food “as sinful.” Virginia admitted she is “still addicted, but I’m addicted to the energy now, not food.” Instead of “thinking of chocolate as the big evil,” Virginia has changed her mindset from “thinking it’s a sin that will make me fat” to believing “it is just chocolate” thereby losing its power and control over her. Similarly Heidi likened recovering from an eating disorder to being “like a drug addict on a recovery path. They’ll never cease being tempted by drugs. It’s the same with eating disorders.” Pamela, the only one who received formal treatment for her eating disorder, “buy[s] in only a tiny bit to the addiction model because I was addicted more to the identity and attention my eating disorder gave me more so than the actual behaviors.” For Pamela, her eating disorder was more connected to the “family and the childhood trauma” she endured. Closely joined with her recovery from anorexia were the changes that occurred within her family. In sum, none of these three women interpreted their recoveries in accordance to the dominant master narrative of recovering from an eating disorder through psychological, medical, and nutritional treatment.

The Long and Winding Road of Recovery

Reflecting upon the journey and process of this study it is similar to the long and winding road of recovery replete with valleys and hills. Just as this study is more about the insight gained from the journey than the final end product, recovery from an eating disorder is more about the personal wisdom gained from the non-linear and sometimes circuitous path and less about taking
the most direct route to reaching normal weight, normalized eating habits, or some quick fix solution. For the women in the study the unexpected detours and various routes ultimately led to the same destination of reclaiming their lives. The self-knowledge gained from self-discovery, social activism, and spiritual commitment have proven to be long-lasting, rewarding, and enriching for the women who shared their stories of returning to health, wellness, and healing from their obsessions with food and weight.

Revisiting the primary research questions posed at the beginning of this study (p. 6) concludes the current project. Recovery from an eating disorder appeared to be experienced by recovering/recovered women as a spiritual reconnection of the self to body, nature, and society (Garrett, 1998; Newmark, 2001). Much like Garrett’s participants, my participants’ recovery occurs through an “ongoing, transformative, [and bodily] process” (Garrett, 1998, p. xii). These three women describe “a continual descent and return, rediscovering and remaking” their recovery stories as they continue to grow, evolve, heal, and change (Garrett, 1998, p. 12). Just as Pamela spoke of “moving two steps forward, then one step back,” all three women endorsed non-linear and fluctuating recoveries that consisted of much more than stopping the restricting, binging, and purging behaviors. Each of their stories focused on what they felt and who they have become. These three women described recovery as a whole change in lifestyle in their shift beyond the self. Changing their lifestyles, developing a greater, different, or revised sense of self, fostering new relationships, and finding different ways of relating to others promoted a sense of purpose and direction in life through community involvement, social activism, and spiritual engagement. Fully realizing that recovery from an eating disorder is not a static state (Root, 1990) these recovered women instruct us that coming to find meaning in some cause or entity beyond themselves is crucial to recovery.

Coming to realize what recovery is and is not informs the field at large. Goldkopf-Woodtke (2001) explains from the position of both a recovered anorectic and therapist, that “recovery does not mean getting rid of the fears, instead it means moving forward in spite of them” (p. 169). Heidi, Pamela, and Virginia’s narratives attest to moving beyond the fears and finding it easier to push on in spite of them when involved with a larger community. In closing, Goldkopf-Woodtke (2001) asks some thought-provoking questions to ponder and further our thinking about when and how one determines that recovery from an eating disorder has occurred:
Had I recovered once I gained back enough weight to have my menstrual cycle return? Had I recovered once I could tolerate wearing bigger sizes? Had I recovered when I happened to glance at my chart in the doctor’s office, which read, “Diagnosis—anorexia nervosa/recovered?” Had I recovered when I could start making important life decisions based on my needs? Had I recovered when I could listen to my hunger? Had I recovered when I could tolerate uncomfortable feelings without starving myself? Had I recovered when I could laugh again? (p. 176).

Clearly each of these questions begets further questions surrounding what recovery from anorexia, bulimia, and compulsive overeating includes and requires. The current study problematized narrow definitions of recovery and offered three women’s answers to what recovery has meant to them. Heidi, Pamela, and Virginia’s stories stress that long-term recovery requires letting go of the symptoms (i.e., the starving, binging, excessive exercising, and purging) and that full recovery is possible if recovered women are committed to continue their work after their symptoms disappear. Their work continues to this day and what Heidi, Pamela, and Virginia ultimately needed to recover they found in reaching out to others through social activism, community involvement, and purposeful spiritual engagement. In the words of another recovered anorectic, Aimee Liu, their recoveries are truly “an ongoing process of restoration and discovery” (2007, p. 260).
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Appendix A
Excluded Participants

Carlotta, 43 years old and a homemaker, presented with a history of bulimia and compulsive overeating. She described herself as “hating the rules and the establishment,” but felt compelled to adhere to the rules of being thin during her years of binging and purging twice a day. She shared her story in a loose and unstructured way, much in the way she described her approach to home schooling her nine children.

Frances, 48 years old and a librarian, presented with a history of anorexia. She presented herself as ambivalent about the future and does not believe that she is (or ever can be) fully recovered from anorexia. She admitted coming to the study “looking for some free insight from psychology” and appeared to be searching to see if the interviewers believed her to be recovered. Despite the fact that she is currently in the low range of normal weight for her age and height, the self-critical tapes she plays over in her head along with the lingering “bad eating habits” indicate that Frances is still distressed and grappling with parts of her eating disorder that “are all really still a part of me.”

Jenna, 23 years old and a college student at the time of our interviews, presented with a history of both anorexia and bulimia. She aspired to be a personal trainer for overweight kids and maintained an extremely physically active lifestyle. She appeared to struggle with chronic invalidation and wondered why her fiancé wanted to marry her. She also recounted a recent incident where she fell off of her bicycle, required medical assistance, but refused it because she felt it was a waste of money to call for an ambulance.

Kelly, 36 years old and a homemaker, presented with a history of anorexia. Upon first meeting she still appeared emaciated. She indicated that she is still an avid exerciser and unable to relax. She admitted to still thinking that “fat is the enemy.” She stated that she “still watches the scale and plays number games.”

Sara, 18 years old and a student, presented with a history of anorexia. She eagerly displayed a photo of herself from the period she was hospitalized. At the time of our interview Sara visually appeared to be extremely thin even though she certainly had gained weight since her discharge from the hospital. She described social struggles and began working the night shift in lieu of starting college because it “felt safer” and helped her feel a sense of accomplishment versus experiencing the terror of “potential failure.”
Appendix B
Interview Questions

Narrative
1) I’d like to hear the story of how you gave up your eating disorder (or for participants who identify themselves as recovering: what do you think the process of recovery will involve?)

Defining Recovery
2) When did the recovery begin? Were there turning points/stages/key factors?
3) What prompted a desire to change? Was it your choice to begin the recovery process?
4) What do you think you were/are recovering from?
5) Do you think there are degrees of recovery? Or that you are never fully recovered?
6) What were some epiphanies/turning points in healing?
7) What is it that you needed in order to recover?

Process/Change
8) What experiences marked a shift in your readiness to change or in your belief that you could change? What made those pivotal experiences possible?
9) Did you experience ambivalence about changing and if so how did you continue to recover in spite of that ambivalence?
10) What has changed since you were active in your eating disorder? What features did you find easiest to change? Hardest?
11) To what do you attribute the changes you made in recovering? How do you maintain the changes you’ve made?
12) What did you gain, or most appreciate, in recovering? What did you lose, or miss most?
13) How do you know/would you know that you had recovered? What are your criteria for recovery?
14) Do symptoms of the eating disorder persist? Do you expect them to?
15) Why did you need your eating disorder? And why don’t you need it now?

Identity
16) Do you feel like the same person you were when you were active in your eating disorder? How about before the eating disorder?
17) How do you now make sense of your identity apart from your eating disorder? What does it mean to you to no longer identify yourself as anorexic/bulimic?

Societal Influences
18) How much reading have you done about eating disorders? Do any of the accounts resemble your own experience?
19) What did you experience as helpful and harmful, both in & out of formal treatment? How did these experiences impact your recovery?
20) What, to your mind, led to your developing an eating disorder?
21) What role do you see family playing in the etiology of eating disorders?
22) How you define feminism or think about femininity? Have your views of femininity changed?
23) What does it mean to be a successful woman?
24) What would living a good life mean for you?

**Spiritual/Imagination/Purpose**
25) Do you have any particular religious or philosophical beliefs? Have they helped at all in your recovery?
26) Has imagination or creativity played a role in your recovery?
27) How do you define your sense of purpose/destiny?
28) What are your goals & ambitions? What do you aspire to become?
29) Have you had any significant dreams related to your eating disorder or recovery?
30) Have hobbies or creative outlets played a part in your recovery? Such as keeping a journal?

**Message to Others**
31) What advice would you give to someone struggling to recover from an eating disorder? What do you know now that you wish you had known pre-recovery?