The Voices of Recovery:
A Qualitative Investigation
of Women Recovering From Bulimia

Dissertation

Presented in Partial Fulfillment of the Requirements for
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By

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To my mother
Evelyn St. John Shillito
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TABLE OF CONTENTS

DEDICATION .................................................................................................................. ii

ACKNOWLEDGMENTS ............................................................................................... iii

VITA ............................................................................................................................. vi

CHAPTER PAGE

I. INTRODUCTION ...................................................................................................... 1

   EXTENT OF THE PROBLEM .................................................................................. 1

   NATURE OF THE PROBLEM ............................................................................... 4

   SIGNIFICANCE OF THE PROBLEM .................................................................. 6

   STATEMENT OF THE PROBLEM ....................................................................... 7

   RATIONALE FOR THE STUDY ......................................................................... 8

   PURPOSE OF THE STUDY .................................................................................. 9

   KEY TERMS ........................................................................................................... 10

II. REVIEW OF THE LITERATURE .......................................................................... 12

   INTRODUCTION .................................................................................................. 12

   POSTTREATMENT FOLLOW-UP STUDIES ..................................................... 12

   COMMUNITY BASED RECOVERY STUDIES .................................................. 18

   POPULAR LITERATURE ON RECOVERY ....................................................... 20

   COMMENTARY ON THE LITERATURE REVIEW ............................................ 21

III. METHODOLOGY .................................................................................................. 23

   INTRODUCTION ................................................................................................. 23

   CONGRUENCE WITH SOCIAL WORK .......................................................... 24
DESIGN ................................................................. 24
FOCUS ............................................................... 27
SITE OF THE STUDY ................................................ 28
SAMPLE ............................................................. 28
DATA COLLECTION PROCEDURES .............................. 29
DATA ANALYSIS ..................................................... 33
TRUSTWORTHINESS ............................................... 37
PILOT STUDY ......................................................... 40
PROTECTION OF THE PARTICIPANTS ........................... 40
EXPECTED IMPLICATIONS ......................................... 41

IV. TURNING POINTS .................................................... 42
   INTRODUCTION .................................................... 42
   CHARACTERISTICS OF TURNING POINT EXPERIENCES .... 43
   RELATIONSHIP OF TURNING POINT EXPERIENCES TO
   RECOVERY FROM BULIMIA ...................................... 45
   CONCEPTUAL FRAMEWORKS FOR STUDYING TURNING
   POINT EXPERIENCES ............................................ 53

V. DIMENSIONS OF RECOVERY ...................................... 62
   INTRODUCTION .................................................... 62
   BULIMIA AS SYMPTOMATOLOGY ................................. 62
   PSYCHOLOGICAL DIMENSION OF RECOVERY .................. 65
   SOCIETAL DIMENSION OF RECOVERY ........................... 77

VI. ENVIRONMENTS OF RECOVERY .................................. 90
    INTRODUCTION .................................................... 90
    QUALITIES OF THE ENVIRONMENT .............................. 91
    CONTEXT OF THE ENVIRONMENT ................................ 92
    CONCLUSION ...................................................... 102

VII. PRACTICES OF RECOVERY ....................................... 103
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>..........................................................</td>
<td>103</td>
</tr>
<tr>
<td>STRUCTURING EMPTY TIME</td>
<td>.........................................................</td>
<td>103</td>
</tr>
<tr>
<td>DIETARY AND WEIGHT MANAGEMENT PRACTICES</td>
<td>..................................................</td>
<td>105</td>
</tr>
<tr>
<td>FOOD JOURNALING PRACTICES</td>
<td>.......................................................</td>
<td>108</td>
</tr>
<tr>
<td>RELAPSES</td>
<td>..........................................................</td>
<td>109</td>
</tr>
<tr>
<td>MEDICATION PRACTICES</td>
<td>.....................................................</td>
<td>112</td>
</tr>
<tr>
<td>CONCLUSION</td>
<td>........................................................</td>
<td>113</td>
</tr>
<tr>
<td>VIII.</td>
<td>DISCUSSION</td>
<td>..................................................</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>........................................................</td>
<td>115</td>
</tr>
<tr>
<td>DISCUSSION OF THE THEMES</td>
<td>...................................................</td>
<td>116</td>
</tr>
<tr>
<td>SELF REFLEXIVITY AND METHODOLOGY</td>
<td>..................................................</td>
<td>122</td>
</tr>
<tr>
<td>RESEARCH ISSUES</td>
<td>.....................................................</td>
<td>123</td>
</tr>
<tr>
<td>LIMITATIONS OF THE STUDY</td>
<td>....................................................</td>
<td>126</td>
</tr>
<tr>
<td>RECOMMENDATIONS FOR FURTHER STUDY</td>
<td>..................................................</td>
<td>127</td>
</tr>
<tr>
<td>IMPLICATIONS FOR SOCIAL WORK</td>
<td>..................................................</td>
<td>128</td>
</tr>
</tbody>
</table>

APPENDICES

A. DESCRIPTION OF THE STUDY | .................................................. | 130 |
B. LETTER FOR INFORMANTS TO GIVE TO POTENTIAL PARTICIPANTS | .................................................. | 132 |
C. EXPLANATORY LETTER TO POTENTIAL PARTICIPANTS | .................................................. | 134 |
D. DATA SHEET | ..................................................... | 137 |
E. CONSENT FORM | ..................................................... | 139 |
F. INTERVIEW GUIDE | ..................................................... | 140 |
G. BULIMIC RECOVERY CHARTING ASSIGNMENT | .................................................. | 142 |
H. FORMAL MEMBER CHECK EXPLANATORY LETTER | .................................................. | 143 |
I. FORMAL MEMBER CHECK QUESTIONNAIRE | .................................................. | 144 |
J. CODING ILLUSTRATION ................................................................. 145

LIST OF REFERENCES ........................................................................ 147
CHAPTER I
INTRODUCTION

Extent Of The Problem

The escalating incidences among females of the eating disorders anorexia nervosa and bulimia are considered by many authorities to be reaching alarming proportions (Crisp, 1988; Johnson & Connors, 1987; Taub & Blinde, 1992; Worth, 1989). There is consensus among eating disorder specialists that our nation’s emphasis on female thinness causes many women to be preoccupied with physical shape, body weight and food intake (Connor-Greene, 1988; Gordon, 1990; Haimovitz, Lansky & O’Reilly, 1993; Hsu, 1990; Kolodny, 1992; Plinter, Chaken & Flett, 1990; Wooley & Wooley, 1985). Experts in the field of eating disorders link the dramatic increase of eating disorders in contemporary Western society to the sociocultural pressures on females to become and remain slender (Chernin, 1985; DiNicola, 1990; Gordon, 1990; Hsu, 1990; Jablow, 1992; Johnson & Connors, 1987; Vandereycken & Hoek, 1990). Most experts postulate that the female slender ideal puts some women at risk for resorting to drastic measures to ascertain the lowered weight associated with slenderness. Of these women, some will develop eating disorders (Taub & Blinde, 1992).

Although the 30-year passage from the early 1960’s “Twiggy era” to the early 1990’s “athletic strength era” has allowed for some latitude in female proportions, the sociocultural emphasis on slenderness remains a constant ideal for female beauty (Kearney-Cooke, 1990; Seid, 1989). Haller (1992) considered eating disorders to be affecting between 1% and 2% of adolescent and college females. Rosen (1989) estimated that there are about 1.26 million American women experiencing eating disorders, plus another 3.5
million exhibiting subclinical conditions, bringing the total to approximately 4.5 million American females manifesting anorexia or bulimia. Wolf (1991, pp. 181-182) cited the American Anorexia and Bulimia Association estimate that anorexia and bulimia strikes a million American women yearly.

In the field of eating disorders there is consensus that the overwhelming number of people who develop anorexia nervosa or bulimia are female (Garner and Garfinkel, 1985; Gordon, 1990; Taub & Blinde, 1992; Zraly & Swift, 1992). Researchers report that between 90% and 95% of eating-disordered individuals are females (Jablouw, 1992; Levine, 1988). Most experts agree that eating disorders predominantly affect adolescent and college age Caucasian females in the middle and upper socioeconomic stratifications (Gowers & MaMahon, 1989; Harper and Shillito, 1991; Hsu & Psych, 1987; Smith & Krejci, 1991). Recently, however, a few studies on the incidence of eating disorders in minorities have indicated an increase in disordered eating among African American, Hispanic, and Native American females (Hsu & Psych, 1987; Smith & Krejci, 1991; Snow & Harris, 1989). Gordon (1990) estimated that between one and two million American women experience clinically significant problems with their practices of bulimia. Epidemiological studies confirm the clinical impression that bulimia is predominantly a woman's disorder (Hsu, 1989; 1990). Sherman and Thompson (1990) estimated that 95% of all bulimics are female.

Prior to the early 1970s, binge eating and purging in normal-weight females was considered a rare phenomenon. Gordon (1990) pointed out that the 1950s and 1960s stand in sharp contrast to the early 1990s, when nearly every college student knows of at least one practicing bulimic. A retroactive survey of women who were college students in the 1950s and early 1960s revealed that bulimic behavior in female college students was unusual during that period (Rosenzweig & Spruill, 1987).
As previously mentioned, research studies indicate that female bulimic incidence increases with increased social class (Gordon, 1990; Hsu, 1990; Silverstein, Perdue, Peterson, Vogel & Fantini, 1986). According to Johnson and Connors (1987), approximately 8 percent of American females are actively bulimic. Many authorities in the field consider bulimia to be a hidden epidemic because only a small percentage of practicing bulimics are diagnosed as suffering from the disorder (Drewnowski, Hopkins & Kessler, 1988; Gordon, 1990; Jablow, 1992; Zraly & Smith, 1992).

The number of women suffering from bulimia is difficult to determine because of the secretive nature of this disorder (Jablow, 1992; Zraly & Smith, 1992). In addition, estimates of bulimic prevalence in females vary because of inconsistency in the way the disorder is defined and surveyed (Connors & Johnson, 1987; Fairburn & Beglin, 1990; Kirkley, Schneider, Agras & Bachman, 1985; Mitchell & Eckert, 1987; Rand & Kuldaau, 1992). Although there is variability in the reporting of bulimic prevalence, most authorities believe that the incidence of bulimia nervosa in females is steadily rising (Drewnowski, Yee & Krahn, 1988; Gordon, 1990; Smith & Smith, 1988). Gordon (1990) stated that surveys of female college students indicated a bulimic prevalence of between 10 and 20 percent of the female college student population. Zraly & Swift (1992) reported that bulimic incidence among high school and college student populations ranged from 8 to 20 percent of the female population.

Although early literature concerning bulimia nervosa was drawn from studies of anorexic patients who manifested bulimic behaviors (Norman, Herzog & Chauncey, 1986), a new phenomenon emerged in the 1970s. Women who were neither anorexic nor obese began presenting themselves for treatment because of their inability to refrain from binging and purging (Johnson & Connors, 1987). The increasing number of normal weight females caught in binge/purge eating patterns became significant enough to warrant the publication of an article in the mid-1970s in which the nomenclature "bulimarexia" was
coined by the author to describe the symptoms of binge/purging among normal-weight young women (Boskind-Lodahl, 1976). In 1979, bulimia nervosa was identified as a diagnostic entity (Russell, 1979). In 1980, the American Psychiatric Association (APA) distinguished bulimia as a distinct clinical syndrome, separate from anorexia nervosa, in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980). Seven years later, the APA changed the term bulimia to bulimia nervosa in the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1987). During the 1980s, bulimia nervosa gained momentum as a clinical phenomenon to the extent that it displaced anorexia nervosa as the most common eating disorder (Gordon, 1990; Stein & Laakso, 1988).

The growing number of normal weight bulimic females requesting treatment in the 1970s and 1980s resulted in a proliferation of popular and professional publications and television and radio shows on bulimia in normal-weight females. The International Journal of Eating Disorders, as well as other professional journals, responding to the growing number of bulimics requesting treatment and to the professional community's interest in this cohort, publishes increasing numbers of articles on bulimia nervosa (Gordon, 1990).

Nature Of The Problem

Features of bulimia nervosa include recurrent and often uncontrollable episodes of binge eating in which large amounts of food are consumed over a short period of time (usually less than two hours). Binges are followed by purging strategies to evacuate the stomach of ingested foods prior to body absorption. Purging most often takes the form of self-induced vomiting, but may also include laxatives, diuretics, exercise, dieting, or fasting (Abraham & Llewellyn-Jones, 1992; American Psychiatric Association, 1987; Sherman & Thompson, 1990). Experts describe normal weight bulimics as preoccupied with their calorie intake, dissatisfied with their body shape and fearful of weight gain (Anderson, 1985; Chernin, 1985; Goldbloom, Zinman, Hicks & Garfinkel, 1992; Harper,
1984; Hsu, 1990). In order to control weight gain, bulimics not only follow food binges with purging but also resort to dieting strategies to lose weight or to maintain low weight ranges.

The cycle of dieting, binge eating and purging can have a deleterious effect upon a woman's physical and psychological well-being. Physical complications of bulimia nervosa include, but are not limited to, electrolyte disturbances, neurological abnormalities, esophagus damage, gastrointestinal disturbances, dental deterioration and hypokalemia, a condition in which lowered levels of serum potassium can result in cardiovascular or kidney failure (Bonne, Block & Berry, 1993; Comerchi, 1990; Garner, Rocket, Olmsted, Johnson & Coscina, 1985; Hsu, 1990; Spack, 1985). Psychological complications associated with bulimic behaviors include shame and guilt, lowered self-esteem and social isolation (Frank, 1991; Jablow, 1992). Bulimics often retreat to the safety of their preoccupation with food and to bulimic activities rather than risk relating to other people, and then compound the problem by feeling ashamed of their secretive activity (Johnson & Connors, 1987). Hsu (1990) warned that many impressions regarding bulimic personalities have not been researched or have resulted in conflictual findings. However, there are some personality characteristics that are commonly attributed to female bulimics. The majority of bulimics are believed to experience low self regard and depression, are other-directed in their need for affirmation and have difficulty taking charge of their lives (Chernin, 1982; Humphrey & Stern, 1988; Johnson & Connors, 1987; Squire, 1983, Yates, Sieleni & Bowers, 1989). Some researchers consider the mood swings and general malaise associated with female bulimia to be exacerbated by electrolyte disturbances brought on by purging and laxative abuse (Garner et al., 1985; Zraly and Swift, 1992). Bulimics place importance on having the approval of others and are prone to be demanding of themselves in regard to appearance and performance. As a result of placing high
standards on image and achievement, they are often described as living stressful and anxious lives (Jablow, 1992).

The literature is consistent in reporting that bulimics have a propensity to abuse alcohol and/or drugs (Bulik, 1991, 1992; Bulik, Sullivan & Epstein, 1992; Bulik & Sullivan, 1993; Garner & Garfinkel, 1985; Goldbloom, Naranjo, Bremner & Hicks, 1992; Johnson & Maddi, 1986; Mitchell, Hatsumkami, Eckert & Pyle, 1985; Mitchell, Soll, Eckert, Pyle & Hatsumkami, 1989; Schneiter, 1988; Watts & Ellis, 1992). Hsu (1990) reported that alcohol and drug problems are evidenced in a third of the bulimics receiving therapeutic services. Many bulimics report using alcohol and/or other mood-altering chemicals to reduce appetite or to medicate depression and anxiety, or to relax (Bulik, 1992; Killen, et al., 1987; Schneiter, 1988).

Significance Of The Problem

Bulimia nervosa is an eating disorder affecting a large number of individuals, most of whom are female. The dieting, binging and purging behaviors of bulimia nervosa create serious physiological and psychological impairment and detour individuals from discovering meaning in living that is independent of physical appearance.

Bulimia nervosa is a significant social problem tied to the sex-class oppression of women. In their struggle to maintain slenderness at any cost, female bulimics manifest the effects of a patriarchal society and its ensuing body politics on the health and welfare of its female constituency. Bulimia nervosa is also a significant feminist issue because of its prevalence in females. The increasing number of disclosing bulimics and the indeterminate number of undetected bulimics warrants an informed understanding of what constitutes bulimic recovery in women. Treatment providers need to know what methods are most effective in terminating bulimic behaviors. They also need to familiarize themselves with strategies that diminish the likelihood of bulimic relapse. Practicing bulimics would benefit from learning what others did to extricate themselves from their bulimic practices.
Statement Of The Problem

The media gives considerable attention to Jane Fonda, Cherry Boone O'Neil, Gelsey Kirkland, Lynn Redgrave, the Princess of Wales, and many others who speak out about their bulimia practices and/or recoveries (Janos, 1985; Kirkland, 1986; Morton, 1992; O'Neill, 1983).

However, researchers pay little attention to what former bulimics have to say about their recoveries. Most of the literature focuses on the etiological and treatment facets of the disorder. Studies that do examine treatment outcomes rarely offer former bulimics opportunities to share their phenomenological perspectives on how they recovered. The paucity of professional literature on what recovered bulimics believe to have been determinants of their recoveries leaves practicing bulimics and clinicians with limited information pertaining to the processes and practices of bulimic recoveries. In the professional literature, qualitative studies on bulimic recovery experiences are rare. This researcher identified only three qualitative/phenomenological dissertation studies (Kirk, 1986; O'Bryne, 1992; Powers, 1986) in which former bulimics told their personal accounts of how they had recovered. The scarcity of phenomenological studies on bulimic recovery suggests that there is limited appreciation for the viewpoints of recovered bulimics. When a woman's recovery experience does appear in a lay publication it is not likely to be incorporated into the knowledge accumulated by the research community. The researcher's (outsider's) perspective, as evidenced by the proliferation of quantitative research studies, as well as the emphasis on causes and treatment issues, leave the professional and lay communities with little information on the practices of recovery or on the recovery perspectives of former bulimics.

In summary, the research community, when it does study bulimic recovery in women, relies upon outside authorities, statistical analysis, and subject/researcher detachment in determining what supports recovery. The irony is that, while positivistic
researchers privilege themselves as the knowers in determining how female bulimics recover from the disorder, the community of recovered bulimic women remains muted.

**Rationale For The Study**

Although much is written about many aspects of bulimia nervosa, little attention has been given to what former bulimics have to tell us about what helped them to recover. Given the importance of understanding the dynamics of recovery in designing effective treatment, this deficiency in the literature is critical. The lack of literature on former bulimics' perspectives on what facilitated and supported their recoveries speaks to the need for phenomenological and exploratory research in this area.

There are women who have extricated themselves from their bulimic practices. These individuals achieved their recoveries through the use of various strategies. Some have turned to eating disorders specialists or have benefitted from less specific therapeutic intervention and/or support groups; others have found recovery through individual effort. These women have much to offer in terms of expanded understanding of the dynamics of bulimic recovery. The recovery knowledge gained from their testimonials will contribute to the therapeutic community's understanding of the facets and processes of recovery and will inform practicing bulimics of strategies that assisted others to give up bulimia.

The disclosures of recovered bulimics will document whether the treatment methods identified by researchers and practitioners as supporting recovery are as valued by recovered bulimics as they are by the therapeutic community. Former bulimics may also specify conditions that support recovery that have been overlooked by treatment providers.

The testimonials of recovered bulimics may also reveal unique and divergent recovery methods for women with differing bulimic characteristics (e.g., early-onset versus late-onset bulimia; short versus long bulimic duration; non-substance-abusing versus substance-abusing, etc.). The recovery information shared by former bulimics with
dissimilar bulimic behaviors will assist therapists in choosing treatment options dependent upon the characteristics of the bulimic under care.

The orientation of this study was phenomenological and exploratory. Through in-depth personal interviews and writing assignments each woman was given the opportunity to tell her recovery story and to describe strategies and methods that she relied on to give up her bulimic practice. A conscious attempt was made to analyze the data without alliance to particular theoretical orientations so that the women’s meanings could naturally emerge out of their recovery stories. The goal was to expand the empirical understanding of bulimic recovery with personal accounts of women who considered themselves in recovery.

**Purpose Of The Study**

The intention of this study was to advance understandings of what facilitated bulimic recovery by having women share their views on what helped them give up their bulimic practices. Specifically, the researcher hoped to gain information on the processes and practices that facilitated and supported bulimic recoveries. The researcher also wanted to understand the women’s bulimic recoveries without losing the subjective and contextual perspective of each woman’s experiences. This research study intended to make a contribution to social work practice with bulimic women, to the therapeutic and research communities and to practicing bulimics. The study examined the facets and practices of bulimic recovery by interviewing women who defined themselves in recovery. Their testimonies contributed to expanded understandings of the recovery process and identified differing conditions that facilitated recovery. The researcher relied on naturalistic inquiry and qualitative methodology to inquire into the women’s bulimic recoveries. The researcher believed that her approach and methods were congruent with her desire to capture the women’s subjective understandings of their recoveries while remaining sensitive to the social context of their lives.
Key Terms

Although considerable literature is devoted to bulimia nervosa, its essential characteristics remain unclear (Mintz, 1985; Shapiro, 1988). Because of the differing and inconsistent definitions of bulimia nervosa and its variants (bulimia, bulimarexia, dietary chaos syndrome, etc.) in the research literature, it is the aim here to define critical terms related to bulimia nervosa in women as they are used throughout this study. Based on definitions of key terms, decisions will be made regarding who shall participate in the study. The key terms are bulimia nervosa, normal weight bulimia, and bulimic recovery.

A review of the literature on female bulimia revealed that many researchers have differing opinions as to what the term "bulimia nervosa" means and to whom it applies. The inability of researchers to reach consensus on what constitutes bulimic behavior in females affects research outcomes and interpretations (Shapiro, 1988). Frequently, quantitative research findings are generalized to all bulimic women without regard for the diverse binging and purging styles of bulimic subgroups within the study's sample. Often, quantitative research findings are generalized to all bulimic women without consideration for divergent bulimic profiles within the sample (i.e., chronological age, alcohol/drug usage, etc.). Because researchers often fail to specify bulimic criteria, the findings, when generalized to the bulimic population, are skewed by the particularities of unidentified subgroups within the sample.

For the purpose of this study, the terms bulimia nervosa and bulimia are used interchangeably to refer to recurrent episodes of binge eating followed by efforts to undo the caloric intake and prevent weight gain through self-induced vomiting. Although the use of laxatives or diuretics, strict dieting, fasting or vigorous exercise may be used, these behaviors are secondary methods by which the bulims in this study attempt to undo their food binges.
*Normal-weight bulimia* refers to individuals who participate in bulimia while retaining weight within a relatively normal range.

*Bulimic recovery* refers to individuals who have refrained from both binge eating and self-induced vomiting or alternative purging methods to evacuate food intake for a minimum of two years. Although these individuals may overeat on occasion, such food intake does not have the characteristics of binge eating. Bulimic recovery, as defined in this study, also allows for individuals to experience a minimal number of short-term bulimic relapses.
CHAPTER II
REVIEW OF THE LITERATURE

Introduction

This literature review examined currently available literature on bulimic recovery in women published between 1981 and 1993. This review was divided into four sections. The first section examined posttreatment follow-up studies of clinical populations of bulimics. The second section examined recovery studies of bulimic samples drawn from the community. The third section critiqued popular literature on recovery as reported by former bulimics. The fourth and final section is a commentary on the literature review.

Posttreatment Follow-Up Studies

Russell, Szmukler, Dare & Eisler, 1987; Sohlberg & Norring, 1992; Swift, Ritholz, Kalin & Kaslow, 1987; Wilson, Rossiter, Kleifeld & Lindholm, 1986; Wolchik, Weiss & Katzman, 1986). All but one of these studies used quantitative methodology. Keller, et al. (1992) did not place controls on the treatment that their subjects received and stated that their research was a naturalistic study.


Outpatient Follow-Up Studies

The literature review revealed that the outpatient setting was the favored milieu in which to treat bulimics. In all but two of the studies, bulimic clients received therapy in outpatient clinics. The review of the follow-up literature also disclosed that outpatient treatment emphasized cognitive behavioral approaches in individual and group settings. Only eight of the twenty-six outpatient studies failed to specify treatment or modality (Herzog et al., 1988; Johnson-Sabine, et al., 1992; Keller, et al., 1992; Mitchell et al., 1986; Norman & Herzog, 1986; Norman & Herzog, 1984; Norman et al., 1986 and Sohlberg & Norring, 1992).
Inpatient Follow-Up Studies

Bulimic patients in two of the twenty-eight posttreatment outcome studies were treated initially in inpatient settings, followed by outpatient treatment (Russell et al., 1987; Swift et al., 1987). In their study, Russell and colleagues (1987) randomized their female clients into family and individual support therapy groups and found that, at one-year follow-up, family therapy resulted in higher recovery rates for clients who experienced early-onset bulimia (age nineteen or younger). They also found that chronologically older bulimics evidenced better rates of recovery when placed in individual psychotherapy. Swift and copartners found in their two- to five-year posttreatment outcome study (1987) that their data supported the view that bulimia nervosa is a chronic disorder that often persists after treatment.

Methodological Pitfalls

Differences across the twenty-eight posttreatment studies regarding bulimic definition, recovery criteria, treatment and follow-up duration, data collection methods and sampling selection, as well as concerns about the control of extraneous variables, make it impossible to construct a meta-analysis that generalizes conclusions about the overall effectiveness of psychological treatment in terminating women's bulimic practices.

Reports on bulimic recovery vary widely. This is true, in part, to discrepancies in diagnostic criteria, recovery definitions, treatment and follow-up time frames, data collection methods, client selection, and failure to hold extraneous variables constant. Ranges of posttreatment recovery vary from as low as 2% of the sample (Ordman & Kirschenbaum, 1985) to as high as 100% of the sample (Wilson et al., 1986). Factors contributing to such extreme posttreatment recovery ranges include inconsistent criteria used to define both bulimia and recovery status across studies.

The use of different testing instruments to measure improvement and/or recovery also contributes to the extreme variability in the number of posttreatment clients across
studies who are reported as either improved or recovered. For instance, Hsu and Sobkiewi (1989), in their four- to six-year posttreatment outcome study, determined recovery to be an absence of binging, vomiting, and other forms of purging for six months preceding the follow-up study. Mitchell, et al. (1986) defined recovery as complete abstinence from binging and vomiting for the twelve to fifteen months between initial evaluation and follow-up. Norman and colleagues (1986) defined recovery as a decrease in disordered eating without specifying the parameters of bulimic decrease. Hsu and Holder (1986) determined that recovery meant that patients markedly improved. The varied criteria for the rating of outcome across studies cause confusion over the meaning, demarcation and interrelationship among remission, recovery and improvement and make direct comparison among outcome recovery studies unrealistic.

Variability in treatment duration and posttreatment follow-up time frames also contributes to the extreme ranges in the numbers of posttreatment clients reported as improved, in remission or recovered. Examples of variability in treatment duration include Baell and Wertheim’s investigation (1992) in which bulimic clients received four months of treatment, Freeman and co-workers’ study (1985) in which bulimic patients received an average of eight months of treatment and Maddocks and colleagues’ follow-up study (1992) of bulimic clients who had received ten to eleven weeks of intensive day treatment. Furthermore, Mitchell, et al. (1986) conducted a posttreatment outcome study in which 18 percent of their respondents received no treatment between initial evaluation and follow-up. Posttreatment follow-up duration varies from as short as 10 weeks (Wolchik et al., 1986) to as long as six years after receiving treatment (Hsu & Sobkiewi, 1989).

Many experts view bulimia nervosa as a chronic episodic disorder that often goes into remission only to reactivate during stressful periods (Hsu & Holder, 1986). Therefore, the seventeen short-term studies occurring within the first eighteen months after presenting for or completing treatment may have measured bulimic remission rather than
bulimic recovery. Hsu and Holder (1986) recommended that a reliable follow-up study on posttreatment outcome should be conducted no earlier than four years after treatment to allow bulimia nervosa to run its course.

Diverse methods of collecting data (mailed questionnaires, face-to-face interviews, telephone interviews), as well as use of different measuring instruments, resulted in sundry outcomes that make direct comparison among studies and generalized conclusions about treatment effectiveness across studies an impossibility. For example, Abraham, et al. (1983) used four methods of assessing posttreatment outcome with one bulimic sample. Their findings revealed different rates of posttreatment recovery within this one sample, dependent upon which data-collection method was used to measure bulimic recovery.

As previously discussed, posttreatment bulimic clients cannot be compared across studies because of inconsistencies regarding bulimic definition, outcome criteria, length of treatment, duration of follow-up, type of treatment (i.e., inpatient versus outpatient services; individual versus group and/or family treatment; cognitive behavioral versus insight-oriented therapy) and data collection methods.

Furthermore, many researchers did not specify whether their bulimic samples included or excluded various behavioral subtypes (e.g., laxative-abusing, chemical-abusing, ipecac-abusing). Only Johnson, et al. (1990) and Mitchell, et al. (1990) designed studies comparing posttreatment outcome between bulimic samples with divergent psychological profiles (borderline bulimics versus non-borderline bulimics and bulimics with and without prior chemical dependency problems).

follow-up on ninety one bulimic clients and Mitchell, et al. (1990) followed one hundred former clients.

The age homogeneity of respondents also limits generalizing of these outcome studies to the general bulimic population. The majority of these twenty-eight outcome studies conducted research on female samples in their early to mid-twenties, leaving the research and clinical community with limited information regarding the posttreatment outcome of chronologically mature bulimics.

The biopsychosocial complexity of bulimia nervosa suggests that the recovery process, like the disorder process, is multidetermined. An analysis of bulimic recovery necessitates a consideration of environmental (non-treatment) factors. However, the majority of researchers have focused upon the linear relationship between treatment and recovery without considering the impact of non-treatment variables on the recovery process. Furthermore, the failure of many researchers to meet quantitative standards for controlling potentially contaminating situational and environmental variables results in a lack of confidence in the supposition that the posttreatment outcome findings may be attributed directly to clinical treatment.

Conclusions

The methodological pitfalls of quantitative posttreatment outcome studies compromise the value of findings regarding the effect of treatment on bulimic recovery. Individually, the majority of these twenty-eight posttreatment outcome studies failed to meet the criteria of their own scientific rules regarding methodological and sampling procedures, particularly in regard to client selection and control of confounding variables. Collectively, these studies adhered to no universal consensus regarding bulimia and recovery criteria, treatment and follow-up time frames, data collection methods and bulimic sampling selection. A casual reading of the outcome research suggests that outpatient settings utilizing cognitive behavioral therapies in both group and individual treatment
positively impact upon bulimic recovery. However, a more thoughtful analysis of the posttreatment outcome literature indicates that procedure discrepancies and inconsistencies across studies invalidate any meaningful generalizations about the effectiveness of psychological treatment in terminating bulimia.

In conclusion, the quality of the quantitative studies on posttreatment outcome is suspect because they fail individually and/or collectively to follow the rules of scientific research, and in that failing, allow for no definitive conclusions about the effectiveness of the therapeutic process in eliminating bulimia.

Community Based Recovery Studies

Only three studies on bulimic recovery that drew samples from the community were located. These studies utilized qualitative methodology in ascertaining some or all recovery information.

Kirk (1986) conducted a descriptive survey on community-based former bulimics to gain an understanding of their views on their recoveries. As a component of her study, Kirk conducted a mailed questionnaire to determine whether treatment modalities identified by the professional treatment community as assisting in the recovery process were perceived by recovered bulimics as having aided them in ameliorating their bulimia. Kirk also conducted a mailed questionnaire to determine whether bulimic behavioral subtypes (laxative-abusing versus non-laxative-abusing) used differing methods to sustain recovery. Furthermore, Kirk attempted to discover whether duration of bulimic behaviors affected the ways in which recovery was achieved and sustained.

By using methodological triangulation Kirk improved the probability that her findings would be credible. She used both closed-ended (predetermined response categories) and open-ended questionnaires with all respondents and conducted personal interviews (telephone or face-to-face) with twelve of the one hundred and twenty-three respondents.
Kirk found that community-based former bulimics used a variety of supports and strategies to achieve bulimic recovery. Most germane are the findings of the closed-ended questionnaire:

Of the 74 identified aspects of recovery from bulimia suggested in the literature, only 45 of these aspects had been tried by the majority of the respondents to this survey. Of those aspects tried, only 18 were found to be helpful at least 50% of the time (Kirk, 1986, p. 136).

Kirk also found that respondents having longer bulimic duration (three or more years) and respondents having fewer than three years of bulimic behavior recovered in similar ways. The research literature suggests that laxative-abusing bulimics require a different treatment process than non-laxative-abusing bulimics if they are to achieve recovery (Kirk, 1986). Kirk found that, although former laxative-abusing bulimics placed more reliance upon psychoeducational materials from self-help groups, both former laxative-abusing and non-laxative-abusing bulimic groups were similar in their use of all other recovery supports. According to Kirk (1986, p. 149), no research study prior to her project affirmed self-help and support groups as advantageous to recovery. However, respondents in Kirk’s study reported that self-help and support groups were important dimensions of their bulimic recoveries.

In contrast to Kirk’s study, Powers’ (1986) community-based study of practicing and recovered bulimics found that 90 percent of the recovered bulimics viewed psychotherapy as crucial to their recovery process. Nine of the ten former bulimics found individual or group therapy to be central to their learning to deal with disquieting emotions and thoughts that had previously triggered their bulimic episodes. However, caution must be taken in drawing conclusions about the importance of therapy in ameliorating bulimia because ninety percent of the recovered bulimics were in therapy while participating in the study. Perhaps their perspective on the role of therapy in their bulimic recovery would be more reliable several years after terminating the therapeutic process.
O'Byrne's (1992) community based qualitative study of seven former bulimics found that four of the women did not participate in any form of formal psychotherapy to facilitate or support their bulimic recoveries.

Conclusion

Because of methodological dissimilarities in the three studies, it is difficult to compare findings in any meaningful way. However, the contrasting findings regarding the value of therapy in terminating bulimia warrant continued investigation into women's accounts of how they recovered from their bulimic practices.

Popular Literature On Recovery

During the past twenty years the popular press has published prolifically on this syndrome (Gordon, 1990; Kirk, 1986). The focus of much of this literature is upon detailed descriptions of bulimic behavior with intent to identify the disorder and to dramatize its damaging effects. Although most of the lay publications discuss treatment options, many fail to communicate the subjective experiences of former bulimics.

Autobiographical accounts of bulimic recovery are another aspect of the popular literature. Famous (Jane Fonda, Lynn Redgrave, Gelsey Kirkland etc.) and unknown women have written of their experience with bulimia and with bulimic recovery (Fonda, 1981; Hall, 1987; Kirkland, 1986; O'Neill, 1983; Redgrave, 1991; Rowland, 1984; Miller, 1988). All of these bulimic testimonials are shared by women who consider themselves to be in recovery.

believed that the skeletal-frame aesthetics of ballet led her into disordered eating; however, she failed to identify what augmented her recovery.

In a detailed description of her incremental recovery, Hall (1987) wrote that, with the emotional support of her lover, she slowly replaced binging and purging with other activities, such as meditation, writing, artwork and friendships. Hall's testimonial indicated that as she discovered more meaningful pursuits, her reliance on bulimic activity diminished.

The autobiographical accounts suggest that meaningful activities came to replace obsessional relationship with food and weight. However, many of these personal accounts of bulimic recovery are hindered by a lack of specificity regarding the kinds of environments and practices that facilitated their recoveries.

**Commentary On The Literature Review**

The literature review of research studies on clinical posttreatment bulimics and community-based recovered bulimics, as well as the popular literature on bulimic recovery, discloses no collective consensus on what strategies, treatments and/or supports enable some bulimics to give up their eating disorder.

The conviction that eating disorders are disproportionately represented in young, white, middle- and upper-class female populations (Gordon, 1990) is reinforced by the research studies reviewed by this investigator. The posttreatment outcome studies drew samples from predominantly young female Caucasians in upper socioeconomic stratifications. The three community-based research studies recruited a majority of their respondents from Caucasian, upper-income female populations with a mean age under 30. This researcher is not challenging the accuracy of the skewed class distribution of eating disorders, which is documented in the literature, nor discrediting the value of research studies that drew samples or recruited respondents from Caucasian female middle and upper classes. However, the lack of sampling from racial, ethnic and lower-socioeconomic
populations, as well as lack of sampling from older women does not allow for recovery information to be gathered on these bulimic populations.

Finally, only three of the thirty one research studies emphasized the bulimic's point of view (Kirk, 1986; O'Byrne, 1992; Powers, 1986).

Due to methodological concerns in quantitative studies, no universally accepted understanding of what facilitates and supports recovery is presented in the positivist research studies on bulimic recovery.

More important, from a postpostivist perspective, is the sparsity of qualitative studies on the phenomenological realities of bulimic recovery as constructed by former bulimics. Only the autobiographical accounts in the popular literature voice the stories told by women who have recovered from bulimia. In general, narratives of recovered bulimics, told in their own voices, are not reflected in the professional literature. The paradox is that, although most experts agree that a bulimic's subjective perceptions about her relationship to her body and to food are pivotal to recovery, her understanding of her own recovery is largely ignored by the professional community.
CHAPTER III

METHODOLOGY

Introduction

Very little research has explored bulimic recovery from the perspectives of those who have experiential insights. Few studies have focused on the subjective understandings and lived experiences of recovery as constructed by former bulimics. Existing research based findings most often rely on statistical analysis of recovery information, objectivity and subject/object detachment. Often, outside authorities determine the realities of bulimic recovery through statistical procedures while the voices of recovering bulimics remain silenced.

The purpose of this descriptive, exploratory study was to gain understandings of what facilitates bulimic recovery from the point of view of former bulimics. A naturalistic approach and qualitative methods were selected as the most effective means by which to examine the subjective meanings that women attached to their recoveries from bulimia nervosa.

This study depended on the self reporting of women who considered themselves in bulimic recovery as defined in this study (refer to chapter I under key terms) as the data for analysis, relying upon their recall of what supported them as they learned to eat without resorting to bulimic practices. The phenomenological orientation of this inquiry respected the unique perspective of each woman. Inquiry depended upon women’s subjective reporting in their particular context. It was expected that multiple ways of interpreting and supporting recovery would emerge from the study.
Congruence with Social Work

Naturalistic inquiry, rooted in the phenomenological perspective, is suited, not only to this study, but also to our profession's ecological perspective of understanding people in their situational and environmental transactions. Ruckdeschel (1985) suggests that naturalistic inquiry is congruent with social work because it values the contextual aspects of perception, believing that context influences people's construction of reality. Naturalistic inquiry, like social work, focuses upon the meanings persons bring to their interactions with their environment. Furthermore, the values undergirding qualitative methodology are consistent with social work's axioms regarding interactive processes and phenomenological shaping of reality.

Design

The design of this naturalistic inquiry into women's recovery from bulimia was characterized by principles and methods that are discussed by Berg, 1989; Bogdan and Biklen, 1992; Denzin, 1989c; Glaser and Strauss, 1967; Glesne and Peshkin, 1992; Lincoln and Guba, 1985; Marshall and Rossman, 1989; Miles and Huberman, 1984; Patton, 1990; Strauss, 1987; and Strauss and Corbin, 1990.

Instrumentation (The Human Instrument)

The researcher was the primary data-gathering instrument, utilizing interactive interviews. Tacit (intuitive) knowledge, in addition to propositional (expressed through language) knowledge, were the indispensable components of the research process, yielding the concepts, categories and themes that emerged out of this naturalistic inquiry.

The researcher brought to this investigation "sensitive insights" (Glaser & Strauss, 1967, p. 251) about the practice of and recovery from bulimia nervosa. Glaser and Strauss, in discussing the relation of insight to theory, stated that "The root sources of all significant theorizing is the sensitive insights of the observer himself" (1967, p. 251).
The researcher's personal journey into and out of bulimia contributed to her subjective understanding of at least some of the meanings that former bulimics brought to their recovery experiences. In addition, the researcher's clinical social work practice with women experiencing abusive relationships with alcohol, drugs and food gave her another dimension of understanding of bulimic practices and recoveries.

Emergent Design

The conceptual structure of naturalistic inquiry is predicated upon the ontological axiom of multiple realities and upon the epistemological axiom of participant-and-inquirer interactive influence upon one another. These naturalistic axioms meant that the design and procedures could not be fully specified by the investigator prior to the collection of data, but remained emergent. The design of this naturalistic study unfolded dependent upon the ongoing interactions among investigator, participants and context.

Inductive Analysis and Grounded Theory

Naturalistic inquiry does not work with a fixed predetermined design or a priori theory but rather, allows design and theory or themes to emerge naturally out of the inquiry. Consistent with the idea of emergent design and grounded theory, data analysis was an ongoing and emergent process. The data collected in this naturalistic study was analyzed inductively from "...raw units of information to subsuming categories of information" (Lincoln & Guba, 1985, p. 207). Categories of meaning emerged from the coding of units of information through the use of the "constant comparative method" (Glaser & Strauss, 1967, p. 106). Through ongoing constant comparison of newly collected data with existing codes and categories a full range of a category's characteristics were identified and the category's relation to other categories was established (Glaser & Strauss, 1967). Constantly reshaped by new data, ongoing coding and data analysis let the focus of inquiry narrow and generated the development of
grounded concepts, categories, core categories and/or themes. The data analysis for this study were the words that the women used to tell their recovery stories. The following procedures of analysis, developed and/or advocated by Glaser and Strauss (1967), Strauss (1987) and Bogdan and Biklen (1992) were utilized:

Strauss' "Concept-indicator model" (1987, p. 25) directed the conceptual coding. Text was examined for participant described actions, events, ideas, etc., that, when integrated with ongoing data collection indicated a concept.

Data collection was considered a procedure of analysis because collecting and analyzing data were mutually shaping. In this study, following Strauss' advice (1987), analysis began shortly after the first interview and continued throughout the period that the researcher was in the field conducting interviews.

Coding is the term for naming and conceptualizing data. Coding was derived from identifying conditions, actions, ideas, events, etc. Beginning with unrestricted "open coding" (Strauss, 1987, p. 28) that identified provisional codes, the naming of data become more selective as data analysis progressed. Coding were "in vivo codes" (Strauss, 1987, p. 33) or "sociologically constructed codes" (Strauss, 1987, p. 33). In vivo codes were codes using the participants' terms. An example was red flags. Sociologically constructed codes were codes that the researcher named. An example was bulimic recovery definitions. "Prefabricated start list of of codes" (Miles & Huberman, 1984, p. 57) created prior to data collection were rejected in order to remain sensitive to the particularities of each woman's story. The researcher, taking the grounded approach to coding advocated by Glaser (1978), let the codes emerge out of the data of each woman's story.

"Core categories" (Strauss, 1987, p. 34-35) are categories of concepts from which theory is generated. Core categories were determined by following the core categories criteria established by Strauss (1987). Each core category related to many
other categories, appeared frequently, had implications for a theme or theory, and allowed for maximum degrees of change in the analysis.

**Integration**, or as Strauss said, “how to make everything come together” (1987, p. 170), was the process by which the researcher determined the importance of identified categories and pulled them into a collective to build themes.

**Purposeful Sampling**

Purposeful sampling, as discussed by Bogdan and Biklen (1992), Lincoln and Guba (1985) and Patton (1990), depends on selecting participants from whom much can be learned regarding the topic under investigation. Purposeful sampling was used to access information-rich cases for in depth study. The participants were chosen because they believed that they met the bulimic recovery criteria for participation in the study and because they had much to offer regarding their personal bulimic recoveries.

**Triangulation**

In this study two data collection methods, individual interviews and a bulimic recovery charting assignment (appendix G) were utilized to enhance the credibility of the findings. In addition, formal and informal member checks were utilized as a third method of triangulation to further strengthen the credibility of the findings.

**Focus**

This study examined the elements of recovery from the points of view of former bulimics. The problem for research was what constituted bulimic recovery. The central research concern was what facilitated and supported bulimic recovery. Participants who resided in the states of Ohio and Michigan and defined themselves in bulimic recovery as defined in this study participated in the study.
Site Of The Study

Individual interviews were conducted in multiple locations dependent on where the participants judged that they would do their best talking. To ensure convenience, time and place of the interviews were determined by the participants. Two women chose to do all interviews at my home, two did one interview in my home and remaining interviews in their homes. The remaining women did all the interviews in their own homes.

Sample

Recruitment of Participants

Identification of information-rich participants for in-depth study were accessed through a sampling technique that Patton described as “snowball sampling” (Patton, 1990, p. 176) and Glesne and Peshkin labeled “networking” (1992, p. 27). The researcher expected that locating participants would be problematic because research based findings supported that women are hesitant to expose their bulimic histories (Jablow, 1992; Zraly & Smith, 1992). However, that was not the case. Every women who made contact was enthusiastic about telling her recovery story and wanted to participate in the study. Although six women were needed for the study, fifteen women contracted the researcher in hopes of being in the study. The investigator contacted individuals (liaisons) whom she thought might know recovered bulimics and requested that they serve as liaisons between potential participants and the researcher. Liaisons were sent a follow-up letter that described the research study (appendix A) and a letter to give to potential participants (appendix B). Liaisons gave the potential participants the letter of introduction (appendix B) and encouraged them to make phone contact with the researcher. All contacts with the researcher, as well as name identification, were initiated by the potential participants.

Subsequent to making phone contact with the researcher, prospective participants who defined themselves as meeting the criteria for inclusion in the study were mailed a
packet containing an explanatory letter (Appendix C), and a data sheet (Appendix D). The packet included an addressed, stamped envelope so that the data sheet could be returned by mail. After reviewing the returned material the researcher notified the potential participants as to whether or not they would be included in the study.

The explanatory letter (appendix C) explained the study’s purpose, the interviewing format and bulimic recovery charting assignment. Potential participants were encouraged to contact the researcher to ask questions and to explore concerns prior to deciding to take part in the study. The letter reminded subjects that confidentiality would be maintained and that they could terminate participation at any time.

The data sheet (appendix D) verified that the prospective participant met the bulimic recovery criteria set forth in the study.

Women who participated in the study were asked to read and sign a consent form (appendix E) prior to beginning the first individual interview. The consent form specified the purposes and stipulations of the research study. The participants were informed that focused recall of past experiences might result in emotional discomfort and that the researcher maintained a reference list of competent mental health specialists with expertise in eating disorders to whom she might refer participants should the need arise.

Data Collection Procedures

Triangulation

Methodological triangulation improved the probability that the findings and interpretations of the study would be credible (Berg, 1989; Denzin, 1989c; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Patton, 1990). Two data collection methods were used. The first method of inquiry consisted of individual interviews. The second method of inquiry entailed participants self-selecting a method by which to communicate their recovery experiences (appendix G). This assignment was called the bulimic recovery
charting assignment. In addition, findings were shared and negotiated with research participants through member checking. Informal (ongoing) and formal (at the conclusion of all interviewing) member checks constituted another method by which to establish credibility of the researcher's representation and interpretation of the participants’ bulimic recovery stories.

The next section elaborates on the data collection and member checking methods utilized in this study:

**Data Collection Methods**

**Phase One: Individual Interviews**

Because qualitative interviewing assumes that the phenomenological perspective of others is meaningful (Patton, 1990), it was the dominant strategy for data collection. Through interactive and purposeful interviewing, the researcher encouraged the participants to bring her into their worlds of constructed meaning (Patton, 1990).

Five of the six women were interviewed individually in three separate sessions. The sixth woman was interviewed in two separate sessions. Each session lasted two hours and took place at a time and location determined by the participant. Each interview, with the consent of the participant, was tape recorded. Written notes were also taken by the researcher during each interview session. The interviews were minimally structured from the central research question: **Describe your bulimic recovery process and how it came to be.** Consistent with the concepts of emergent focus and design (Lincoln & Guba, 1985), more specific questions developed as data were collected.

The researcher conducted first interviews with the women prior to conducting second interviews. All second interviews were completed prior to returning to the women for third interviews. Each level of interviewing, building on preceding in-depth interviewing, moved to a higher level of inquiry.
The first interview was loosely structured to give participants the opportunity to share what they believed to be relevant to their bulimic recoveries in their own voices. The initial open-ended research question (Describe your recovery process and how it came to be) gave participants the opportunity to discuss what they determined were salient issues. Some open-ended questions were held in reserve and available at the discretion of the researcher (Appendix F). Informal member checking occurred at the end of the interview.

The second interview served for further and more focused exploration of topics and issues raised by the participant in her first interview and to discuss the completed bulimic recovery charting assignment. Informal member checking occurred at the end of the interview.

The third interview was conducted with five of the six participants to further explore topics and issues raised during first and second interviews. Informal member checking occurred at the end of the interview.

Phase Two: Bulimic Recovery Charting Assignment

At the end of the first interview, participants were requested to return home and construct a chart or any other method by which to convey important events and persons in their recovery process (appendix H). The participants were instructed to identify and explain why specific events and people were important to their recoveries. Participants who had experienced bulimic relapses were encouraged to identify events and persons triggering those episodes.

The researcher remained sensitive to the multiple ways in which participants would bring meaning to this assignment. Therefore, specific instructions regarding how to complete this assignment were not given (appendix G). However, participants were encouraged to telephone the researcher for interactive discussion during the process of
doing the assignment. Participants were requested to return their bulimic recovery charting within a week. Such a short turnaround encouraged immediacy of recall and protected participants from making too much of the assignment. Unique and idiomatic executions of this assignment were expected. Three of the participants charted their information. One participant relied on both written and audio-taped information and another did a charcoal drawing of the events, people and animals that played a role in her recovery.

Phase Three: Member Checks

Although member checking was an on-going process, it was also a distinct phase of the design in which data analysis were shared with participants for their verification. Member checks occurred at four different intervals of the study and are best categorized as informal member checks for text accuracy and formal member checks for participants’ validations of the researcher’s representation and interpretation of their recovery stories.

Informal member checks followed the conclusions of all interviews to clarify any informational aspect of the interview process. Informal member checks also occurred when the participants were sent their transcribed interviews so that they could determine if the text was factually accurate.

Formal member checks took place at two junctures. The first formal member check occurred at the beginning at the last interview and is best described as the within case analysis member check. This formal member check focused on receiving the participant’s reaction to the researcher’s thematic interpretation of her data. The researcher took notes and tape recorded the participant’s comments. The third interview focused on the participant’s clarifications and elaborations on the thematic interpretation of her story. Feedback from each participant was sought using the question: Do you feel that you your recovery experiences and views are represented in this analysis?
During this interview some participants were also asked to comment on cross-case findings that they had not mentioned as relevant to their own recoveries.

The second formal member check occurred after all interviews had taken place and the cross study analysis was completed. The participants were mailed an explanatory letter (appendix H), a stamped self-addressed envelope for returning the completed questionnaire, and the four findings chapters. A brief questionnaire requested their written responses to the researcher’s representation of their recovery stories (appendix I). The questionnaire sought participant feedback by posing three open-ended questions: Do you feel that your experience is represented accurately? How would you change it? What did you get out of being in this study? The explanatory letter (appendix H) stated that if the questionnaire was not returned by a specified date, the researcher would assume that the participant felt that the researcher’s representation of her bulimic recovery was accurately portrayed.

Responses were supportive of the researcher’s findings. Participants, under question two, also used this membercheck opportunity to expand on their views of recovery. An important participant contribution to the researcher's analysis were their comments regarding the positive effect that participation in this study had on their lives (refer to chapter VIII, under participant responses to researcher’s findings for discussion).

**Data Analysis**

The data that were analyzed in this study consisted of text, or the words that women used to tell their bulimic recovery stories. The researcher also relied on text when a participant presented her with a charcoal rendering of her bulimic recovery charting assignment. Because the artwork was filled with images that held highly subjective meanings, the participant verbally explained the meanings of her art images during the formal membercheck that preceded her third interview. Text was transcribed verbatim
from the tape-recorded interviews by a professional typist. Because the study focused on individuals and on recovery issues it required two different but complementary data analysis strategies. Individual case analysis caught the particularities and idiosyncrasy of each women's story. Cross-case analysis focused on recovery perspectives across themes that appeared in each women's story. These two data analysis approaches in tandem focused on the variations in individuals and the issue of recovery across women. Heeding Patton's warning that "trying to do both individual case studies and cross case analysis by issue at the same time will likely lead to confusion" (1990, p. 377), I completed phase one analysis (within case analysis) prior to doing phase two analysis (cross-case analysis).

**Phase One**

The inductive analysis of data was a two-phase process. **Phase one** occurred while in the field. Data analysis, while in the field, was an ongoing process concurrent with data collection (Bogdan & Biklen, 1992). In phase one, I focused on the data generated by each woman (within case analysis) with an eye for what spoke to the central research question: Describe your bulimic recovery process and how it came to be. Relying on Strauss' "concept indicator model" (1987, p. 25), text was analyzed for patterns which when compiled indicated a concept. An example of a code was exercise.

**Phase Two**

In phase two, those core categories that appeared across the women's stories generated grounded themes. These themes were identified as the commonalities in the cross-case analysis while the concepts particular to each woman's theme indicated the differences and diversity in the ways the four themes of recovery were played out by individual women.
Coding

Coding is the term used for “conceptualizing the data” (Strauss, 1987, p. 20). In phase one the coding system for each of the six women was dependent on her unique and idiomatic text. No cross analysis attempt was made while in the field until after the second interviews were completed. Developing a coding system to categorize each woman’s data was adapted from the steps suggested by Bogdan and Biklen (1992). Emergent codes were grounded in what was discussed. Most women had between twenty and twenty-five coding categories. Most codes named relationships, events, activities or definitions. Data were coded by hand on the interview transcripts. Coding began with an open, unrestricted coding of the data (Strauss, 1987) which identified provisional concepts, that in time through the “constant comparative method” (Glaser & Strauss, 1967, p. 104) began to generate the full range of characteristics of a category.

Categories

Categories are clusters of concepts, linked together by their relationship to each other (Strauss, 1987). An example was bulimic recovery strategies. Developing categories from each woman’s codes consisted in collapsing clusters of concepts under a category heading that represented the concepts interlocking relationship to each other. The researcher also used the constant comparative method described by Glaser and Strauss (1967) to generate the full range of attributes of the category under review.

Core Categories And Themes

“Core categories” (1987, p. 34) is the name that Strauss gave to those categories of concepts from which theory evolves. Core categories account for most of the range of characteristics and variations in a behavior. (Strauss, 1987). The themes that emerged out of each woman’s story were grounded in the core categories that reflected her point of view about her bulimic recovery.
Editing The Quotes

Deciding to edit quotes of the six women’s points of view on the four emergent themes lead to computer-assisted editing (Bogdan & Biklen, 1992; Glesne & Peshkin, 1992). However, this approach created a sense of distance from each participant. The sense of objectifying and separating out pieces of each woman’s story remained when edited quotes were put on file cards (Bogdan & Biklen, 1992). I resolved the quote editing problem by devising a visualization approach that served the within case and across case thematic needs of the project.

Using what I call “charting the data”, I started by editing participant quotes within case across the four identified themes. Using large drawing paper I cut and pasted germane quotes from each women’s text under each theme, producing in the end all the quotes across the four themes for each of the six women. This product was the completed within case edited quotes for each women. This product also served as the across case edited quotes by theme. By taking the women’s drawing sheets of pasted quotes by theme and putting them in thematic subdivisions I created the across case edited quotes. Therefore, by having the edited quotes of all the women on drawing paper, I was able to move from within case edited quotes across the four themes to cross-study edited quotes by theme. Whenever I felt a sense of distance from a woman’s experiences with a particular theme during cross analysis, I returned her drawing paper of edited quotes back to her within case thematic story across all four themes and read her quotes in entirety with cross reference to her unedited text which was kept in a ring binder. To further guard against losing the women’s stories or distorting meaning through extracting quotes from context, I frequently cross read the participants’ edited quotes with their unedited transcriptions.
Trustworthiness

According to Giesne & Peshkin (1992), Lincoln and Guba (1985), and Patton (1990), trustworthiness is concerned with the ways in which a researcher persuades an audience that the findings of an inquiry have “true value” (Lincoln & Guba, 1985, p. 290) and are worth paying attention to. As with all research, the researcher wanted to establish the trustworthiness of the findings of study. Furthermore, she was concerned with determining the findings’ applicability in other contexts, with other participants, and with determining the degree to which the findings would be consistently repeated if the study were to be replicated with similar participants in similar context. Finally, the researcher was concerned with determining the degree to which the inquiry’s findings and emergent themes were grounded in the perspectives of the participants rather than shaped by the researcher’s biases and interests.

Built on their premise that conventional criteria be replaced with new terms that are congruent with the naturalistic paradigm, Lincoln and Guba (1985) provided guidelines for the development of trustworthiness in naturalistic inquiry. Their criteria replaced the positivist rules for establishing trustworthiness through internal validity, external validity, reliability and objectivity. In naturalistic inquiry, credibility replaces internal validity, transferability replaces external validity, dependability replaces reliability and confirmability replaces objectivity.

The trustworthiness of the findings of this study were established by adopting the following techniques that were proposed by Lincoln and Guba (1985) and expounded on by Berg (1989), Denzin (1989c), and Patton (1990).

Credibility

Credibility is the extent to which the findings and further interpretations reflect the participants points of view (Lincoln & Guba, 1985). Credibility was achieved
through four processes built into the research design that increased the probability that credible findings would be achieved. The four techniques were prolonged engagement, triangulation of methods, peer debriefing and member checks.

**Prolonged engagement** allows for an extensive investment of time with the participants to increase the probability that the findings will be credible (Lincoln & Guba, 1985; Patton, 1990). In this study, prolonged engagement was achieved through multiple interviews and the bulimic recovery charting assignment. These two activities gave the researcher sufficient time with the participants (via telephone and in person) to build trust and rapport and to test out researcher distortions and misinformation that infiltrated the data.

**Triangulation of methods** improves the probability that findings will be credible (Berg, 1989; Denzin, 1989c; Lincoln & Guba, 1985; Patton, 1990). By using two different methods of data collection (individual interviews and bulimic recovery charting), the uncertainty of findings was reduced.

**Peer Debriefing** improves the likelihood of credible findings by exposing the researcher to an impartial peer through analytic sessions for the purpose of exploring facets of the inquiry that might otherwise remain unexamined (Lincoln & Guba, 1985; Patton, 1990). The researcher shared her methodological and analysis processes, examined her interpretations, and evaluated her biases with a “disinterested peer” (Lincoln & Guba, 1985, p. 308) who was not involved in the research study. For over a year’s time, biweekly sessions were held between the researcher and a fellow doctoral candidate who was well informed on postmodern paradigms and qualitative methodology.

**Member Checking** is considered by Lincoln and Guba (1985) to be the most crucial technique for establishing credibility because it provides an opportunity for participants to respond to the researcher's representation of their realities. In this study,
member checking was both an informal process (at the end of each interview) and a formal process (phase three of the data collection process).

**Transferability**

Transferability, according to Lincoln and Guba (1985) demonstrates the applicability of a study’s findings to another context. Transferability was achieved through thick descriptions that would enable an individual interested in making a transfer of the findings to determine whether transferability of the findings was feasible.

**Dependability**

Dependability of the findings was strengthened by using overlapping methods of collecting the data (interviews and charting) and by maintaining records of all phases of the study that served as an audit trail. The rationale of the audit trail was to make available the researcher’s process of gathering data, as well as the data producing product so that an examination of the audit trail could determine the dependability of the final product.

**Confirmability**

Confirmability is the process of determining the accuracy of the data. Confirmability determines if the findings are grounded in the participants stories or are an outcome of the researcher's fancy (Guba and Lincoln, 1989). In this study confirmability was achieved through three techniques: a confirmability audit, triangulation of data collection methods and the keeping of a reflexive journal. The researcher kept an audit trail (comprised of record keeping of all facets of the inquiry). The audit trail has been made available to anyone who wished to confirm the findings of the research. The researcher used triangulation of methods for the collection of data. Finally, the researcher kept a reflexive journal in which she wrote information about herself and her
methodology. She recorded self reflections (thoughts and feelings about the research and the participants) and methodological concerns.

**Pilot Study**

One pilot study was conducted to improve the quality of the actual study. All of the requirements of the actual study were strictly followed. The pilot study provided an opportunity to identify unanticipated issues related to the participants, interviews and the bulimic recovery charting assignment. Knowledge gained from the preliminary study contributed to more efficiency in collecting the data of the research project. Because no complications arose, the participant of the preliminary study was considered one of the six women of the actual research project. No effort was made to analyze her data in relation to the study until phase one of the formal study commenced.

**Protection of the Participants**

The researcher anticipated that the exploration of bulimic recovery would be an affirming experience because it would connect participants to their personal strengths in overcoming an eating disorder. However, there was always the possibility that some participants in the study might experience psychological stress and/or behavioral impairment as a result of exploring their bulimic experiences. The researcher, a Licensed Independent Social Worker and member of the Academy of Certified Social Workers, has extensive clinical experience in the mental health field, working with women. The researcher would have utilized her clinical skills to evaluate problems if they had arisen for participants and to handle immediate needs. In addition, she maintained a reference list of competent mental health specialists with expertise in eating disorders to whom she could have refer participants if the need had arose.

To protect the confidentiality of participants, all protocol materials, tapes, transcripts and notes were kept in locked files. No taping was conducted without the
written consent of participants (see consent form appendix E). Although transcripts will be preserved after publication of the research project, all tapes will be destroyed at the end of the study. Confidentiality was assured by obscuring identifying information (names, places, time frames) in the discussion and writing of the study.

**Expected Implications**

It was expected that the women's points of view about their bulimic recoveries would generate new knowledge about bulimic recovery. The study was descriptive and exploratory and did not seek to make generalizations about what facilitates and supports bulimic recovery.
CHAPTER IV
TURNING POINTS

Introduction

The women’s stories of recovery from bulimia are filled with similarities and differences. Although common themes emerged from the women’s stories, their phenomenological perspectives and divergent pathways into recovery produced rich variations in their experiences with each of the following themes.

The women identified and discussed experiences that sparked their impulses to change and went on to extend the concept of recovery beyond the resolution of bulimia. In addition, the women discussed environments that supported their recoveries and strategies that helped them sustain their recoveries. These commonalities in their stories are best described as the themes of turning points, dimensions of recovery, environments of recovery and practices of recovery.

The themes emerging out of the experiences of bulimic recovery that are common to all the women in the study must be analyzed without losing each woman’s particular context and subjective understanding of her specific recovery experiences. Therefore, the final theme emerging out of the particularities of the six women’s stories and permeating the themes of turning points, dimensions of recovery, and environments and practices of recovery is best described as “no one way.”

The findings begin, in chapter four, with an examination of the relationship of the turning points in the lives of these six women to their recoveries from their bulimic practices. Chapter five is an analysis of the women’s understandings of the meaning of their recoveries that culminates in the development of a concept of recovery that is inclusive.
of but moves beyond recovery from bulimia. Chapter six is an exploration of their environments of recovery. The analysis concludes, in chapter seven, with a critique of the practices that sustained their recoveries.

This chapter begins with a discussion of the characteristics of those milestone experiences that the women in this study identified as pivotal to their recoveries from bulimia and then moves on to examine the relationship of these turning points to recoveries from the practice of bulimia. The chapter concludes with a discussion of the relationship of the women's turning point experiences to conceptual frameworks for studying turning point experiences that take place in adult life. Particular attention will be placed on the epiphanal typology posited by Denzin and the classification of transformational experiences put forth by Strauss.

**Characteristics of Turning Point Experiences**

Denzin described turning point experiences as "moments of revelation in a person's life" (1989a, p. 33). It is those revelations, according to Denzin (1989a, p. 70), that alter a person's fundamental meaning structures. Strauss described turning point experiences as "points in development when as individual has to take stock, to re-evaluate, revise, resee, and rejudge" (1959, p. 100). Strauss stresses that turning points occur in a person's life when incidents happen that force that person to realize that they are no longer the person that they once were (1959, p. 93).

For the women in this study personal commitments to bulimic recovery occurred only after significant experiences caused them to realize that their styles of living were no longer tenable. Although the specifics of the critical events are unique to each woman, certain common features emerged from their turning point experiences. Central to the women's turning point stories are intensely-felt convictions that life as they knew it needed to change.

_Alex:_...[bulimia] wasn't doing what it really was that I needed.
Mary: I think my self esteem was rising some and I just didn’t want to treat myself like that [practicing bulimia] anymore. You know, I just felt I can’t go on living like this.

Joan: One night while at their [friends] house, the discussion turned to our annual seasonal depression. We commiserated, I ate. He [husband] drank. Aha! I suddenly saw myself in a downward spiral and knew I had to get out or go down in it. It was the turning point for me.

Beth: This [Karen Carpenter’s death from eating disorders] really made me realize I was seriously into something that I needed to put every effort into getting out of.

Lynn: Because I knew, it just finally hit me that this was something that I can’t hide anymore and obviously the bulimia has gotten in the way of getting what I want in life.

Ann: And so I began to realize, I mean I was feeling, just in a matter of a couple of months [of being in therapy for depression] that there must be some things there that I need and I needed to start thinking about what I needed and not so much thinking about what everybody else needed.

Some of the women entered events in which they had no prior understanding of what would occur. Abrupt intuitive realizations characterized these women’s turning point experiences. They described their experiences in words expressive of sudden breakthroughs of understandings. Terms such as waking up, slapped in the face, sparked, flashes of light, and making the connection permeate their stories.

Lynn: Well, as far as then really waking up, what I call waking up to take care of myself and realizing what I was doing. I had applied to be a volunteer for VISTA...and this was the event that really slapped me in the face, woke me up, or whatever.

Beth: What convinced me that I needed help was when Karen Carpenter died and it was revealed that it was eating disorders that killed her. That sparked something in my head that said this is really serious. You could really mess yourself up for a long time by what you’re doing.

Joan: And I was sitting there on a Saturday night and I thought, I can’t live this way any longer. If I don’t get out of this, it’s going to consume me. And it was like a, like a ...like a flash of light going on in my head.

Alex: ...even while I was throwing up, I think I realized that I wasn’t really concentrating on throwing up, it was more the people in the room, and that, you know, it was just the whole situation and just how, it just, it took all the darkness and secretiveness and the you know, everything out of it [purging] and I realized it was just really, you know it wasn’t doing what it really was that I needed... I think that’s when I made the connection.
For others, cumulative reactions to habitual events resulted in unfolding turning points of realization about their practices of bulimia and their lifestyles. Wearing down is the context in which turning point realizations occurred. Phrases such as “out growing,” “getting in the way”, “tired of it” and “hitting bottom” are used in describing these turning point experiences.

Mary: More I just outgrew it [bulimia]. Or I [pause] sure, it was getting in the way and I think I was just becoming more, um, just didn’t want to do it anymore. I was just tired of it.

Ann: ...just being completely overwhelmed by my own life and not happy, really realizing that I was going through the motions, making it from 6:00 in the morning until midnight every night and not doing anything but going through the motion and that I wasn’t going to live my life that way. I don’t know why exactly then, but it had been going on for a while, but I was miserable and it was that misery that got me to go and actually talked to this internist who recommended Janice [her therapist]...It was almost like hitting bottom or something.

Relationship Of Turning Point Experiences To Recoveries From Bulimia

The women placed their turning point experiences in either one of two localities. The two sites of turning point experiences are best described as in the realm of their bulimic practice or in the realm of their total lifestyles. These turning points, although situated in different areas of the women’s lives, were experienced as pivotal to their recoveries from bulimia. All of the women in this study, as a result of these turning point experiences, changed their perspective from being in bulimic practice to being in bulimic recovery.

Women whose turning point experiences related to their eating practices initially focused on giving up binging and purging. For them, the practice of bulimia was originally perceived as the central issue.

Beth, Mary, Alex and Lynn experienced turning point revelations directly related to their practice of bulimia. Fear of dying from practicing bulimia and/or the awareness that
bulimic practices no longer meet their needs marked the incidents that where turning points in the four women’s relationships with their bulimic practices.

Beth’s Story

Beth, motivated by a strong desire to be thin, had been a sporadic bulimic while attending high school and college. She identified the break up and dissolution of her first marriage as the point in time in which she became a daily binge purger. Beth continued her “full fledged” bulimic practice for almost two years. The turning point in her bulimic practice occurred in the winter of 1983. Several months prior to this turning point experience that launched her bulimic recovery, Beth began reaching out for help. Encouraged by a male companion, she sought professional help for her practice of bulimia. However, her counselling experience left her unsatisfied.

This guy I talked to had no clue about eating disorders and so I went like three times and said “Nope. There’s not anybody that’s going to be able to help me, that’s it.”

Beth then asked for information from a female friend about therapists who specialized in eating disorders. She remembered:

So, she got me all the information, but I didn’t do anything about it.

Although the groundwork was in place, Beth procrastinated confronting her bulimic practice. The event that precipitated Beth’s changed relationship with her practice of bulimia was the death of the singer Karen Carpenter in 1983. She recalled:

When Karen Carpenter died, it was just like, get serious about this.

Fear of dying from bulimic complications convinced Beth that she wanted to live more than she wanted to be thin. She remembered the action that she took.

And I called [an outpatient treatment facility specializing in the treatment of eating disorders] and that’s when I got hooked up with Rita [her therapist]. At that point, I had set my mind to the fact. I didn’t want to die. I want[ed] to get over this [bulimia], and you know, maybe I’ll gain weight, maybe I wont, but I at least have to try and get over this.
Beth has experienced only a few short lived bulimic relapses since her 1983 decision to give up her practice of bulimia. Her last brief relapse occurred in 1990.

Mary’s Story

Mary had experienced a full range of eating patterns. She began overeating in her mid teens, practiced anorexic and bulimic behaviors while attending college and continued practicing bulimia, with intermittent periods of normal eating until her cumulative reaction to her practice of bulimia marked her turning point experience. Although Mary’s turning point revelation was tinged with her fear of dying, the most salient aspect of her experience was wearing down.

It was time [to give up bulimia]. I wanted to move on. I wanted to develop some intimate relationships. I was tired of living in this isolation...emotionally and everything. I just started bottoming out...I knew I would die if I kept some of these behaviors up and, yeah, it was kind of like I just (pause), bottom out meant there’s got to be another way, there’s got to be...That was the turning point.

Mary began therapeutic treatment for her bulimia in 1980 and has been “relapse free” since 1988.

Alex’s Story

Alex was sixteen years old when she began to practice bulimia to offset her recent weight gain. While attending high school she binged and purged as often as seven times a day. Alex described herself as more a purger then a binge eater.

...I remember that throwing up gave me this like chemical rush like I just feel, you know, I could feel it in my body. It wasn’t just throwing up because I was mad or I was grossed out or I was whatever, you know, whatever it was. It did something for me...when I’d think about what I was doing and what I was looking for I binged for the purge.

Although Alex began seeing a therapist specializing in eating disorders in 1986 she did not experience a turning point in her practice of bulimia until 1989.
Alex’s turning point experience related to purging and took place while participating in an inpatient program for women with eating disorders. While in treatment the women were asked to participate in a group vomit. Alex remembered:

We were given an assignment to binge and purge together...We had to, um, be in the same room and somebody had to be touching you and um, it was totally bizarre....We ate like in one person’s room, or in their little apartment and then we just took turns running from everybody’s bathroom to the next bathroom and, you know, and then everybody threw up.

It was this experience that caused Alex to redefine her relationship to bulimia.

...but even while I was throwing up, I think I realized that I wasn’t really concentrating on throwing up, it was more the people in the room, and it [the group vomit] just took all the darkness and secretiveness and the, you know, everything out of it, and I realized it was just really, you know, it [purging] wasn’t doing what it really was that I needed.

Alex spoke of how this turning point experience revealed to her that attempting to nurture herself through purging was less satisfactory then connecting to people.

I just wanted to feel like some type of connection with something...It was there [the people in the room while she vomited]. And I hadn’t, like, I think that’s when I made the connection, and then, you know, after we had all thrown up and we were screwing around and we just talked about everything, you know, we weren’t, you know, there weren’t any secrets about it [bulimia] anymore...I guess that’s when I really made the decision [to give up bulimia]...it didn’t give me any type of, like, you know, release or comfort or anything. It was just throwing up and it was really, it just seemed really, um, useless, I guess.

Later, reflecting on the group vomit experience, Alex disclosed the revelation in this turning point experience.

When I was alone it [vomiting] would just be the main focus. Just, you know, throwing up and just seems totally ridiculous and, you have ever many other people in the room...They were really the focus for me and what I guess if I had to empty the room out and what I would leave in the room...is that [people]. You know what I mean? Like that was more important I guess for me then the vomiting.

Alex has had only one bulimic incident since the group vomit experience in 1989 and discredited this relapse as related to needing to find connection and release through vomiting.
But I think, I don’t know, I think that the main, the last time I really threw up and it really meant anything was, um, well, actually, well, it was like the last time I threw up. The time that I threw up since then, um, I think it was alcohol related.

Lynn’s Story

Lynn began practicing bulimia at the age of thirteen and remained a daily bulimic for over ten years. At the age of sixteen Lynn’s parents insisted that she be in therapy for her bulimic practice. Lynn remembered her resistance.

When I was told I had to do it [recover from bulimia], I resisted...I knew it [bulimia] was a problem, knew I had to someday deal with it, but I didn’t have time with my schedule.

Two years prior to her turning point experience Lynn began to see Melissa, a therapist who did not force Lynn to deal directly with her bulimic practice. Rather, they worked on what Lynn described as the underlying things that were manifested in her daily practice of bulimia. During sessions Lynn choose to underreport her practice of bulimia.

In 1989 a turning point event “woke her up” to the role bulimia played in handicapping her life choices. After being accepted as a VISTA volunteer, Lynn had to make out a medical form in which a question asked if she was in therapy. Although in therapy and still practicing bulimia, Lynn stated that she had been in therapy and had recovered from bulimia. Unexpected consequences occurred several weeks prior to her departure date.

...I had planned my goodbyes, moved out, was sort of in limbo living at my parents', waiting to go. I get a call from them. Well, we just wanted to have a final review of your application and everything, your papers, blah blah blah. “And we're just wondering, we just wanted to check on this--are you still in therapy?” And I said, "Yes." "Oh." I said, "What do you mean, oh?" "Well, our rules say that if someone is in therapy, they need to wait six months after the therapy has stopped to see how you're doing and if you're fit to go." I was just devastated because not only was this like saying you can't go now, but I felt like people are finding out, you know, this is the start of me having to wake up.
While waiting for her VISTA reevaluation for acceptance into their volunteer program, Lynn described the transformation that occurred in how she perceived her practice of bulimic and her attempt to keep it a secret from others.

So deep down, even though I told everyone I was waiting the six months, I knew I was not going because I knew, it just finally hit me that this [bulimia] was something I can't hide any more, and obviously the bulimia had gotten in the way of getting what I want in life.

Lynn’s turning point experience made her realize that her practice of bulimia was keeping her from what she really wanted to do and so she altered her attitude about bulimia, replacing resistance to recovery with a willingness to deal directly with her practice of bulimia. When Lynn returned to her therapist, Melissa, her desire to change the way she lived her life allowed her to tell the entirety of her bulimic secret. Lynn no longer needed to conceal or minimize her binging and purging episodes. In a straight forward manner Lynn told her therapist about the extent of her bulimic practice.

I said, "It's very embarrassing to me to admit, but I lied to you. I lie to myself. I am much worse off, you know. Yes, I get everything done, but it's like, I hide from my roommates, hide from everybody, drive, you know, drive through the drive-thru, eat, eat, eat, throw up, eat again. I am not doing well."

The VISTA denial catapulted Lynn from her secretive bulimic practice into bulimic recovery. In admitting that she practiced bulimia in secret, Lynn began her recovery journey. Lynn, knowing that she needed more intensive eating disorder treatment than that offered by Melissa in an outpatient setting, chose to participate in an residential treatment program for women with eating disorders.

Although Lynn experiences bulimic relapses on a monthly basis and describes her recovery as an “active effort,” she dates her recovery from bulimia as beginning in 1989 while participating in the inpatient treatment program.

Joan and Ann are the two women whose turning point experiences related to their lifestyles in general rather then their practices of bulimia in particular. Joan and Ann
focused on realigning their lifestyles. Their practice of bulimia was perceived as a secondary issue. The prevalent theme of their turning point stories is getting out from under.

Joan’s Story

Unlike the other women in this study, Joan did not begin her practice of bulimia while in her teens. Rather, Joan was in her mid twenties when she began to binge and purge. Joan wrote that “The binging [bulimia] was going on almost daily” and that she spoke to no one about it. In the winter of 1978 Joan experienced a moment of insight that was the turning point in how she choose to live her life. Joan described this event as the “episode of the doldrums.”

...we were all sitting around their house, it was about this time of year, and it was our typical seasonal depression. Everybody at that table would get depressed and start kind of moaning and groaning about life...And I remember the image at the time of being caught in a vortex, and if I didn’t somehow get out of it, I was going to be sucked right on through the bottom.

Following her sudden insight into her lifestyle, Joan began to realign her life. As she altered her life Joan remembered that her need to practice bulimia diminished.

But the bulimia itself really began to resolve without much effort on my part consciously when I made the decision to get out of that marriage and to go back to graduate school.

Joan reflected that the bulimia seemed to fall away from her as she redirected her life and found in that redirection a sense of purpose. She wrote that “The more my life took direction, the less need I had to binge.”

Joan remembered her life taking direction and offering her a hopeful future.

And within four or five months, within about three or four months, [of] the whole episode of the doldrums and the sense of if I don’t get out of this, I’m going to die. And, you know, by the following April I was looking down the road.

Joan’s recovery from her practice of bulimia began in 1978. She never relapsed.
Ann’s Story

Ann has experienced a full range of eating styles. She identified anorexia as manifesting at the end of her freshman year of college. Her restrictive eating caused her, at one point, to seek professional help on a daily basis. Ann’s practice of restrictive eating was later replaced by binge eating. After gaining eighty pounds, Ann remembered resorting to purging to avoid the calorie absorption of her binge eating and thereby lose weight. Ann described herself as practicing bulimia on a daily basis for over ten years. At times she would binge and purge up to five times a day.

The overwhelming responsibility of taking care of others was how Ann perceived her life prior to her turning point experience.

...we thought we would have one child, and we adopted one, and we adopted another, and I had another and you know, it was very overwhelming to him [her husband] because he would have been perfectly happy not to have any children. And so I went through this long phase of feeling like I had to protect him from the kids...and so much work that I was doing, you know. I’d wait till I could get them all three in bed for a nap before I’d run out and do all of these errands, you know, and then rush home so that he didn’t have to, you know, stuff. I was living a life that was, well, you know, overwhelming.

In the late winter of 1988 Ann began to see a therapist [Janice] for her bouts with depression. She remembered the discomfort that she was going through at the time.

I was working full-time...with three children in a very demanding job, and I felt myself getting more and more and more depressed. Something was wrong. I had not a clue what it was, but something was wrong.

Ann remained actively bulimic during the early months of therapy and was not interested in dealing with her daily practice of bulimia. She stated:

The bulimia to me was not an issue. I mean, it felt like it was what was keeping me afloat. It wasn’t what I wanted to get rid of. There were other things I wanted to get rid of, but not that.

During this extended period of feeling burdened by responsibility, and while seeing her therapist, Ann took stock of herself and the life she was living.

...at one point I just thought, you know, what [do] I really want to do? I want to take a vacation. I want to visit my parents. My parents live in New Mexico now...I just decided one thing I wanted to do for myself was I wanted
to go and spend five days, or I don’t know how long, in New Mexico and
just be with my parents. So I did that.

Ann reflected on her decision to visit her parents in New Mexico

So taking the trip to New Mexico was saying that OK, I’m making a lot of
money every year, I can take a trip to see my parents. It was just something
that I really, that I could do, that I could just decide that I was going to spend
some money on only my pleasure, or my sanity, and do that.

Ann’s turning point experience was breaking away from a burdened life. In
recollecting her visit to her parents Ann reflected on its impact on her practice of bulimia.

And it was really neat... I mean, I just felt very free [in New Mexico]. I didn’t
have any responsibilities at all, and that is when I stopped the bulimia. I mean
I had no intention of doing it... My mother’s doing all of the cooking, which I
had been doing all of, you know. There wasn’t any house to clean, there
wasn’t any job to go to... I just felt very sort of taken care of, you know, in a
really relaxed way, and it just seemed one meal led to another that I didn’t feel
the urge to either binge or throw up. And I got to the end of maybe one day
and I thought, well, that’s pretty neat, you know, so I went to the end of the
second day.

Ann never resorted to bulimic practice again. Looking back on her trip to New
Mexico in 1989, Ann remarked that the trip took away her need to binge and purge.

..and then it just, I never really have had the urge to do that [bulimia] again. I
mean, I still like to eat, sometimes I think I eat too much, and at different
times I’ll worry about it a little bit, but the thought of going back to that
[bulimia], I mean I think I would rather look like a balloon then go through
what I did for that...

Conceptual Frameworks For Studying Turning Point
Experiences

Each woman’s turning point experience lead directly or indirectly to a changing
relationship with the practice of bulimia. Powerful experiences as change agents have been
explored by others, in particular by Denzin and Strauss. In their classifications of
transformational experiences Denzin and Strauss offer conceptual frameworks for studying
the turning point experiences identified by the women in this study as pivotal to their
recoveries from bulimia. This chapter concludes with a discussion of the congruency of
the women’s turning point experiences to Denzin’s epiphanal topology and Strauss’ classification of transformational experiences.

Denzin (1989a, p. 22) chose the word “epiphany” to describe a sudden insight into the meaning of something. He views epiphanies as “moments of revelation” (1989a, p. 33) evolving out of “problematic experiences” (1989a, p. 33) that change the way people perceive themselves. Denzin analyzed types of experiences in which epiphanies occur. His exploration lead him to classify epiphanies as occurring in one of four types of experiences.

**Major epiphanies** (Denzin, 1989b, p. 129) are sudden insights arising unexpectedly out of experiences. Persons enter into these experiences without foreseeing or contemplating revelations. Denzin (1989b, p.129) describes the effects of these turning point experiences as major because the revelations arising out of these experiences affect every aspect of a person’s life. Furthermore, the effects of these revelations, according to Denzin “are immediate and long term” (1989b, p. 129).

Alex and Lynn spoke of sudden insights that precipitated their bulimic recoveries in contexts that are characteristic of Denzin’s major epiphany. Both women had unplanned experiences that had an immediate effect on how they chose to relate to their practices of bulimia.

Alex went into the group vomit experience without an understanding or anticipation of what would happen to her. She even wondered if she should participate in such an unusual assignment.

We had to, um, be in the same room and somebody had to be touching you [while vomiting] and, um, it was totally bizarre. And at first I’m like no, you know, I’m not going to do that.”

Lynn was unexpectedly denied VISTA. She had no prior warnings that the organization would reject her. The denial had an immediate and dramatic effect on her. She described herself as “ripped apart.”
Both Alex and Lynn spoke of the experiences that “turned them around” as having long term effects. Alex, who had been binging and purging on a regular basis, lost her need to practice bulimia while participating in the group vomit exercise. During this activity she had a sudden insight into the meaning of her purging. She explained:

I don’t know, I mean, I guess I just wanted to feel like some type of connection with something.

Lynn, as a result of a sudden insight into how bulimia blocked her from what she wanted, told her therapist about the extent of her bulimic practice and voluntarily entered an inpatient facility specializing in the treatment of eating disorders. She also began to move away from the need to excel at the cost of her health. The VISTA denial was a major turning point for Lynn because the revelations arising out of this experience affected every aspect of her life. This event not only “woke her up” to the need to recovery from bulimia but it also caused her to reassess her core beliefs and ways of living her life. Prior to experiencing her major epiphany, Lynn held beliefs about achievement that were potentially injurious to her health.

I look back now, and the way my attitude was, it was a very selfish attitude, thinking I can do whatever I want in this world if I try hard enough. But I figured its not selfish because I’m not hurting anybody by it, so I’ll just work harder, and if I kill myself, it doesn’t really matter. If my health suffers, it doesn’t matter, as long as I produce, as long as I do everything.

After the VISTA epiphany Lynn changed her beliefs about achievement.

...I finally realized that someone, something, whatever it be my own control or whatever, something deep within me is saving me here. Because otherwise, if I had gone to VISTA, I would still be, I’m sure I would probably still be doing that [being bulimia and overachieving] today, because I probably would have come back and thought, oh, got to get into a career now, get my master’s and beyond, you know, and I realized that [VISTA denial] saved my life, is what I’ve realized.

Cumulative epiphanies (Denzin, 1989b, p. 129) are insights that arise out of a collection of past experiences and “represent reactions to events that have been going on for a long period of time.” Denzin (1989b, p. 129) views cumulative epiphanies as erupting into major events.
Joan, Ann, and Mary told of turning point experiences that precipitated their bulimic recoveries in contexts that are congruent with the experiences from which Denzin’s cumulative epiphanies arise. Although each woman’s experience is unique to her, all the women had sudden insights into events that had been going on for a period of time. Joan, Ann, and Mary spoke of unfulfilled lifestyles that preceded their turning point experiences.

Joan, prior to her turning point experience, was married to a practicing alcoholic whom she “kind of supported.” During this period she was experiencing a lack of direction in her life.

I wasn’t quite sure what I wanted to do with my life. I’d been working toward a doctorate in Art and the bottom had fallen out of that market. So I was not sure what I was going to do with my life. I figured it was ridiculous to continue to pursue a Ph.D. in a market where there were no jobs. I took a job, I took a couple [of] jobs, I guess tried some freelance work at different times. And it was around that time that the bulimia started, and I don’t really recall how it got started. I just remember coming home days, late afternoons, and feeling incredibly hollow and empty and a real desire to just eat and eat and eat.

Joan described her life during this time as exhausting.

I hadn’t really thought much in terms of the future. I was so obsessed with just trying to get through the day. It was very difficult to lift my head and look out down the road.

Ann recalls life prior to her cumulative epiphany as being one in which guilt and responsibility weighed her down.

I was feeling guilty about everything in my life. I was feeling guilty that we had these children. I was feeling guilty that it was hard on my husband. I was feeling guilty that I had wanted to move to a suburb where it was very expensive for us. You know, I was just feeling responsible for everything that that ever happened to us.

Mary, prior to her cumulative epiphany, was growing dissatisfied with her practice of bulimia.

I just think that for me it was so disgusting to either make myself throw up, it was hard for me, that’s what I mean. I mean, I mean I’m thankful that it was hard...but doing the laxatives thing was disgusting...It got disgusting and I just didn’t want to do any of that any more...
Illuminative epiphanies (Denzin, 1989b, p. 130) are insights that reveal underlying problems. These revelations reveal what has already occurred. Denzin (1989b, p. 17) states that the illuminate epiphany highlights underlying tensions and problems in a situation.

Joan crosses over Denzin’s epiphany classification scheme by not only experiencing a cumulative epiphany in the context of the “episode of the doldrums,” but also by experiencing an insight related to her recovery from bulimia in the context of what Denzin describes as an illuminative minor epiphany. Joan remembered listening to a friend tell a story about a mutual acquaintance named Harry. She recollected having an insight about herself based on the storyteller’s comment about Harry’s reliance on his physique.

...and the husband [story teller] of this couple said around this time, “It’s going to be extremely difficult for Harry to grow old. When he begins to lose his physical prowess, he’s not going to know who he is.” And that rang, set off bells all over my head...I heard him saying what was going to happen to me...when I lost, when the physical attractiveness started to go, and I started to sag and have wrinkles and gray hair and, Heaven forbid, pick up weight. What was going to be there? Was there going to be anything there? And he talked about Harry in a very sad tone...As doomed. And I remember thinking, oh God, I don’t want that to happen to me. I want something else to be there. That was a realization for me. To this day I remember that conversation. And I think, I can’t tell you what connection that has with the bulimia, but I know there was a connection there. I hadn’t really thought much in terms of the future. I was obsessed with just trying to get through the day. It was very difficult to lift my head and look out down the road. And here somebody had said, “Hey, look down the road. Look where this person over here is going to be.” And I looked and I said, “Christ, that’s exactly where I’m headed.”

Relived, retrospectively meaningful epiphanies “are those episodes whose effects are immediate but their meanings are only given later, in retrospection, and in the reliving of the event” (Denzin, 1989b, p. 130).

Each of the six women identified experiences in which they had “moments of revelations” (Denzin, 1989b, p. 33) that altered their understanding of their lives and/or practice of bulimia. However, as they recollected their moments of sudden insights, they reconstructed past experiences through lenses adjusted for their present lives. Relived and
retrospectively meaningful turning point experiences that the women described as pivotal to their recoveries are spoken of and relived years, even decades, after they occurred.

In characterizing epiphanies, Denzin describes them as expressive of individual psyche and societal conscious. In stating that “every life is a moral, political, medical and economic production” (1989a, p. 29), Denzin places the personal meaning of epiphanies within the larger societal context that influences and shapes individual interpretation of phenomena.

Strauss, like Denzin, positions turning point experiences and personal insights into the meaning of those experiences within the larger societal context that shapes an individual’s interpretation of experiences. He determined that turning point experiences are “socially patterned” (1959, p. 100) and stated the “Although stock-taking goes on within the single individual, it is obviously both a socialized and a socializing process” (1959, p. 100). He went on to write that “...the same kinds of incidents [turning point experiences] that precipitate the revision of identity are extremely likely to befall and to be equally significant to other persons of the same generation, occupation, and social class” (1959, p. 100).

As the women recollected their turning point experiences, the meaning of their experiences is changed not only by the passage of time but also by the values and beliefs embedded in the women’s therapeutic and cultural environments.

Strauss chooses the word “transformation” (1959, p. 92) to describe changes in how people perceive phenomenon. He views transformations as shifts in conceptualizations that manifest as “radical changes of action and person” (1959, p. 22). In his critique of transformations, Strauss describes four critical incidents (turning point experiences) that force a person to realize that “I am not the same as I was, as I used to be” (1959, p. 93). He describes these four critical incidents as milestone markers, forecasting,
meeting a challenge, and revealing. Of particular interest to this study are milestone marker and forecasting turning point experiences.

The **milestone marker**, similar to the situations in which Denzin's cumulative epiphany occur, is a turning point incident that makes an individual recognize the extent of change that has already occurred in a relationship. Marker incidents reveal what has gradually changed in particular relationships but had gone unnoticed. Strauss describes marker incidents as milestones because they force insights that "necessitates new stances, new alignments" (1959, p. 93).

Joan, Ann, and Mary, who experienced revelations in the context in which Denzin’s cumulative epiphanies happen, also can be said to have experienced milestone marker incidents because their insights made them realize the extent of change that already taken place but had gone unnoticed.

**Forecasting**, for Strauss (1959, p. 94) is a critical incident in the form of a prediction that proves true. According to Strauss (1959, p. 94), when predicted events occur, individuals have conversions. That is, "When the graph of experience is plotted and confirmed, then the person can recognize his own transformation" (Strauss, 1959, p. 94).

Beth identified Karen Carpenter’s death from complications associated with the practice of bulimia and restrictive eating as the turning point experience that lead her to give up the practice of bulimia. Beth spoke of having read about the problems associated with the practice of bulimia prior to Karen Carpenter’s death. She declared:

I knew it [the practice of bulimia] was wrong. I had read all of the books.

Beth’s prior knowledge about the medical consequences of practicing bulimia predicted what could happen to her if she continued to binge and purge. When Karen Carpenter died, the materials that Beth had read predicting the possibility of death associated with bulimic practice proved true. Beth perceived bulimia in a new way that resulted in her decision to give it up regardless of a possible weight gain.
Although Denzin and Strauss offer frameworks for studying turning point experiences, their focus is restricted to descriptions of structures in which revelations occur. Because their classifications do not include categories for the phenomenology of turning point experiences there is no way to attend to individuals interpretations of their own transformational experiences.

For the women in this study, their turning point experiences reflected changes in their self concepts and ways of attending to their emotional needs. Their experiences warrant an exploration into what they discussed explicitly and implicitly as meaningful about their transformational experiences.

Taking charge appears to be the phenomenological meaning of Joan’s turning point experience. Joan’s life was lacking direction and purpose prior to her sudden insight into the way her life was unfolding. Joan lacked a career focus and described herself as a “classic enabler” in an alcoholic marriage. Joan’s turning point experience allowed her to realize that her life was being pulled down by her lack of direction and her marriage to an alcoholic. After her moment of revelation, in which she saw herself “in a downward spiral,” Joan began to empower herself to take over and direct her own life. Once she planned to attend graduate school and to divorce her husband she was able to “look down the road.” While she was taking charge of her life her bulimia fell away from her.

Breaking free best describes the phenomenological meaning of Beth’s, Ann’s, Mary’s and Lynn’s moments of revelation.

Beth’s desire to be exceptional in some way had lead her into the practice of bulimia in order to be “exceptional at being thin.” When Beth realized, in her turning point experience, that taking care of herself was more important then attempting to win approval through a slender body, she began to break free of the need to win the approval of others.

Ann put the needs of others before her own needs and experienced depression. In the turning point experience of taking a vacation for herself, Ann began to break free of
denying herself basic emotional care. As Ann began to care for herself she lost the need to seek comfort in the practice of bulimia.

Mary sensed that her practice of bulimia was interfering with what she wanted to do. Her desire to get on with her life was the turning point realization that caused her to begin to break free of her practice of bulimia.

Lynn’s sudden realization that her practice of bulimia was keeping her from ascertaining what she wanted coupled with her revelation that overachieving would destroy her health lead her into breaking free of trying to be exceptional. Lynn, by releasing herself from the facade of perfection, was able to admit that her practice of bulimia was out of control and that she needed and wanted professional help in overcoming it.

Letting people in catches the phenomological meaning of Alex’s turning point experience. Although Alex had friends, it was only during her participation in the group vomit that she realized that seeking “connection to something” through purging blocked her from relating to and bonding with people.
Chapter V
Dimensions of Recovery

Introduction

As the women spoke of their understandings of their personal recoveries, they expanded the concept of recovery beyond food and eating issues. These six women, who all defined themselves in bulimic recovery, offered perspectives on recovery that were inclusive of but moved beyond bulimic issues. The women did not view giving up or reducing their binging and purging practices as the single measure of recovery. Rather, they understood their recoveries as having several dimensions. Not only did they describe their recoveries as giving up or minimizing bulimic incidents but also as resolving psychological and societal issues that they perceived as entwined with their bulimic practices.

As the women spoke of their understandings of recovery, they linked their bulimic practices to psychological and cultural influences. Their views of the emotional and societal forces that contributed to their bulimic practices shaped their understandings of their recoveries.

Bulimia As Symptomatology

The women’s understanding of their recoveries incorporate but move beyond recovery from bulimia. The women described their bulimic recoveries as moving out of painful circumstances. The women, in discussing the functions of bulimia, pointed away from the specific activity of bulimia and focused on its broader implications. Most of the women understood the binging aspect of their bulimia as attempts to satisfy emotional
hunger arising out of difficulties in living. Furthermore, most of the women viewed their purging practices as a function of their pursuits of the cultural ideal of feminine beauty.

The women adamantly declared that bulimia was not the problem that they are recovering from but rather served as the warning signal heralding conditions in their lives needing resolution.

**Joan**: Well, I don’t really think of it [recovery] in terms of deciding not to be bulimic. I think of bulimia as a symptom of other problems going on in my life at the time.

**Ann**: So, you know, every once in a while we talk about it [bulimia], but I’ve never seen it as the problem. I’ve never seen it as, I knew that that was not the problem.

**Lynn**: It’s [bulimia] just a substance, it’s not the root of the problem. It’s [bulimia] not just the food, it’s the way you deal with people, it’s the way you deal with yourself. You’ve got to realize that the eating disorder is not just the eating disorder. It’s every, it’s the way you look at things, it’s the way you look at yourself.

**Alex**: Realizing that food has nothing to do with it, with anything. I mean the reasons why I’m doing it [bulimia]. And, and I mean there are reasons behind why I don’t eat or I throw up or just the way it makes me feel and why I want to feel like that...It’s not the problem. It looks like the problem but it is not the problem.

**Beth**: When I speak of recovery, I speak of it in terms of using the food to deal with it [underlying issues], to deal with anything that might come up.

**Mary**: I think the bulimia was a symptom of some of the underlying feelings of worthlessness, feelings of shame, feelings of being left behind. It’s kind of a pretty heavy list of real negative thoughts and yucky feelings.

Although all the women defined their recoveries as resolving more than food and eating issues, they viewed both their bulimic practices and their recovery issues somewhat differently.

Some of the women never viewed their bulimic practices as the recovery problem. These women did not define recovery as giving up bulimia so much as they defined it as resolving those issues that they perceived as interfering with the quality of their lives. As those issues were resolved, the bulimia ceased to be practiced.
Joan: And I remember the image at the time of being caught in a vortex, and if I didn’t somehow get out of it, I was going to be sucked right on through the bottom. So I ..., got myself into graduate school, and the more involved I became in that, the crazier my lifestyle looked...but the bulimia itself really began to resolve without much effort on my part consciously when I made the decision to get out of that marriage and go back to graduate school.

Ann: I don’t, I don’t think I ever made the decision to give it [bulimia] up. I never felt like I did...I was working full time...with three children in a very demanding job, and I felt myself getting more and more depressed. Something was wrong. I had not a clue what it was, but something was wrong. The bulimia, to me, was not an issue. I mean it felt like it was what was keeping me afloat. It wasn’t what I wanted to get rid of. There were other things I wanted to get rid of, but not that.

Lynn understood recovery as being concurrently concerned with life issues and her bulimic practice. She describes her recovery as an incremental process in which dealing with problems in living preceded dealing with her practice of bulimia.

Lynn: I guess that the first thing that stands out in my mind would be that we didn’t start treating my eating behavior first, even though that was the most obvious external thing that showed that this was my disease, it was not the first thing we addressed. And I mentioned before that I went to someone first who wanted to do that, and I just realized this isn’t it, this is not it, because I think at that point I was so ashamed of that [bulimia], the way I manifested my disease, as far as the activity and the obsession with food, I was too ashamed of that to really deal with it. So, I think for me it was more important and most effective to realize, well, why am I doing this than treating the outward result of my difficulty. So we tried to look at what are the difficulties, and so with her [therapist], we never mentioned food for the first two years that I was in therapy with her. Never...what we needed to find out was why do I choose that, you know, but then I started to realize, especially now, looking back, I realize it wasn’t time, you know, it just was not time.

Others initially understood recovery to be concerned with giving up practices of bulimia. Only later did these women come to understand their recoveries as moving beyond the resolution of their bulimic practices.

Beth: And when I first entered into this [therapy], like I said before, I had no idea that there could be underlying things, and anything beyond wanting to be thin...Recovery was the process of learning what was causing me to act the way I did and learning how to deal with things without using those same behaviors [binging and purging]...

Mary: I guess I knew that it [bulimia] was masking something, but I didn’t know at the time what exactly...So, at first it was a matter of tackling the problem of getting rid of the symptom, which was the eating. And then once that happened, those other feelings started surfacing and it kind of started seeming like, “Oh, I get it. I’m eating maybe when I feel this way, or I’m
eating when such and such happens to me.” And I would start making the connections, but it was just awareness along the way...But I could see, probably in my mind, what was causing me the most pain at the time [when first started therapy] was the eating disorder. I didn’t know that there was anything else that went along with it at the time.

Alex: [When] I initially went to see her [therapist], it was about my eating, really, is what we were concerned about. And then all this. So it went from dealing with the eating, but then we couldn’t deal with the eat[ing], you know, we, you know, that was that, but there were reasons why I, why I’m like this...

**Psychological Dimension of Recovery**

“It seems to me that our three basic needs, for food and security and love, are so mixed and mingled and entwined that we cannot straightly think of one without the others” (Fisher, 1976, p. 353).

Most of the women viewed the binging aspects of their bulimic practices as attempts to fill up their lives. Words such as hollow, lonely, emptiness, floundering, void and phrases such as being in limbo, not having direction, and empty feelings color their descriptions of how they experienced their lives prior to and while practicing bulimia. These women understood their recoveries from the binging aspects of their bulimic practices as built on resolving aspects of their lives that left them feeling empty, isolated, and directionless.

**Joan’s Story Of Practice**

Joan remembered her life while practicing bulimia as directionless and chaotic. She described herself as situated in professional, interpersonal and economic uncertainty. She wrote that “Bulimia began in tandem with a period of being in limbo.”

Joan spoke of her academic preparation for a career in the arts as bottoming out several years prior to her first marriage and just prior to the the onset of her bulimic activities.

I wasn’t quite sure what I wanted to do with my life...So I was not sure what I was going to do with my life. I figured it was ridiculous to continue to pursue a Ph.D in a market where there where no jobs.
Joan drifted professionally after dropping out of her graduate program. She recalled:

I'd finished my M.A., left the doctoral program, and was working at so-so jobs. I didn't have much direction in my own life.

During this period she remembers her romantic relationship and later marriage to a practicing alcoholic as lived in the context of emotional and financial insecurity. Joan recollected that they "...were living hand to mouth." In this atmosphere of uncertainty Joan remembered:

…it was around that time that the bulimia started and I don't really recall how it got started. I just remember coming home days, late afternoons, and feeling incredibly hollow and empty and a real desire to just eat and eat and eat…I just remember coming in and that insatiable need to fill myself up, just a feeling of emptiness.

**Joan's Story Of Recovery**

In discussing her understanding of bulimic recovery Joan commented on the spirit of discovery in the recovery process.

Recovery, to me, implies return to a previous state of more normal functioning. We recover from colds or from a broken bone. The recovery from bulimia was not that way because I don't think I was a very healthy person to begin with, so I didn't have a solid base or a healthy base to return to to recover. So the process, for me, has been more one of trying to figure out who I am and where I fit in this world. That's why I think I view bulimia as a symptom. It was indicative of something else or the lack of something else, which was a sense of esteem and identity and worth. I didn't have them to begin with, so I didn't have them to recover.

Joan's recovery from bulimia was related to changes that she augmented in her life that positively affected her sense of esteem and her sense of self. By moving out of a marital situation that she described as "a downward spiral" she removed herself from a relationship that did not offer her a constructive way to live her life. By developing a focus for her career aspirations she began to fill her life with a sense of professional purpose and direction.
Joan remembered that she stopped her practice of bulimia after she removed herself from her unpredictable and erratic marital situation through divorce.

I had to decide if I was going to stay where I was or if I was going to get out of the situation, which was an unhealthy relationship, an unhealthy marriage. And when I got out of the marriage the bulimia began to resolve itself.

During this phase of her life, Joan described herself as "...still casting about for what I wanted to do with my own life." After deliberation she began to put her professional aspirations into action.

And I remember having lunch with a good friend of mine who said, "Why not go back and get a Ph.D.? You’re going to be 35 someday, anyway. You might as well be Dr. 35." And I thought, that’s pretty good reasoning...So I decided to go back to graduate school and I also decided that I had to get out of that marriage. I had to get out of that relationship...I knew I had to get out of that marriage. Um, he was drinking harder than ever, he was contributing nothing to the company. I was upset, there were creditors. I mean, there were piles of bills 14 inches high on his desk...the bulimia itself really began to resolve without much effort on my part consciously when I made the decision to get out of that marriage and to go back to graduate school.

Joan captured the essence of her recovery when she wrote that "The more my new life took direction, the less need I had to binge."

Ann’s Story Of Practice

Ann remembers her life during her years of practicing bulimia as lacking direction.

I had no clue to who I was and what, what I was supposed to do and what I thought they wanted me to do.

Ann went on to discuss how her life became filled up with taking care of other people’s needs to the extent that it even crowded out the time she allocated for her bulimic practice.

But it got to the point where I didn’t have time to do it. And mostly it was people’s things that were filling my time. It was my kids or my husband or my work, which I never have considered mine, you know, and I still don’t. It was other people’s time that was filling my time and so I didn’t have a lot of time for it...I did want to find time for the eating and the bulimia. I mean, I felt like that was my time and I needed it, but it wasn’t fitting into my schedule very well.
Ann understood her bulimic practice as a preoccupation with food and weight management that diverted her attention away from finding more productive directions and purposes in her life.

I think part of me was afraid of that time. What was I going to do in that time if I gave it [bulimia] up? How was I going to do it? Because you have to deal with yourself during that time. You have to think about what you like to do and what gives you pleasure and satisfaction...

Ann also described her daily bulimic practice as an isolating activity that kept her from developing relationships.

...I think it [bulimia] took away from relationships, which, you know, I did not have a good background in relationships, and really didn’t feel very good in relationships, that I was adequate to be in relationships. And I think, you know, it [bulimia] definitely took time from that. You know, that I didn’t have to deal with that.

Ann’s Story Of Recovery

Ann, like Joan, described her understanding of recovery as processing the element of discovery.

I don’t think I ever really used the word recovery. I think it’s a process of finding out who I am and living that life instead of another...Recovery probably doesn’t fit how I think about it. I think it’s more discovery than recovery because I don’t feel like I’m recovering something I once had. I feel it’s [practice of bulimia] gone back so far that I never really had a chance to have it, so it’s discovering who I am.

Ann’s understanding of her recovery from the binging aspect of her practice of bulimia is linked to her realization that she had needs of her own.

I was seeing [while in therapy] that I had needs and it had never occurred to me that I had needs. That concept was very foreign to me, that I had needs, and that I wasn’t having my needs met...I mean, the need to be loved, I mean, just little needs, little physical needs, you know, the need to be kissed every night, or the need to have someone say “I love you”...and so I began to realize, I mean, I was feeling, just in a couple of months [of therapy] that there must be some things that I need and I needed to start thinking about what I needed and not so much thinking about what everybody else needed.

Ann observed that as she began to pay attention to satisfying her own needs that her bulimic practice ceased to exist.
So I started doing what I wanted to do a little bit and it [bulimia] began to fall away from me.

Ann, in hindsight, realized that her practice of bulimia was isolating her from others because it drew her into her own small world of food obsession.

I was very, very busy, There was no time to have friends...

Ann understood one aspect of her bulimic recovery as allowing people into her life. She was involved in several activities that she described as very satisfying. She spoke of regretting having lived a life that focused on her daily practice of bulimia and kept her from making and enjoying friendships.

I didn’t have time, and I feel, you know, so sorry that I missed a lot of years of that kind of time with other people.

Finally, Ann understood her bulimia as an activity that pulled her away from her children and negatively affected their welfare. She understood her recovery as developing interpersonal connectedness not only with friends but also with her children.

I think it [bulimia] could have gone on forever if I hadn’t had kids...because kids just bring things out in you so much faster than any other process. You see how you behave like your parents or you see how your behavior is affecting your children. I feel so responsible for them. I’m their sole source, you know, for awhile, at least, you’re their sole source of everything [so] that I wanted to change because of my kids.

Beth’s Story Of Practice

Beth described her basic needs for interpersonal connection and emotional security as being placated through food consumption.

I just spent a lot of time seeking comfort in food...Whenever I was lonely, whenever I was unhappy, whenever I felt insecure, inadequate, I ate.

Beth understood the binging aspect of her practice of bulimia as an attempt to alleviate feelings of emptiness. She described her bulimia as escalating when she felt “very insecure and alone” after separating from her first husband and beginning the dissolution process.

So much of what caused it was feeling alone, the lonely feelings, the empty feelings, the unloved feelings.
Beth, in describing the few relapses that she had after giving up practicing bulimia, reiterated the emotional feelings that triggered her reliance on binging.

...it [bulimic relapses] seemed to have happened as a result of being alone or feeling empty or just some void there of some sort in my life.

For two years following her divorce Beth binged and purged nearly daily. She described her life as lacking a satisfactory focus.

I was kind of floundering, you know. I'd been divorced...Tom on weekends but basically by myself. My sister was having her first child at the time so I was watching the family developing there. And getting back to work related. I was like, I don't want to sit in this job forever. This is not what I want to do. What am I going to do? What can I do to do something else?

Beth's Story of Recovery

Beth described her bulimic recovery as discovering meaning in living.

Just accepting myself, realizing who I was, what my beliefs were, what I wanted and what I wanted me to be, not what others wanted me to be. Then coming to terms with that.

Beth also reflected on the fact that taking responsibility for discovering meaning in her life was the only way that she could move beyond her personal sense of stagnation.

I needed some direction in life as to where was I going. Work wise I wasn't happy where I was. I needed to take charge and do something about that rather than just sitting around being unhappy.

Beth understood her recovery as living "...a lifestyle that was away from focusing on the food." She dated her recovery as beginning in 1983 with only a few short-lived bulimic relapses since that time. She viewed those bulimic incidents as associated with the voids in her life resulting from infertility issues, miscarriages and failed adoptions. Beth has given up the quest to have a child and now focuses on interests other than raising a family. She understood her work in the animal welfare movement as a redirection of her potential to love children to a capacity to care for animals in need.

It's just like a chapter in my life has been closed. And now we're starting a new one. And that's why I, I, you know, I'm doing the volunteer work with an animal welfare shelter. If I can't, you know, I thought I was going to be
spending my thirties and my forties going to parent teacher conferences and scouting trips and that’s what I was going to be doing with my life. Well, I’m not. So what am I going to do? So that’s why I go to work with the animals now.

Beth continues to expand her interests and activities on behalf of others. In 1992 she began co-facilitating a support group for binge eaters. She shared:

I’m enjoying co-facilitating this support group. I feel like that’s something I can give back. I can be there as an example of someone who has recovered.

Beth has also brought animals into her home. At the time of the interviews she had three dogs and identified each dog as being purchased or found after a miscarriage or a failed adoption. In regard to adopting her first dog, Beth wrote:

This allowed my maternal instincts to take over and really helped me to cope with the loneliness when Bill [her husband] was out of town.

Furthermore, Beth has found work that satisfies her.

I’m where I want to be. I love my job. I couldn’t be in a better place. I couldn’t work with better people. So that’s good right now.

Mary’s Story Of Practice

Mary connected her growing reliance on the binge eating aspect of her bulimic practice with parental loss, lack of direction and growing isolation. When Mary was in her late teens her father succumbed to cancer.

I just think I was so depressed and so, just miserable and frightened. It [father’s death] just, it triggered all, my coping, you know, was still the eating. And so my weight just took off.

Her father’s death occurred during a period in which Mary lacked direction.

I was eighteen, nineteen, twenty, so I finally decided, I didn’t know what I wanted to do with my life. I was totally indecisive, but I did know that I felt so much pain.

Mary understood her binging as comforting her during periods of emotional upheaval and disequilibrium. During the years in which she practiced bulimia Mary became more isolated and she described food not only as her comfort but also as her friend.

Yeah, that was my soul, me and food, and everybody else was, and uh, it was miserable. It was like food was my friend.
Mary’s Story of Recovery

Mary dates her recovery from bulimia as beginning when she realized that her friendship with food and her bulimic practice interfered with her growing desire to develop relationships.

I wanted to move on. I wanted to develop some intimate relationships. I was tired of living in this isolation.

Mary’s involvement in Alcoholics Anonymous was an avenue by which she affiliated with others and formed friendships. As she became involved in Alcoholics Anonymous activities she discovered meaning in living that was not related to binging. She remembered:

...[a] whole gist of professionals in my life were pushing me towards community, getting involved. I had to get involved in a 12 step program...I believe it [bulimia] is a disease of isolation, and it was really a struggle to get out, but once I did it took a lot of the power out of it [bulimia].

Mary understood her sustained recovery to be strengthened by her connection to people. Furthermore, her commitment to the sobriety movement was an endeavor that replaced her sense of directionlessness. Mary also pointed out that in time her connection to people extended beyond the Alcoholics Anonymous Fellowship:

I don’t want to make that [AA] my only life, you know? I want to meet people outside of AA and I want to do things...

Mary, by allowing people into her life and by her involvement in the sobriety movement, discovered ways of living that reduced her risk of turning to food for emotional nurturance. She discussed her understanding of recovery as entailing:

Being with people. I still fight that. I still fight that isolation stuff that I know...That’s [isolation] a real comfortable spot for me because that’s what I grew up doing and I feel like it’s comfortable, so I’m attracted to it. It’s not necessarily healthy but it’s comfortable. I fight that by making phone calls, taking the risk to share with safe people how I’m feeling, generally something to get it out instead of stuffing it.
Alex’s Story of Practice

Alex described her practice of bulimia as one of several self-destructive practices by which she blunted her sense of loneliness. They were activities that filled voids in her life. Alex articulated her understanding of her practices of self-mutilation, alcohol abuse, anorexic and bulimic practices.

I think, um. as far as, um, what I used the eating or the starving, you know, purging or, you know, not eating, the self-mutilation, you know, drinking, I think all these things that I was doing, I think it was because I was lonely and I needed something there. And, um, they are obsessions.

Unlike other women in the study, Alex attempted to fill her sense of inner emptiness through purging rather than binging activities.

When I think about what I was doing and what I was looking for, I binged for the purge...for me, it was the purge. It wasn't going and eating a gallon of ice cream because I don't think that was my focus ever. Sometimes, I miss that [the chemical rush that accompanies throwing up] and I want to feel that, just so that, because I think that it erases everything.

Alex’s Story of Recovery

Alex understood her bulimic recovery as linked to her decision, in early bulimic recovery, to determine the direction of her life.

For me, it’s been getting my life in order, some sense of order in my life...

In recalling her life while practicing bulimia, Alex described living without a sense of direction or purpose.

Everything used to be just chaotic. I mean, and it’s all so crazy, like how chaotic could it be for you, like, to not have to work today and to get up and then to just have this day and then go to bed, but my day was just totally, I mean, I didn’t know, it was horrible. I had no routines, I had no, um, it was just weird.

In early recovery, while living alone, Alex began to replace her chaotic life as a practicing bulimic with a recovery founded on discovering the direction she wanted to take to live a meaningful life.

...I feel good because I’ve been able to change that [chaotic life]...When I kind of started cleaning up my life and kicking out all of those people that
were sleeping all over my house and, you know, not going out [partying] decisions about that, it gave me time to be alone and to figure out what I wanted to do...

As Alex talked about her understanding of recovery she described it as unchartered waters. Like Joan and Ann, Alex emphasized that it had more the element of discovery in it then recovery of something that was previously in her possession.

It’s not like I had had all of this. It’s not like I had this life ever that is normal...It’s not like I was at a point, then all this chaos and sickness happened and that I was trying to get back to this point. I didn’t know what I was trying to get to and I still don’t really know what I’m trying to get too. I know that I feel better now than I did and this is kind of what I thought you know it could feel like...recovery isn’t going back.

Furthermore, Alex understood that an aspect of her recovery was replacing “connection with something” through purging with a non-bulimic lifestyle in which she connected and bonded with people. In talking about her understanding of recovery, Alex stressed the importance of friendships in her life. In discussing one of her three women friends, Alex used phrases such as I don’t think I could go through the day without her in my day somehow, we just are really good together and she’s there and I know that she’s there, and we’re just very, um, close.

However, Alex’s understanding of her bulimic recovery is colored by melancholy for the absence of intense experiences. As Alex spoke about what she missed about her practice of bulimic purging she shared that she continues to struggle with a lingering sense of boredom.

...Sometimes I think life’s boring. I mean good, I don’t know. I mean it’s almost normal. I guess, but I’m not used to that.

Calling the lack of intense experiences “a void of some sort,” Alex went on to elaborate:

I miss, like I don’t miss feeling bad or feeling nervous or feeling, um, totally stressed out or, you know, upset. I don’t miss that. And I do feel, still like that a lot. But, um, I miss like the release, I miss the focus, things like that...and I write a lot and I paint, so I try to do that instead, and it’s good and it helps, but it doesn’t do the same thing, you know...Because I think I miss the intenseness, too, because, yeah, yes, making breakfast is not as, you know, it’s good and everything, but it’s not as intense. It doesn’t really fill
that void because I have always, have always had these like intense things happen and intense way like that, I feel about things, and, um, it's just not the same.

However, by her last interview, Alex was changing her perspective on missing her purging practice.

I think the only way to deal with, um, I mean, I think what I have to do is really change my perspective on it, which is what I've done. I guess that's where I am now. That's because my perspective has been changing.

Lynn’s Story Of Practice

Food was comfort and solace for Lynn. In recollecting stressful incidents in which she turned to food, Lynn reflected on how she comforted herself.

It [food] was my comfort. It was my panic release. When I just felt stress, I'd eat. Every emotion was satisfied by food.

However, Lynn viewed her bulimic practice as a double-edged sword. On the one hand, binging gave her a sense of comfort and companionship. On the other hand, binging and purging pulled her into the darkest recesses of her being. A sense of isolation and despair accompanied her bond to food. In just a few words, Lynn poignantly expressed her sense of isolation when practicing bulimia:

...I always felt very, I mean like I was in a different world. I can’t even verbalize it, like I said, sucked into a dark hole or something. It felt like I had no contact.

Lynn, like Ann and Mary, understood her practice of bulimia as drawing her away from making and enjoying friendships. In discussing her high school and college years, Lynn reflected on her loneliness and lack of connection to others.

As I think back, you know, through the years, like even in high school, I really didn't have, I avoided relationships because I just didn't like myself. You know, as far as cliches, you know, you have to like yourself before you can love someone else. It is so true. I avoided [friendships] because I hated myself so much, literally hated. I felt like how could anybody else accept this [bulimia], because I thought, you know, I just did the most shameful thing. I was out of control. I just hated how I looked, what I felt about myself...I chose to avoid people. I chose to avoid relationships.
Lynn’s Story Of Recovery

Lynn does not define recovery as an absence of bulimic behaviors. Rather, she understands bulimic relapses as a facet of recovery. In discussing her recovery through relapses, Lynn spoke of the advice that changed her interpretation of bulimic relapse.

...she [her therapist at the treatment center] said to me “Remember, you know, if you do start using food to deal with your feelings, don’t get mad at yourself. Realize it’s a sign you’re neglecting yourself,” and that has always stuck with me...I think what was really central for me to move on was to get rid of the shame that this [relapsing] was something I did, and once I got rid of that, I just looked at, hey, it’s a symptom of something else.

In summarizing her acceptance of bulimic relapses as an aspect of her “active effort” to sustain recovery, Lynn said:

I guess now I just see every step I take as progress now, whether it’s a relapse or not, it’s progress.

By understanding bulimic relapse as a symptom of self neglect, Lynn defined her recovery not as an absence of bulimic episodes but rather as learning to value herself.

Possibly, you know, I might still have a couple of relapses here and there, but that’s all right as long as I keep growing to realize that you know, food has to be a part of my life but it’s nothing to be ashamed of. It’s through all of this, you know, I’ve learned just so much about myself and really learned to appreciate myself.

One aspect of Lynn’s understanding of her recovery was based on moving out of social isolation. Lynn viewed her recovery as enhanced by allowing people into her life.

As I realized at the program [inpatient], just having contact, when I was active in the bulimia, when I was in those down, down moods, I felt like, I guess I referred to it as like a black hole, just lost and by myself, disconnected. And I realized through the program that having contact with people during those times really helped to bring me out of it and helped me take care of myself.

Like Alex, Lynn’s understanding of recovery expresses a sense of melancholy for things lost. Whereas Alex missed intense experiences, Lynn missed being exceptional:

I loved being able to have people say “Well, geez, how do you do all that?”...What do I do that’s exceptional anymore? And that’s what I’m really struggling with right now, knowing, it’s the knowing that having a more balanced life is good for me, but keeping it in mind that that is more important then being exceptional in different things or pulling myself, you know, in all different directions. Even though I know, deep in my heart and my mind, this
is the more important way to go as far as balancing my life, taking care of myself, there’s still a part of me that liked the results of having such a chaotic life.

Like Alex, Lynn understood bulimic recovery as leaving a void in her life.

You know, I don’t feel like I do anything extremely well anymore...it’s like, you know, I’ve a normal life...It’s almost like a negative. It’s like, you know I have a normal life...and it’s hard to deal with.

The women’s understandings of their bulimic practices place them in the context of lives focused on eating behaviors but otherwise experienced as empty, isolating, and often directionless. Although most of the women attempted to remedy feelings of emptiness with binge eating, Alex’s understanding of purging to connect with something also placed her in a life that was otherwise experienced as empty. The women’s views of their bulimic binging recoveries, or in Alex’s case, bulimic purging recovery, situate recoveries in lives that connect to others, and are driven by senses of purpose that move beyond preoccupations with food and weight management.

The women in this study not only understand their bulimic practices as connected to psychological needs but also linked to cultural pressures. Their perceptions of the societal forces contributing to their bulimic practices influenced their understandings of recovery.

**Societal Dimension Of Recovery**

...society constitutes itself psychologically in the individual...To the extent that females and males experience different interpersonal environments as they grow up, feminine and masculine personality will develop differently and be preoccupied with different issues (Chodorow, 1978, pp. 50-51).

Most of the women understood the purging aspects of their bulimic practices as serving cultural imperatives regarding female beauty. These women linked their physical appearance with social acceptance and self worth. They viewed their purging as functioning to create and maintain the thin physiques associated with contemporary beauty standards for women. The women, in varying degrees, tied their bulimic practices and especially their dieting and purging activities to concerns with the size of their bodies. Messages regarding the unacceptability of heaviness, recognition through slenderness, and
a drive to be thin emerged out of each of these women’s recollections. These women, who struggled with becoming and remaining thin through practices of food evacuation, viewed one dimension of their recoveries as an attempt to release themselves from the need to meet our cultural standards of female slenderness. Recovery for these women meant redefining what constitutes female worth. These women viewed their recovery from the societal pressures to be slender as replacing mastery of their bodies with other ways of affirming their self worth.

Joan’s Story Of Practice

Joan’s weight was central to her understanding of ways to gain social approval and to feel valued. She remembered how closely linked her sense of worth was to the appearance of her body.

Men were attracted to me, but I didn’t have any sense inside of who I was and so sometimes, a lot of times, I’d get attention that I didn’t feel I warranted but I knew it was related to my physical appearance, and so my weight became a real issue. Especially when I noshed my way across Europe and gained weight. I didn’t have much sense of who I was aside from this physical creature...So that’s where the connection between bulimia and esteem in that regard came from.

When Joan gained 25 pounds while on an European trip and the man she later married “didn’t recognize me, I had picked up so much weight,” she felt that her sense of self worth through the appearance of her body was seriously compromised. Joan recalled that her weight gain augmented her struggle to be thin.

...that’s when the real struggle to lose weight began and that’s when I started trying to diet and started reading [nutritional and diet] books...but I started making those changes and then the bulimia started.

Joan’s Story Of Recovery

Joan recognized the difficulty attached to discovering ways to define herself in a society that puts much emphasis on physical attractiveness. In looking back on her bulimic practice Joan reflected on her struggle to define herself beyond the proportions of her body.
I think the symptom of bulimia emerged because of this intimate connection to physical appearance and the intimate connection between physical appearance and recognition by others. I think it’s really difficult for attractive people in this society to develop a sense of personal competence and confidence that goes beyond their appearance because the rest of the world does respond to physical, to physical beauty.

Joan, who had little sense of she she was aside from “this physical creature,” described herself as “...just kind of not existing as a person aside from how I looked.” Joan, stating that she had fought for years with self esteem problems, recalled putting a great deal of emphasis on her physical image. While struggling for the low weight that she associated with what our society values in women, Joan confronted the dangers inherent in defining herself through her appearance. As discussed in chapter four, Joan remembered a conversation about a man named Harry that caused her to grapple with her reliance on her physical attributes for recognition and validation. Joan described Harry as living his life and relating to others through his physical stamina and strength.

...he wasn’t a big man, but he was a powerful man, and his physical prowess was something that was obviously very important to him.

Joan shared that when she realized that Harry would loose his self identity when he grew older and his physical strength deteriorated that she examined the importance she attributed to her own physical size and appearance.

And I remember thinking, oh God, I don’t want that to happen to me. I want something else to be there.

In the months following the conversation about Harry, Joan began to seek ways to define her worth that were not tied to the shape of her body. Beginning with a return to graduate school, Joan began focusing on accomplishments of the mind rather then restrictions of the body. She stated:

I think, for me, the task was to really develop a sense of competence and a sense of esteem that was rooted in myself...

Joan, in moving beyond the “physical creature,” started her journey into bulimic recovery by establishing new criteria by which to define her competence. As Joan put her
energies into graduate study and the career that would evolve out of her professional training she found that the practice of bulimia fell away from her. She has had no relapses.

**Lynn’s Story Of Practice**

Lynn’s drive to be thin began when she was thirteen years old. She recalled the dynamics that underpinned her first purging incident.

I thought, I hate how I feel because I feel fat. Because I was already getting into the mind set of I don’t want to look overweight when I ride [horses], that type of thing. So I went into the bathroom and threw up.

Lynn elaborated on her dissatisfaction with her physical appearance in the years that she practiced bulimia.

I remember going through a stage when I wanted a face job. I wanted this, I wanted that, just hated my body.

As Lynn thought back to her years of practicing bulimia, she connected her drive to be thin to her overall dissatisfaction with her appearance. In describing her drive to be thin, Lynn said:

...I never, ever thought that I could walk down the street without comparing my body to everyone’s. And I did all the time. It didn’t, I think I mentioned this before, it didn’t matter whether this person was any, it could have been someone, you know, lying near death in a hospital, who is obviously very thin because of medical reasons, it didn’t matter, I would compare myself to that person and say I’m fatter than that person, that person is thinner than I. And I was just obsessed with it...

Competence, for Lynn, was understood as realigning her body to conform to the female configurations appreciated by our society. Lynn viewed her drive to achieve and maintain thinness through exercise, laxatives, dieting and purging as a project that gave her a sense of power, accomplishment and mastery over her life.

...it just gave me a great sense of pride that I had control over that thinking that I could make my body the way I wanted to...
Lynn’s Story Of Recovery

Although Lynn continues to struggle with bulimic incidents, she defined herself in recovery through relapse. Lynn, stating that recovery “is just redefining what successful living is for me,” understood her recovery as discovering ways to affirm herself that excluded control of her body size. Lynn, while critiquing how we are socialized to value certain body types stated:

You know recovery is a very intellectual thing...I think realizing what learning what things your thoughts, are they real? Are they concrete? Or are they, you know, are they your own or are you being influenced by the outside?

She has begun to challenge our contemporary criteria for what constitutes female beauty.

You know, now I can really, I never felt I could, but I can look at magazines and look at things and really realize how ridiculous it is, what society has done to women, and I’ll say, you know, it has done this to women, it’s made women feel unless you fit this model, unless you fit this, you are, you are, you know, [not desirable]. And it’s, I think, you know, I thought about this a few years ago, but then I thought, well, no, I’m just trying to rationalize that, you know, I don’t fit that mold so I’m trying to make it better. But now I can straight see it’s just absolutely ludicrous, you know, just it’s, it’s starting to appreciate my own differences and everyone else’s and realize, you know, it’s just, you know, it’s just, we all are unique, and it’s just ludicrous to think that we should all look the same, or all be the same...

Beth’s Story Of Practice

Beth recalled negative familial and community messages about being overweight.

My mother was always heavy, and all my life I always heard, “Don’t let yourself look like me. Don’t let yourself get heavy. You don’t want to be like me.”

While in high school, Beth described herself as having “a little bit of a weight problem at the time” that drew negative comments from the band director.

And then I vividly remember in high school, I was a majorette and we had gone on a band day somewhere, and we had stopped somewhere on the way back and gotten ice cream, and the band director came up to me and took it from me and said “You put on one more pound and I’m not going to let you march anymore.” So, you know, those kinds of messages.
Beth’s lessons regarding attitudes towards weight gains continued while she attended college.

I went off to college and once I adjusted there and my sophomore year was when I gained more weight and so my parents came to pick me up and told me I looked like a butterball turkey waiting there, you know, waiting for them. I had picked up so much weight. And it was after then that I started back to vomiting...knowing that it was a way to lose weight.

Beth recalled “I wasn’t a star academically, and so the way I looked became important, I guess.” She went on to explain the logic behind her decision to be thin.

...being thin was my way of saying what I can do, you know, look what I’m good at. I’m good at being thin. Um, and then why did I need to be thin? Well, I didn’t feel like I was good at anything else, so I finally found something I could do...I just wanted to be thin. I wanted to be thinner than everybody. Because that’s what I wanted to do best. That was where I was going to be a star, was to be thin.

Beth remembered that after separating from her first husband and moving into a residency of her own that her practice of bulimia “…really became full blown.” She described her determination to be thin.

Everything that went down came back up, used a laxative two or three times a week, anything to make my stomach flat, anything to be thin because first divorce in the family, you know, all of this stuff. And I never had lived up to what my sister was, except my sister was always overweight, so I was going to be thin. That’s what I was going to do well.

Purging, for Beth, served the function of helping her achieve and maintain the culturally appreciated slender form. Beth remembered the positive comments she received as she continued her quest for thinness.

I had to have attention, I mean, and it was like, the fact that somebody would say “Are you losing weight?” just made my day. That was attention. I was getting attention.

Although Beth had read extensively about the medical consequences of practicing bulimia, her need to be thin overrode her need to protect her health.

…I knew this isn’t normal, this isn’t how other people maintain their weight. I knew, so there was the intellectual level that knew this is wrong, but then there was the other side that this [purging] is the only way I can be thin and being thin is important, and, um, this gets me attention [for being thin] and oh, if I can get into a size two, that’s better than getting into a four, and, you
know, if the scales can stay under 100, that’s just great. You know, those were the things that made me feel good.

Beth’s Story Of Recovery

Beth, like Lynn and Joan, understood one dimension of her recovery to be an attempt to release herself from the societal standards for female slenderness. She defined recovery as “...leading a healthier lifestyle.” However, Beth viewed her recovery as an ongoing struggle against seeking self affirmation through reduction of her body size. Recalling a period in her bulimic recovery when she gained weight, Beth described her fear of fatness overtaking her.

...I knew the clothes were feeling a little bit tighter...and I knew my weight was creeping up, but when it finally hit that one hundred and four mark, it was like, Oh my God! What am I going to do now?

Beth went on to describe her recovery from societal pressures to be thin as an acceptance of weight gain.

And what I did was bought bigger clothes...It was scary, and I didn’t want it to happen, but I just bought, I bought bigger clothes. This is what I had to do. And I packed up the ones I couldn’t get into...

Reflecting on her recovery struggle to move beyond defining herself through her body proportions, Beth stated:

I think it would be very easy to let myself slip back to looking at vomiting as a way to lose weight...like right now, we’re going to California. I’d like to have a little bit of my stomach off of me, and I know that one way to do that would be to throw up everything I ate for the next week. I know I could do that. I know how to do it. I know I could do it but I’m making a choice not to do it.

Beth remains concerned about the size of her body and stated that “If I get up to one hundred and sixteen, I start watching what I eat.” Thinness, although no longer central to how she establishes self worth, remains a recovery issue. However, taking drastic measures to achieve thinness is no longer how Beth practices weight control. Rather, she stated, “I cut out the sweets, but I do it rationally now. You know, I don’t follow a strict diet.”
Mary’s Story Of Practice

Mary, like Beth, recalled familial messages about the importance of being thin.

My mother always kept very thin and would say something to us, like if we’d put on weight, she’s say “You know, you’re getting,” just these comments like, not directly like you’re getting fat, but that was the message. You know, just like, “Well, you know, the heavier you get, the harder it is to take it off.” Just things like that. My stepfather had said at one point, “You’re going to be a good looking woman if you keep your weight down.” Always just real shitty messages about weight from both male and female.

Mary, like Beth, remembered her reaction to being told that she was thin. When her college roommate commented on “how incredibly thin” she was, Mary recalled that:

...I loved it. I had an incredible high about it.

Mary’s Story Of Recovery

Mary viewed one dimension of recovery as extracting herself from the societal pressure to be thin. Although she described her previous practice of bulimia as “...not a real issue anymore,” she understands recovery as a process of working through societal messages about female worth and body image. Mary, like Lynn and Joan, gained insights into patriarchal oppression through her experience with bulimia. Associating eating disorders with “food traps,” Mary stated:

I think women in our country, I think women are so objectified, that’s why percentages of women have more eating issues, that’s one of my theories.

Mary described her sense of self worth as “...in the gutter” during those periods in which she was most susceptible to affirming herself through a loss of weight. Looking back on her focus on weight management, Mary, like Lynn, described her mission to be thin as giving her a sense of control over one aspect of her life.

You know, I can control how much I eat or how much I don’t eat, and I can control my weight and that much [control] I do have.

Furthermore, Mary situated her bulimic practice in the patriarchal oppression of female emotions.
I also believe it’s women were taught that, you know, it’s not ladylike to get mad and things like that, and I always felt guilty for displaying anger or macho...I would get angry and then I would drown it in food instead of being assertive.

Mary, who defined recovery as not purging, understood her recovery as a struggle to release herself from the societal pressure to be thin. However, her self worth was still, to some extent, linked to her body size.

I want to maintain a normal weight just because it’s good for me. I don’t want to do the swings. Gain a lot, lose a lot. I just want to take care of myself better because I do believe if I feel I look good, I’m going to feel better about myself. So that’s why I don’t want to gain a lot of weight but I also don’t want to punish myself if I do.

In recovery, Mary continued to be challenged by and reacted to the issue of female weight and self worth.

When I started losing weight, I had a lot more attention paid to me by men. I had dual feelings about that. Part of me loved it, part of me wanted to say, “Fuck you, I’m the same person that I am now as I was when I was overweight.” So I had some real mental tugs of war going on. But yet I was really sensitive to weight. I was extremely sensitive to anyone making the slightest reference to my weight...I let them know that I’m just real sensitive to people judging me on my looks.

Ann’s Story Of Practice

Ann reflected that she “had a preoccupation with weight and food since I was about eleven...” She stated that when she gained eighty pounds in her recovery from anorexia, that bulimic purging played a role in weight management because she “lost forty pounds through it...” Although Ann understood her bulimic practice as allowing her to lose weight, she did not remember any overt familial pressures to be thin.

...I didn’t have pressure to look thin or to be thin or to look pretty or to be attractive. I absolutely did not have that in any direct way.

However, Ann went on to speculate on the impact of her mother’s secretive eating practices and weight gains on the shaping of her own attitudes about heaviness. She connected her mother’s secretive eating with the formation of her own sense of shame over being heavy.
I think there was some of it [pressure to be thin] because my mother has had a weight problem. Hers is sort of a yo-yo dieting syndrome. And I became most aware of that when I was about 11, that she gained and lost maybe 40 pounds several times while I was growing up but she never talked about it. She never ate at meals anything that would cause you to gain 40 pounds. She was, you know, we've talked [about] it a little since, but she was a kind of closet eater...Again it was secretive for her.

Ann went on to discuss her preoccupation with the size of her body and linked her sense of worthlessness to her weight.

I think it was part of my definition of the very core of me was my weight, and oh, some people would talk about their weight, about losing their weight. Losing my weight, it was always a part of me that I hated so much [that] I didn’t want to claim it as my own, but in reality I did inside. It was very much how I defined myself.

Ann’s Story of Recovery

Ann, who’s been in bulimic recovery since 1989 without relapses, no longer viewed her recovery as struggling against the urge to validate herself through reduction of her body size.

And my weight doesn’t feel like it’s describing me. There’s a different part of me than my weight. I mean, there’s not two separate things, but my weight is not what I consider me anymore.

However, early in her recovery a concern about weight gain caused her to wonder if she would ever be able to eat without concern about calories. Early recovery, for Ann, was not succumbing to restricting her food intake to maintain a low body weight.

Could I have, would I, knowing that I’m not going to throw this up, would I be able to eat certain kinds of food and feel okay about that? Or would I stick to skinless, boneless chicken breasts with nothing on them and green beans with, you know. And for a little while...I think I kind of did that. You know, I was very limiting in what I allowed myself to eat and maybe I lost a pound or two. I didn’t weigh myself but I think I probably did for a little bit, but it got into, like I did get into a pattern that just felt like I wasn’t thinking about it that much, you know.

In talking about losing the urge to practice bulimic purging, Ann indicated her successful recovery journey away from attempts to reduce her body to meet the societal criteria for slimness:
Yeah, and then it just, I never really have had the urge to do that again. I mean, I still like to eat. Sometimes I think I eat too much, and at different times I’ll worry about it a little bit, but I would rather look like a balloon than go through what I did for that...

Alex’s Story Of Practice

Alex, unlike the others, did not understand the purging aspect of her bulimic practice as initially functioning as a weight management tool. A drive for thinness did not augment her purging behaviors.

Originally when I first became sick, or when I was consciously, you know, not eating and losing weight and everything...when it [losing weight] first started, it was depression, and I just wasn’t eating and it [weight loss] was just something that happened...I felt like, I think I always knew that I was throwing up not to lose weight or not to control how I looked, it was more how I felt...

However, Alex was later influenced by our societal pressures to be thin and several years into practicing bulimic purging she began to view it as a strategy by which to manage her weight:

At a point I was, it [bulimic purging] became that just because I didn’t, I really just got caught up in the whole loosing weight, but I’ve, I don’t know, I’ve really, it’s really hard to explain what it [bulimia] was...it was definitely to lose weight, and I would be upset if I, if I, you know, gained weight, and I was really conscious of the calories, and, um, you know, I mean, the calories and, you know, everything. I think that just kind of happened, though I think the pattern was already there, and then it just kind of evolved into that.

Alex’s Story Of Recovery

Alex, unlike other women in this study, did not describe her recovery from purging as primarily tied to learning to be less concerned about the societal pressures to be thin. Although Alex remembered that she eventually relied on purging as a tool of weight management, she pointed out:

...I still had the habits of being bulimic, I think, but I don’t think it was for the same reasons as a lot of other people...

Understanding her practice of purging as primarily expressive of feelings and only secondarily attached to weight management shaped Alex’s view of recovery and its
relationship to societal pressures to be slender. Alex illustrated her disregard for societal dictates regarding female form in talking about her post recovery weight gain.

I’ve gained, I’ve gained about thirty-five pounds in the past two years...and I, I don’t know, as far as my body, I’m okay with it, really. I mean, I, you know, it doesn’t, you know, I don’t know, it doesn’t really, it doesn’t bother me. I mean I try to, you know, I try to work out now more and I just, and that makes me feel better, but I’m not doing it to lose weight, and I’m not, I don’t know, I mean, it doesn’t, I mean, I feel better. I feel so much better than I’ve ever felt before. You know, I actively have energy to get through the day and I, I don’t know. I think, I mean, yeah, I feel fat, sometimes [laughs] and I feel like, um, I don’t know, I mean, I feel heavier. I feel, you know, I know I’m bigger but it’s okay, like, you know, I can accept it, it’s better.

All of the women viewed their purging practices as primarily, or in Alex’s case, secondarily, connected to societal norms regarding female beauty. These women spoke of seeking affirmation through the reduction of their bodies. Perhaps Beth captured the drive to be thin most succinctly when she noted that “...so much in society related to being thin.” For these women, validation and worthiness were entwined with body shape and size and so purging functioned to undo their food binging attempts to nourish psychological hungers for meaning and connection. The women, rather than measuring their recoveries through the absence of purging incidents, discussed recovery from purging as finding new ways of defining what constitutes personal worth. Discovering ways to validate themselves that moved beyond measurements of their bodies was a dimension of what they defined as their recoveries.

The phenomenological accounts of the six women in this study expanded the definition of recovery beyond measurements of bulimic incidents to issues regarding purposeful living and gender identity. Although the women did not negate the importance of giving up bulimic practices, they understood their recoveries to be about tending to the voids in their lives and directing their focus away from the idealization of female thinness. The women, rather then understanding their recoveries as having the single dimension of absences of bulimia behaviors, viewed their recoveries as possessing the dimensions of
discovering meaning in living that satisfied their emotional hungers and redefining what constitutes female worth.
CHAPTER VI
ENVIRONMENTS OF RECOVERY

Introduction

One of the findings to emerge out of the women’s stories was the importance of environments in the recovery process. The women, in various ways, described their recoveries as moving out of environment of psychological isolation and into environments in which they felt connected to others. Freeing themselves from their bulimic practices and their senses of separateness was linked to connection with others or, as Mary stated, sharing with “safe people.” The inextricable tie between supportive relationships and bulimic recovery is clearly expressed by both Lynn and Beth.

Lynn: And I think everybody needs someone, you know, whether it be a friend or the therapist or someone that really does, that you’ve told your whole story to and that really gives you praise for it....I think obviously me opening up to other people or one close friend or something had helped me as far as sharing it [bulimic practice] and making it real. It’s also helped me realize that yeah, I’ve gone through hell and back, you know, and because then they can sort of bounce back and say yeah, look at what you’ve done. I’m like yeah.

Beth: I truly think you need a support system. Um, for me, I needed a support system because so much of what caused it [bulimia] was feeling alone, the lonely feelings, the empty feelings, the unloved feelings. But when I had support, then there was someone to share it with, someone who understood, someone to be compassionate about it if I couldn’t be compassionate with myself. So that support had to be there for me.

The women, while bulimic, moved in social circles and appeared to others to be socially interactive. However, they described intrinsic senses of loneliness. Their environments, while bulimic, seemed to fail to nurture them. As mentioned in chapter five, the women described food as functioning as a non critical friend that comforted them and alleviated their feelings of loneliness. Beth remembered:
The binge eating came from food being a source of comfort for me...and my evenings, when I was by myself, were spent more times in the kitchen, standing at the counter, with the butter, the peanut butter and the jellies. You know, spooning it out, eating it and then going to the garbage disposal and throwing it up.

Lynn described food as an inanimate companion that accepted her, regardless of her appearance.

I could be a slob when I was eating...it was like it’s not going to look at me and go, “Oh, you’re not dressed right.” It didn’t matter whether the batter was uncooked, it didn’t matter, you know. The food was not going to be looking at me...

In a similar vain, others spoke of food as offering solace and as substituting for a “sense of connection” to others.

**Alex:** I just wanted to feel like some type of connection with something and feel like, you know, something.

**Mary:** I had always relied on food for comfort.

The environments the women moved in while bulimic contrasted sharply with their recovery environments. The overriding sense of social isolation that distinguished their practice environments was absent from their environments of recovery. The women’s recovery environments were characterized by affiliations, attachments and connection to others.

**Qualities Of The Environments**

The women, in describing what in their environments facilitated and supported their bulimic recoveries, emphasized relationships. They gave considerable attention to the qualities in their recovery relationships that assisted them in turning away from seeking emotional nurturance through relationships with food. For the women, trusting that they were accepted for themselves, regardless of their behaviors, and knowing that they were securely embraced in these recovery relationships, facilitated their movements out of psychological isolation and bulimic practices. Speaking about themselves, their bulimic practices and even, in some cases, disclosing long-kept secrets in emotionally supportive
and steadfast relationships, supported the women’s resolutions to give up their bulimic practices. A common thread through the women’s recovery stories was trusting that they were accepted for who they were and for where they were in their lives. Feeling validated and secure in empathic recovery relationships permeated their stories.

Ann: ...one of the reasons why I was able to give up the bulimia was that I felt for the first time that I had a kind of safety net. I realized that there was a lot below the surface going on for me and that there was going to be somebody who could listen to me through the hard time...

Lynn: I was very threatened by any mention of it [practicing bulimia]...So she told me right at the very beginning that unless you feel a need, we’re not going to discuss that at all. So we started talking about my parents and everything, which was very good and that’s what I needed.

Alex: I feel like she’s completely raised me in the past six years, really, because I didn’t, I mean all areas of my life were really, really a mess.

Beth: I owe a lot to him for being the person to be there for me and not make judgments on me.

Mary: ...she made me feel, she had unconditional love that I, I worked with her a significant period of time so I trusted her.

Context Of The Environments

The women’s relationships that supported recovery, although therapeutic, were not always with therapists, or therapists alone. Some of the women had other or overlapping recovery relationships with peers, groups or animals. Interestingly, neither spouses nor families of origin were mentioned as critically important to the women’s bulimic recoveries.

Although in stable marriages, neither Beth nor Ann identified their husbands as key supporters of their bulimic recoveries.

Beth: ...I told him about my past with bulimia. He didn’t understand it at all...he just like, “Oh, um, um,” you know, but he didn’t understand anything about it.

Ann: I think he would have a hard time understanding it. He would still be okay with it, I mean, it’s not like he would stop loving me because of it, but I think that there’s some level that he couldn’t understand it.
In contrast, Lynn viewed her fiancee’s reaction to her bulimic history as very empathic and openly enlisted his support when she felt an urge to binge or purge.

Lynn, Alex, and Mary were empathic that family members were roadblocks to their bulimic recoveries. The three women, who are neither mothers nor wives, moved away from their parental homes to attend college and felt that the geographic distance was beneficial. They talked of occasional familial visits but gave no indication that they wanted to draw them into their recovery environments.

Lynn, whose parents were in the throes of a divorce, spoke of the importance of familial distance.

I think, for me, moving away from home helped. I think if my family would have committed to recovery of the whole family itself, I probably could have remained at home and grown. However, you know, as we’ve all heard, you know, it’s just not one person, it’s the whole family, which definitely was my family, but they were still in denial of what, you know, they still to this day are just fighting and just, you know, the conflicts are still there, never have been resolved in like ten years...so, it’s just an ongoing thing and I think if I would have stayed within that, there’s no way that, there’s no way I would have been able to have grown from it .

Alex described her family as “really bizarre” and remembered “a lot of neglect, I mean, not to mention abuse.” Although her parents are now in alcoholism recovery and she seemed relieved to report that “everybody’s not hitting each other all the time anymore,” she still felt that her family related to each other in an unhealthy way. Alex explained:

...geographic distance helps just because that’s definitely part of it because they are hours away from me and I mean hum, because when I talk to, even when I talk to them on the phone now we talk about absolutely nothing. I tell them nothing about my life...we can be cordial to one another and I can go home for Christmas because it’s my family too, and um, but I don’t expect anything.

Mary described her mother and one of her sisters as practicing alcoholics and commented, philosophically, that “...there are other ways of dealing with life than locked into some of the dysfunction of my family.” She related that she only visited her mother on holidays.
I still have a relationship with those, my mother and my two sisters, but it’s not a close one and my one sister lives in California, the active alcoholic is in California. My eldest sister lives in New York state...the distance is helpful...

While Lynn, Alex and Mary remained wary of familial interaction, Ann and Beth, who are married, are more welcoming of family contact. Ann even began her bulimic recovery while visiting her parents and experiencing an environment in which she “felt very sort of taken care of.” Joan was the only women in the study whose parents live in the proximity. However, Joan’s story of recovery is an anomaly in that she remembered recovering in a fashion that is best described as “going solo.” She gave no indication that her family of origin either facilitated or impeded her bulimic recovery.

Therapists

The women came about discovering “connecting” relationships that supported their bulimic recoveries in differing contexts. Five of the six women began their move out of isolation and the practice of bulimia after forming trusting relationships with female therapists. All but one of the therapists specialized in eating disorders. Only Joan recovered from bulimia without turning to a therapist to support her in her recovery journey. Mary developed a relationship with the first therapist that she saw while the other women did not connected with first or, in some cases, even second or third therapists that they consulted. Emphasizing that they “needed the right person,” the women recollected disappointments before finding therapists with whom they established rapport. Although the women believed that their therapists helped them to give up bulimia, they also identified other types of relationships that supported their bulimic recoveries.

Group As Environment Of Recovery

No where is the reaction to relationships that facilitated or impeded bulimic recovery more diverse then in the women’s stories about their experiences with therapeutic and self help groups. Mary, more then the others, facilitated her bulimic recovery by becoming
actively involved in group relationships. Without threatening or deluding her relationship to her therapist, she found solace and support in group environments. She moved easily in therapeutic and community based self-help groups, often relying on both environments concurrently to support her bulimic recovery. Mary commented on her positive experience in an outpatient therapy group for bulimic women.

She [therapist] put me in a group with other women in bulimic recovery and that helped by not making me feel so lonely and also making me, that I had something to offer. I was in the group for quite a while, then newcomers would come in, and I would pass on my strength to them, and that would make me feel good.

However, Mary’s earlier experience in a therapeutic group for men and women experiencing emotional problems was problematic. Mary found it impossible to disclose her vulnerabilities and concerns in the presence of men.

I did not say a word...I would ask everybody else questions and I would not disclose anything about me...and afterwards I was told that there were a couple of other women in there with eating disorders, but none of us wanted to talk, and I, for me, I think it was just because, again my fear of rejection. I didn’t know anybody else in there had eating disorders. I think the men in there scared me, intimidated me...I didn’t trust them and I just felt that they wouldn’t understand and would reject me.

However, when Mary joined a therapeutic group for women in bulimic recovery, she described a very different kind of environment.

...when I got in with a group of women, it just felt safer, plus we were all in there, we all knew everybody else had a similar eating disorder, so it was already a given, so I knew, all right, these people all share the same thing.

Mary also discovered that not all self help groups were supportive environments for her concurrent bulimic and alcoholic recoveries. She found that Overeaters Anonymous meetings were less helpful for her recovery from bulimia then attendance at the meetings and affiliation with the members of the Alcoholics Anonymous Fellowship. Stating that she felt “more connected to the people there [AA],” Mary elaborated:

...I also feel that I’ve found more recovery at the AA meetings than I have at the OA meetings...I got to the point where I felt like I was just hearing nothing but the problems, and I wanted more recovery. And in OA, now don’t get me wrong, there were some people that worked a very good
program in [OA] and talked a lot of strength and hope, but I just heard more of the dumping and the, um, I got more recovery in the AA meetings, I found...That just worked for me as more, I just got more, for me, out of the AA...

Mary also pointed out that participation in OA groups put her at risk for obsessing about food and that she could apply the twelve steps of the AA program to any area of her life. She summarized by stating, “So AA, I can apply to anything...”

In contrast to her negative experience with mixed therapeutic groups, Mary’s attendance at AA meetings, in which both men and women were present, did not impede her recovery. She shared that it was helpful to hear men share their experiences.

... it just helped me, that was another key piece to make me feel, I don’t know, I didn’t think so negatively of men then and I felt more connected with men.

Alex and Lynn had less positive group experiences. Alex, feeling that she was farther along in her recovery process then other members of the outpatient therapeutic group for women with eating disorders, tolerated but did not bond with members of the group.

I don’t think that was a very successful group, actually. I mean, it didn’t do anything for me because I think, I think it was because I was beyond the point that most of the people were at.

Later, Alex did develop a sense of group connectedness. While participating in a residential program for women with eating disorders she noted that she “actually got close to these people that I was in the program with,” and found that the group connectedness augmented her decision to give up her bulimic practice.

Contrasting with Mary’s positive involvement with Alcoholics Anonymous is Alex’s experience. When her therapist urged her to attend Alcoholics Anonymous meetings to resolve her drinking problem, Alex attended a few of their group meetings. However, her reluctance to connect to any of the people who attended those meetings was reflected in her remarks pertaining to her parents affiliation with Alcoholics Anonymous.

I’ve been to meetings, but I have a really bad, I don’t know, my parents were in recovery, um, they haven’t been drinking for maybe 16 years or something
like that, but they're just like, they just don't drink, but they're still really fucked up, they're completely, um, they're not any different, really, not really any different than they ever were. So, um, no, I mean, I don't think that, well, I mean, AA has probably kept them sober or helped, just the people that they met, but I don't know that it really did much more than that so I just have bad feelings toward it.

Lynn felt neither safe nor secure within outpatient therapeutic groups for women with eating disorders. She remembered feeling shamed whenever she relapsed and often needed to compete with other group members to obtain the status of the best and brightest in the group.

I had gone through groups unsuccessfully because it was very hard for me to break away this shell and this appearance, and I got too competitive with people because I started to look at their recovery and I felt too guilty because I wasn't there...I wasn't really ready to be that open with other people.

Although not faulting the personalities in the group, she recalled these therapeutic group experiences as "forced recoveries" that failed to facilitate or support her recovery from bulimia.

I don't want a forced recovery. That's what I think of [therapeutic] groups...that's how I felt in therapy groups because I felt like, well, I have to be part of the group. You basically say that at the beginning, you know, we need a commitment from everyone to be here and, you know, you need to participate because if you don't, then the group's not there, obviously. So I felt like I had to be there, be strong for everybody, and I thought, you know, I don't want that pressure...

Lynn, like Alex, found that her response to therapeutic group environments changed while she was participating in an inpatient treatment program for women with eating disorders.

...this was the first time that I had ever had people around me that saw me when I had those urges [to binge and purge], that helped me endure the pain.

Lynn, although less wary of community self help groups then Alex, did not embrace them with anything resembling Mary's enthusiasm. For Lynn, moving into and out of Overeaters Anonymous meetings, although a way of touching base, never developed into genuine connection and relationship.
Beth, Joan, and Ann were never participants in either therapeutic or self help groups but, in contrast to Lynn and Alex, remarked wishfully and hypothetically that group environments might have helped them recover from bulimia. Their comments emphasized the importance they placed on supportive group environments.

Joan: If I realized at the time that there was help available, and I could have accepted that help openly, I would have done that.

Beth: I wish I would have...I really wish I would have [had a support group]...because at that point I didn’t know anyone else who was in the same situation.

Ann: I would like to be in a group...and I have, I’ve told Janice [her therapist] that for the last year and a half and I don’t think she really has a group and I haven’t gone out on my own [to join a support group].

Friends As Environment Of Recovery

Although all the women in the study mentioned having friends, only Alex and Beth spoke of specific friends who directly supported their bulimic recoveries. Both women saw their friends on a regular basis and, unlike other women in the study, identified some supportive friends who were themselves in bulimic recovery.

Beth identified two male friends as facilitating and supporting her bulimic recovery. Commenting that she “never had a lot of close women friends,” Beth identified her boyfriend at the time, as supporting her effort to give up her bulimic practice.

He was extremely helpful in helping me get over it...he just listened and he didn’t judge me, or, you know, say “You better get better,” or, you know, and he never said anything about my size. Because I gained a little weight, but he didn’t comment positively or negatively on it...and to this day, we’re still good friends.

Several years into recovery Beth developed a supportive recovery relationship with a recovering bulimia. She discussed the sponsorship dynamics of their relationship.

[He would] keep me from being hard on myself about it [relapsing]. And I would do the same for him. I mean, because there would be times he’d come in and he [would] say, “You know, I threw up last night.” So I’d do the same thing [for him].
Alex spoke of keeping in touch with a recovering bulimic whom she met while both of them were participating in a residential program for women with eating disorders. Alex, in contrast to Beth, referred to her friend as not in her “regular life.”

She and I, she has helped a lot, just as far as I’ve kept in contact with her. And I can always kind of try to analyze things with her, I guess, and talk about things that maybe I hadn’t taken time to think about or just in my regular life.

Lynn, in comparison to Beth and Alex, found that her connection to recovering bulimics changed over time. Although not singling out any particular friend, Lynn remembered that in her early recovery the she had an empathic connection to other bulimics.

...I thought, well the only person who would understand what I’ve gone through is some one who’s bulimic. I thought they were the only people that could understand.

In the course of time, Lynn’s reliance on recovering bulimics to support her recovery changed.

But I guess now I realize that even though other people haven’t chosen bulimia, they’ve chosen other ways...and I realize that I have just as many things that are common with people. I guess for years I thought since I have this, I am so different form everyone else. All their [problems] were just wiped away because, no, they weren’t bulimic...Well, that’s just part of me, it’s not this thing that keeps me from dealing with other people. It’s not something that keeps me from having friends, having close relationships.

A different story is told by Ann. Unlike Beth or Lynn, Ann never experienced an affinity for recovering bulimics.

I mean, I’ve had experiences, both before [recovery] and after, of seeing somebody that I know was either anorexic or bulimic, you know, there were, you know, being in a restaurant with somebody behaving in a certain way that, you know, it had to be, it had to be, or I think anorexia is a little bit easier to see because of some physical things, but, um, there have been times when I’ve known and I’ve had no desire to, to, I mean it’s really lowered my opinion of them...

Alex, as discussed in chapter five, discussed the steadfast and validating qualities in her three women friends. Although pointing out that her six-year relationship with her therapist was “actually the most important thing,” she stressed that “my friends were real
supportive [of my recovery].” Frequent contact and proximity marked these friendships. Alex lived with two of these women in what she described as “a family kind of situation.” Reflectively, she declared:

...this feels more comfortable and more I guess what a family would be like then it felt like when I was growing up. That’s what’s going on, definitely.

She went on to say that she has up to five phone conversations a day with her third woman friend. Alex captured the non-conditional love of these friendships as she talked about their shared evenings.

We just checked in with each other a lot I guess...I mean even if I get aggravated and whatever, it’s, um, we still like cook dinner together.

An aspect of Alex’s and Lynn’s recovery friendships was “sorting through” and letting go of some of the individuals they affiliated with when practicing bulimia. Lynn let go of people that she described as not having a positive effect on her life but remained determined to “choose people that accept me as who I am and don’t judge me.”

Alex, after giving up practicing bulimia, decided to clean up her life by turning out people who had been part of her party and drinking community while she had been practicing bulimia.

...I kind of started cleaning up my life and kicking out all these people that were sleeping all over my house.

Animal Environments

The tie between supportive relationships and bulimic recoveries was not always limited to humans. A surprising and notable finding of this study was the role of animals in supporting bulimic recoveries. Some of the women’s stories offered insights into human and animal interactions in bulimic recoveries. Alex, Lynn, and Beth spoke of their bonds to their animals as curative in that their interactions fulfilled longings to be needed and to nurture. The sense of connection, or as Lynn stated, “living contact,” pervaded their stories.
Lynn: ...he [her horse] was a great support to me because I’d go out, you know, my family would be having difficulties, my parents would be fighting. I’d go out and talk to my horse and just get that support and that living contact with someone.

Alex: I have to, you know, feed her [her dog] and walk her and, you know, whatever. So, and play with her and I want to.

Beth: I mean, we cuddle, I mean that if I’m feeling lonely, she can sense it. If I’m upset, she’s right there, you know? If I’m crying about something, she’s got her head on my leg. If I’m sitting on the couch or something, she’s just right there for me. She senses it. And she makes me feel like I’m needed because she needs me, and I need her ...she’s my buddy.

Alex, who had over a decade-long loving relationship with her dog, identified this relationship as helping her sustain her bulimic recovery. Feeling responsible for her dog’s welfare fueled her determination to give up her bulimic practice.

Maybe it even starts with that because I have to take care of her, this responsibility that I have, so that helps me to have to get out of bed, you know, like that kind of thing...so, I mean, I think it starts with that because I’m, I mean, I like having the responsibility...

Lynn discussed the rewards of being needed.

I think animals were really great for me because I love to take care of them and I love to feel the contact and feel that I was counted on and, you know, that animal was depending on me...And so in that it sometimes brought [me] out of my disappointments or my pain.

Although Lynn did not have animals in her recovery environment she considered how an animal could have helped her.

I think animals, just having the animal there [while actively bulimic]...because at that point I never close to have a person there, that would be much more risky then having an animal, and I think if I would have had an animal there with me, it would have maybe given me a focus to get out of myself and really look at what was going on...and I think, speculating, I think it probably could have been a great help.

With the wisdom of hindsight, Lynn concluded that if she were at the beginning of her struggle to overcome bulimia that she would have sought the support of an animal.

... I would have an animal. I would make sure I had a place where I could have an animal because it would give, for one thing it gives me a purpose even when I’m in my lowest times that I need to, you know, I need to at least pull myself out of this, you know, it might be a forced awakening, you know, to pull me out of that hole, but it, nonetheless it’s necessary, you know, because [I] would be saying, hey, you know, get yourself out of this pit that
you’re in because you need to take care of this animal, and by taking care of this animal, and by taking care of it, you know, the animal most likely will take care of me too, at least giving me contact and love.

Beth, who brought dogs into her home after setbacks related to pregnancy or adoption, wondered if the presence of one of three dogs would have facilitated and supported her recovery.

I wasn’t real responsible then and I don’t think I would have thought of her in the same way as I do now. Um, I don’t know.

Going It Alone

Only Joan’s environment didn’t specify connecting to someone as paramount to her bulimic recovery. The thematic sense of Joan’s story is going solo. She neither spoke of her bulimic practice nor recovery until several years into recovery. Joan, without negating the value of two long term women friends and the man she started seeing in early recovery and later married, did not indicate that she relied on them to support her recovery from bulimia. However, Joan shared, with a tinge of sadness, that she would have appreciated a recovery confidant.

In retrospect, I think it would have been very nice if there was somebody I could have talked with about it.

Conclusion

Supportive environments was a common theme in the women’s recovery stories. The women’s environments of recovery, in contrast to their practice environments, were characterized by rewarding connections to others. However, differences as well as similarities marked the women’s recovery environments. The rich variations running through their environments is best described as “no one way.” The support in the women’s recovery environments was played out in multiple and different kinds of relationships. The women’s stories revealed that there was not one, but rather multiple and diverse types of relationships that facilitated their journeys into bulimic recovery.
CHAPTER VII
PRACTICES OF RECOVERY

Introduction

All of the women, on their own volition, discussed practices that they used to sustain their bulimic recoveries. Some of these practices were suggested by others while the remainder evolved out of their own personal experiences with home remedies. Of particular interest were the ways in which they resolved unstructured time, came to terms with dietary and weight issues, dealt with relapses and related to medications.

Structuring Empty Time

The women used terms such as “gaps of time,” “voids,” “dismal down time,” “emptiness,” “vacuums” and “dead silence” to describe periods of time in which no activities were planned. Those hours in a day in which no scheduled activities were in evidence, especially in early recovery, put many of the women at risk of bulimic relapse.

Beth captured the women’s concern with empty time when she stated:

I needed to structure my time. Learn how to manage my time where I wouldn’t have gaps of time with nothing to do where I could fall back on eating.

The women, in discussing how they resolved unstructured time, emphasized the importance of planned activities. Several women stressed that it was critical to their early bulimic recoveries to plan replacement activities for those hours in the day where they previously practiced bulimia.

Most of the women discussed physical exercise as a planned activity that functioned to sustain their bulimic recoveries. Beth and Joan viewed exercise as functioning, in their
early years of recovery, as a replacement activity for the hours of the day in which they previously practiced bulimia.

Joan: ...what I got into was a pattern of running at the end of the day when I use to binge.

Beth, like Joan, used exercise as a replacement activity for the hours in which she previously binged and purged. Thinking back on her daily exercise routine Beth noted:

Well, I think what I did then was turn to the exercise because instead of, you know, spending the evening in the kitchen eating I was out riding my bicycle or at the health club work out on the equipment, or going to the aerobics class, or doing something like that.

Most of the women were aware that exercise could became a purging technique if use excessively and so they were careful to not “exercise overboard,” or to look at exercise “in a framework of burning calories.” Only Beth commented on having been conscious of using exercise as a purging alternative in her early bulimic recovery but added “I think in my way I was still purging but in a healthier way.”

Several of the women found themselves relying on or confronted by bulimic replacement activities that were detrimental to their welfare.

Mary and Alex discussed cross addiction as an aspect of their recoveries. For both women, the abuse of alcohol and/or other drugs appeared or remained prevalent in their lives after they stopped practicing bulimia. Mary remembered:

When my food issues were at rest I cross addicted. That’s when my alcoholism took off. I also got into speed. I was eating caffeine pills, so I just keep cross addicting.

Alex stated that although abusing alcohol was “nothing new,” that she “was drinking a lot” after beginning her bulimic recovery in 1989. While reflecting on the role of alcohol in her bulimic recovery, Alex remarked that she thought “it was just another way of trying to get something.”

Mary, within a year of giving up bulimia, released herself from using alcohol and other mood altering drugs as bulimic replacement activities and gained sobriety through
membership in Alcoholics Anonymous. Although Alex sustained periods of alcohol abstinence she remained ambivalent about the role of alcohol in her life. Viewing her alcohol consumption as problematic, Alex explained rather sadly:

I probably will drink sometimes because I know that I haven’t committed. I mean I don’t think I’ve committed insofar as saying I am not going to drink or don’t drink any more or whatever, because I don’t say that.

Beth, who began bulimic recovery in 1983, identified her panic attacks as beginning six years after she gave up her bulimic practice. Although neither pleasurable nor escapist, Beth did view her panic attacks as an bulimic replacement activity. Declaring that “...not wanting to seek comfort in food kind of led to the panic attacks,” she went on to describe their nature and occurrence.

...for the last probably four years I’ve been suffering from panic attacks...Yeah, to the point that I still haven’t been able to drive my car on a freeway...And I was doing okay until we had, I had the two miscarriages and the failed adoptions...I was back to beating myself up again. You’re terrible, you’re, you know, you’re never going to be a success in the family, you know, here you go again...

Speculating that her panic attacks functioned as bulimic replacement activity, Beth described them as “sort of like same church, different pew.” Later she returned to her analysis of the etiology of her panic attacks.

It’s another or different way to deal with the insecurity that I felt, the self doubt, the failure to meet people’s expectations um, since dealing with it with food wasn’t a way to do it anymore it kind of built up inside and manifested itself into panic attacks.

**Dietary And Weight Management Practices**

The phenomenon of changing practices is inherent in the women’s stories of bulimic recovery. That is, the women, early into their recoveries minimized the risk of relapsing by changing the ways in which they dealt with hunger, eating and body weight. Mary captured the women’s attitudes underpinning their behavioral changes when she stated “A lot of it [recovery] has to do with my mind reframing thinking in a lot of ways.”
Most of the women reduced their relapse risks by differentiating between emotional and physical hungers. "Listening" was a word often used to describe the practice of paying attention to what triggered their eating urges. Joan, who ran daily in early bulimic recovery, talked about the role of exercise in clarifying her understanding of hunger.

The running was very important to me in terms of learning that sensation, how to tell the difference between emotional hunger and physical hunger because, for me, running curtailed my physical appetite, it’s a physical sensation that’s very clear to me...so I learned what not being hungry felt like and from that I developed the awareness of what was emotional hunger versus physical hunger. So exercise was really the mechanism by which I think I learned how to tell the difference.

Mary spoke of her practice of becoming aware of the sensation of physical hunger and identified the hunger warning signals that warranted her attention.

I eat. I stop when I’m full. I listen to my body now. I feel when I’m full...I ask myself, “Am I hungry?” If the answer is no, I know something else is going on...and it’s also a red flag to me. If I want to eat when I’m not hungry something else is going on.

The six women, who had previous experiences with erratic eating, semi-starvation dieting and avoidance of particular foods, identified eating when hungry as a practice that lowered their risks of succumbing to food binges. The women, to avoid becoming too hungry, relied on dietary practices that replaced the erratic and restrictive eating patterns of their bulimic lifestyles. Their determinations to not trigger binge eating by restricting their food intake is best exemplified by Mary’s recitation of a slogan that helped her avoid hunger induced relapses. “Eat in order not to eat,” Mary said. Most of the women insisted on eating two or three meals a day.

Mary pointed out:

When I eat, it’s like medicine, almost. You know the three meals a day which again, I just do two.

Joan remembered:

...I had gotten into the pattern of having breakfast...but I really stated to realize I felt if I ate breakfast and I wasn’t ravenous at the end of the day like I had been when I was fasting during the day and gradually I began to realize
that this three meals a day or eating when you’re hungry really has some merit to it.

Alex contrasted her eating practices in recovery to her style of eating when she was bulimic.

I usually didn’t eat until maybe like one or two [P.M]. And then I would eat something and then by the end of the day I would be starving and then I would end up binging...so I um, I know now, I mean, I know, like whether I just eat popcorn and coffee or orange juice or something, I mean, I have to eat something [in the morning] and so um, you know, or toast or whatever. I have to eat something in the morning...But that helps, eating three times, eating at the same time, like, basically the same time every day, I guess.

Lynn was emphatic about eating on a regular basis to avoid relapsing and discussed how alterations in this routine puts her at risk of relapsing.

Like for me, it’s three meals a day, as far as very specific food behavior...if I start playing these games again I get caught up in, well, I ate that little bit of sugar so I cannot have this, and it becomes a whole day of just, you know, not directed at all, and then I get lost up in the food again. So that’s something that does keep me directed, it’s saying, “Okay, I need three meals a day” and make sure I do it.

Ann, stating that she doesn’t “necessarily always eat three meals a day” also avoided erratic eating but was a little less adamant about consuming a specific number of meals each day.

Beth also insisted on eating at least twice a day, but unlike Alex and Joan, felt no need to eat in the morning.

Related to warding off becoming too hungry by eating on a regular basis were the women’s avoidance of diets and food deprivations. Most of the women discussed dieting and/or refusing to eat foods they craved as putting them at risk of relapsing.

**Lynn:** ...when I get to restricting, I get to playing games again as far as what is good, what is bad...what I’m working on now is looking at, yes, there are times, many times, that I want food and often if I let myself have it, I won’t overindulge.

**Ann:** I know when I try to lose, you know, five or ten pounds, that I become more obsessed with it, and I don’t know if that’s the weight or the thinking about the food...or the activity, but once I start focusing on it, you know, it’s kind of easy to get sucked up into that.
Joan: ...I've never been able to diet successfully. To this day, the idea of dieting is one of sacrifice to me. I don't think about what I eat in terms of "Oh, I shouldn't eat this, I'm eating too much." I eat what I want to eat.

Mary: Sugar was my main binge food so for a while I was staying away from that. Maybe it was just through the course of my recovery, I learned too that if I felt deprived and I didn't get some [sugar] in here and here I felt deprived and that's when I would binge...That black and white thinking that stayed for so long. So, for me, again, I learned to give myself permission here and there to have a piece of candy or something. That didn't make me feel as deprived.

Breaking the bulimic cycle and the obsession with weight control not only meant practicing bulimic alternative activities but also required omitting particular practices. The women, describing their bathroom scales as a "trap," or as as "putting a number on something that can be harmful," discussed the importance of giving up their practices of weighing themselves.

Beth: I wouldn't weigh myself because if I weighed myself, that would control my whole day...If it was low I'd be ecstatic and if it would be high, then it just ruined my day right from the start. So I stopped letting that number control me. And because, I mean, there were days that it was high that my jeans would feel the same as a day when it was low. And when I came to recognize that was when I said, "I don't need this scale."

Ann: I don't weigh myself now...I'm just a happier person if I don't do that. I mean, it's just a reminder of something that, it puts a number on something that can be harmful to me and I know it can be, you know, to get tied up in numbers like that.

Mary: For me, I would not weigh myself. For me, that was a trap, to weigh myself, because I feel I would obsess about the weight, like if I got on the scale one morning and saw that I had gained two pounds, that would make me panic, and that would get me back into the cycles of eating and dieting....Weighing just ties me to the obsession to lose.

**Food Journaling Practices**

Tied to practices of recovery were the women's diverse reactions to keeping food journals while in therapy. Food journals can best be defined as daily charting of amounts and kinds of food consumed with concurrent notations on the feelings associated with eating and the descriptions of the environments in which the food consumption took place.

Alex and Beth felt that their practices of keeping food journals helped them to recover from bulimia. However, the keeping of food journals strengthened their recoveries
in different ways. Alex monitored amounts of food she consumed to detect when she was not eating enough. Beth, on the other hand, keep a food journal to help her identify emotional states that triggered her bulimic episodes.

Neither Mary nor Lynn looked on food journals favorably. They remembered that keeping food journals reinforced their negative feelings about themselves and/or exacerbated their bulimic tendencies.

Mary: ...The more I would see food written in front of me, the more I would obsess about food and want to binge. When I saw how much I had eaten by recording it, I would get frightened and I’d go on a hard binge.

Lynn: I went to him [behavioral therapist] first, and first what he wanted me to do, he said “Well, what I want you to do is start keeping track of when you binge, what you eat, and things like this.” Well, I had that one hour appointment with him and never went back...because I thought, I don’t want to look at what I’m eating. I don’t want to have anything to do with realizing it. I don’t want to see it because I’m so ashamed of it and if I see it in print it’s just going to make me feel worse.

Relapses

Although the women identified themselves in recovery, three of these women spoke of having experienced one, several or frequent bulimic relapses. Their relapses challenged them to formulate attitudes about relapsing that allowed for incorporating bulimic incidents into their recovery journeys. Taking the shame out of relapsing, as well as minimizing its significance, were attitudinal stances they practiced when dealing with their bulimic relapses. Illustrations are found in Lynn’s and Alex’s comments.

Lynn: I think what was central for me to move on was to get rid of the shame that this [relapsing] was something I did and once I got rid of that, I just looked at, hey, it’s a symptom of something else.

Alex: I don’t think it would be the end of the world if I had a relapse of some sort...I mean, maybe it just happened. I mean, you just have to take it for what it is or something...see it as part of recovery, that it was okay to do that.

Several of the women, who had not relapsed, showed little flair for the dramatic when talking about the possibility of relapsing.
Mary: ...just get back on track, don’t dwell, don’t let it lead into another binge.

Ann: I don’t have a fear of it,...realistically, it could happen, but I also know now that it’s not a forever thing, you know...It’s just, you deal with it when it happens, but there’s a life afterwards...

The women spoke of what put them at risk for relapsing. Their “red flags,” as Mary and Ann labeled those periods of risk, were associated with specific psychological and physiological states.

Beth and Alex discussed emotional states that put them at risk of relapsing. Feeling lonely or empty and being depressed were their particular red flags.

Beth: ...It’s been times when I’ve felt lonely...I’m alone in the house because of my husband’s job with his travel...So he usually is gone one week a month...and so I go through, I would go through a lot of lonely, empty feelings...

Alex: That [wanting to throw up] is not usually based on something that immediately happens. Like say I get into a fight with somebody or I don’t like something that’s going on. I don’t think that triggers it. I think it’s something more and just kind of my depression cycles which I definitely have...

Mary, and Lynn spoke of physiological states that that put them at risk of relapsing, such as sleep deprivation and missing meals. Of particular interest were their identifications of the premenstrual syndrome (PMS) as putting them at risk of relapsing.

Mary: A really important piece of my eating cycle is my menstrual cycle. When I have PMS, that’s when I crave chocolates and I crave carbohydrates. I had to get a lot of education too, about how I could take care of myself and my emotions. I will overeat when premenstrual. My emotions are a wreck around that time.

Lynn: ...I know now that it’s a time when I crave carbohydrates and feel like binging.

Interestingly, only Beth identified weight gain, in her early recovery, as putting her at risk for relapsing. Of particular importance was the problematic nature of possible pregnancy, prenatal nutrition and weight gain. While attempting to conceive, Beth remembered that she would “eat right because there might be a baby inside. So that, of
course, made my weight go up a little bit more.” However, when she would start her period, she recalled:

...that’s when I started back with some relapses of “Oh, you pig, you’re getting fat again.”...because I was eating more than I had been and so that kind of threw me back into more of a temptation to vomit.

The women, through the threat or occurrence of relapses, developed practices to safeguard themselves against bulimic relapses. Their prevention practices might be described as personal safety nets because they evolved out of their own particular struggles to remain free of bulimic incidents.

Beth and Lynn did not go into hiding when they resorted to binging and purging in their recoveries. Rather, they went public and stopped their relapses by talking to others about their occurrence.

Beth: ...if I kept it inside, it was hiding the behavior again, and for me, it was important to get it out.

Lynn: ...I’ll call somebody and I just say, “I need to talk...”

Mary, Alex and Lynn developed “sitting it out” practices for preventing bulimic relapses. Alex, who was vulnerable for relapse when she felt depressed explained:

...now what I do [instead of turning to bulimia] is just kind of sit with it [depression]. I know I’m going to feel like that. I just kind of take it for that because I know really throwing up isn’t going to do the same thing [that it once did].

Mary practiced waiting out her urge to be bulimic by turning to others or by distracting herself.

Reaching out, getting out, there have been times when I have to just read a book, something other than reaching for the food...

Lynn described her practice of waiting out her desire to purge whenever she ate a meal that made her feel too full.

I need to go for a walk or I need to just sit here awhile because I feel very full now. But now I realize, yes, if I wait that half hour, or wait that hour, the fullness will go away.
Mary and Lynn developed differing practices to prevent PMS triggered relapses. Mary simply allowed herself to overeat.

I will overeat when I’m premenstrual but I use low-calorie foods.

Lynn, on the other hand, dealt with lowering her risk of a PMS triggered relapse by taking prescribed medication. Convinced that her PMS syndrome puts her at risk for bulimic relapse, she, on the advice of her current therapist [psychiatrist], began taking Prozac in 1992. Commenting on its effect, Lynn said:

I can notice a subtle difference. I just don’t get overemotional about things...it’s definitely, that it limits your carbohydrate cravings.

**Medication Practices**

Five of the women discussed their practices of taking prescribed medications, especially antidepressant medications, as an aspect of their recoveries. However, they spoke of taking medication not so much to prevent bulimic relapses as to alleviate depressive or anxiety states. Only Lynn described her pharmacologic practice as directly supporting her bulimic recovery. All but Mary were in bulimic recovery for several years prior to taking mood altering medications.

Ann, who gave up her bulimic practice in 1989, began taking an antidepressant in the spring of 1992 when she recognized that she “...was more depressed then usual.” However, she stated that “I can’t say that it’s made a big difference.”

Alex, who had some prior experience with antidepressants, began taking Impramine, an antidepressant, in the spring of 1993, four years into her bulimic recovery, because she stated, “I was anxious all the day.” She reported that several months into her pharmacological treatment that she slept better and “feels good.”

Lynn, who defined her recovery through relapse as beginning in 1989, stated taking the antidepressant Prozac three years into her bulimic recovery. As reported earlier,
she described the medication as helpful in stabilizing her moods and lowering her carbohydrate cravings during PMS.

In 1992, Beth, nine years into her bulimic recovery, started taking Klonopin, an anti-seizure medication that has proven helpful to some individuals experiencing anxiety. Beth shared that she took the drug to reduce her level of anxiety and to minimize the occurrence of panic attacks that had begun six years into her bulimic recovery. She reported satisfaction with the drug and shared that once, when she went off her medication, the panic attacks returned.

Mary described herself as an “extremely depressed person” when she first began to seek professional help to overcome her bulimic practice and started on an antidepressant while still actively bulimic. In the autumn of 1991, four years into her bulimic recovery, Mary decided that it was time to stop taking her medication. She emphasized that during the initial period of adjusting to not taking an antidepressant, it was important for her to continue in therapy “so I, once I get shaky, to have somebody there.” Later, she added “if I really need them, I know I can go back on them.”

Joan, unlike the others, did not report the practice of taking mood altering medication in her bulimic recovery.

Conclusion

The women’s accounts of their bulimic recovery practices disclosed similarities and differences in the strategies that they relied on to sustain their recoveries. A few of the women emphasized that there was no one way to support recovery and in so doing advocated a wide spectrum of recovery practices.

Mary: ...To be real honest with you, weight is still an issue, but the foods I eat, I think it’s so individualized with food that...to me, that my experience with other women with eating disorders, everyone I’ve talked to does a different eating plan and when some things work for other people that don’t work for others...through trial and error I had to find out what worked for me...I believe that there is not one set pattern [of recovery].
Beth: I guess just to summarize what I think is necessary for recovery, I mean it’s all personal for everybody. It’s different because what drives people to eating disorders is different and what helps them recover is different...

Lynn: ...I think there’s been a part of me thinking, you know, even though I have to do it in my own pace, you know, I’ve read so much and I think everybody wants to find the perfect answer to recovery, but there are some things that just don’t work for everyone, and if you try something, it doesn’t mean it’s a fault with you...And I think, you know, just because maybe food lists don’t work or specific groups don’t work, it doesn’t mean that you’re lacking in something, or, you know, just because I don’t feel comfortable in therapy groups, I don’t work well with people or, you know, it’s not that. It’s just it didn’t click with me and, you know, you’ve got to find you own thing by trying and trial and error.
CHAPTER VIII
DISCUSSION

Introduction

The purpose of this study was to explore and describe the lived experiences and phenomenological perspectives of women who defined themselves in bulimic recovery. Although common themes emerged from their stories a conscious attempt was made, through self reflexivity, peer debriefing and member checking, to not allow common themes to suppress the particularities of each woman’s recovery story (Nicholson, 1990). The women’s personal viewpoints and practices produced rich variations with each of the themes that emerged out of the data analysis.

All six women, in their own voices, chose to discuss revelations, recovery concepts and environments and practices that supported their recoveries. These thematic commonalties were defined as turning points, dimensions of recovery, and environments and practices of recovery. Although four thematic commonalties emerged out of the women’s stories, their phenomenological perspectives and differing pathways into recovery challenged the positivist assumptions about universality (Sands & Nuccio, 1992; Nicholson, 1990). The women’s subjective understandings of recovery and divergent pathways into recovery called attention to the multiple realities, contexts and strategies of recovery. Therefore, emerging out the women’s stories and permeating the common themes of turning points, dimensions of recovery and environments and practices of recovery is a theme best described as “no one way.”
This chapter begins with an examination of the common themes that emerged out of the women’s stories to existential, feminist and postmodern paradigms. The chapter then moves to self-reflexivity, methodology and research issues. Following is a review of the limitations of the study and recommendations for further study. The chapter closes with a discussion of the implications of this study’s findings to social work.

**Discussion Of The Themes**

Lincoln and Guba question the assumption that findings can be given more weight if they are consistent with multiple theories (1985). In discussing methods of establishing credibility, they state:

> If a given fact is confirmable within two theories, that finding may be more a function of the similarity of the theories than of the empirical meaningfulness of the fact (1985, p. 307).

In support of their convictions, no attempt to establish credibility through theory triangulation is being undertaken. Rather, what the women shared in common is being examined through its relatedness to theoretical perspectives in order to interpret at a higher level of abstraction. Attention will be given to Frankl’s existential framework as it pertains to discovering meaning in existence. Emphasis will also be given to feminist theory as it relates to engendering the body. Postmodern thought will be discussed as it relates to “no one way” of understanding or practicing bulimic recovery.

The theories that will be discussed are not to be considered an exhaustive analysis. Rather, they are presented to inform the discussion of the themes that emerged out of the women’s stories. Furthermore, the epistemological incongruity of the spiritual essentialism of Frankl’s existential thought, the use of categories, especially gender, by some feminist theorists, and the postmodernists’ emphasis on multiple meanings will neither be contrasted nor compared.

A common theme evolving out of the study was an expanded definition of recovery that moved beyond food and weight issues (refer to chapter V). As previously discussed,
the women understood their recoveries as dealing not so much with food and body concerns as with meaning in living and cultural standards of female beauty.

The Existential Paradigm

The women’s understandings of their bulimic practices placed them in the context of lives focused on eating behaviors but otherwise experienced as empty, isolating, and often directionless. Although most of the women attempted to remedy feelings of emptiness with binge eating, Alex’s understanding of purging to connect with something also placed her in a life that was otherwise experienced as empty. The women’s views of their bulimic recoveries situated recoveries in lives that connected to others, and were driven by sense of purpose that transcended preoccupations with food and weight management.

Viktor Frankl, in his exploration of the human drive to discover meaning in living, offers a conceptual framework for studying the women’s understandings of bulimic recovery. The exploration of Frankl’s existential paradigm of human behavior limits itself to his discourses on the will to meaning, the existential vacuum and the discovery of meaning. Other existential theorists that critique and expand on his work will be included in the discussion.

Frankl’s conceptual framework is built on the premise that an individual’s primary motivation is to discover meaning in existence (1984). According to Frankl, when persons fail to discover meaning in living, they “are haunted by the experience of their inner emptiness, a void within themselves” (1984, p. 111). Frankl describes this situation as being caught in an existential or meaning vacuum (1965, 1984, 1988). Frankl, Lantz, and others explain that persons experiencing a void within themselves will either discover meaning in living or develop compensating reactions (symptoms) to the frustrated will to discover meaning. Individuals experiencing their own inner emptiness will often develop symptoms such as anxiety, depression, substance abuse and interpersonal isolation
(Frankl, 1984; Lantz, 1987; Lantz & Lantz, 1992; Lantz & Pegram, 1989). Frankl (1984) stresses that most symptoms cannot be understood unless the sense of meaninglessness in living is identified as the underlying problem.

Frankl (1984) postulates that individuals can discover meaning through three avenues of endeavor: (1) by creative endeavors, such as work or causes; (2) by interpersonal connectedness or by experiencing beauty, goodness or truth in nature or culture; and (3) by our attitude towards inescapable human suffering. Because suffering is unavoidable, Frankl believes that at the moment a person finds meaning in personal suffering, it ceases to be suffering.

An Existential Understanding Of the Women’s Views Of Recovery

When a person is unable to discover, recognize and accept meaning there is an existential vacuum. This vacuum can be filled by either a developing sense of meaning or by psychiatric and existential symptoms such as anxiety, depression, substance abuse, despair, confusion and the experience of anomie (Lantz, 1987, p. 65).

The interlinking relationship between bulimic practices and existential vacuums was analyzed in chapter V. In summary, each of the women related their binging or, in Alex’s case, purging, to “other problems.” They described relying on bulimic practices to fill up “feeling empty and hollow,” “to connect to something,” or to “fill voids” and “empty feelings.”

Each of the women understood a dimension of her recovery to be grounded in a discovery of meaning that was more fulfilling than her bulimic practice. Each woman discussed discovering meaning through activities that Frankl described as avenues of endeavors and interpersonal connectedness. The women moved out of their bulimic practices and sustained their recoveries by discovering meaning in living through creative endeavors such as work and causes and by experiencing interpersonal connectedness.

Joan’s recovery began when she ceased being a “classic enabler” trying to keep her husband’s life in order while holding “odd jobs.” Joan’s practice of bulimia “began to
resolve without much effort” when she divorced and went back to graduate school to prepare for a professional career. In early recovery Joan also began seeing the man who would later become her second husband.

Ann’s recovery was associated with her commitment to raising her children in a healthy environment. She cut back on her employment hours to be more available to her children and was contemplating leaving paid employment because she no longer discovered a sense of fulfillment in that work. Ann’s daily bulimic practice was further displaced by her endeavor to home school her young children.

Beth’s recovery was supported by her professional and volunteer endeavors and her interpersonal connectedness to animals. She dealt with “empty feelings” and “voids” in her life by “closing the chapter” on having children and on professional “floundering.” She went on to discover meaning in her life through volunteering in the animal welfare movement and by creating a loving “animal kingdom” in her home. Recently, Beth expanded her volunteer work to include working with women with eating disorders. Beth has also discovered meaning in life through her paid employment and through affiliations with people possessing an affinity for animals.

Mary, whose “soul companion” was once food, dated her 1988 bulimic recovery to the anniversary date of her sobriety. She has been an active member of Alchoholics Anonymous since 1988 and her early bulimic recovery was associated with discovering meaning in living through participation in a fellowship that offered both companionship and a cause to believe in.

Although Alex struggles with her perspective regarding the loss of intensity that accompanied her purging, she has successfully managed to connect to something through her “family of friends.” In 1989, when Alex realized that seeking a sense of connection through purging blocked her from connecting to people, she gave up her bulimic practice
and has had only one purging incident since that realization. Replacing her inner void with relationships includes a loving relationship with her dog (refer to chapter VI).

Lynn’s recovery through relapses has been difficult. Her recovery through an “active effort” has included monthly relapses. However, she is beginning to replace her friendship with food with “living contact.” She was preparing for her marriage during the time in which the interviews occurred and was attending a self-help group for binge eaters. Postscript. Lynn married her fiancee shortly after completing her interviews for this study and is currently bringing animals into her life. She has taken in a stray dog and has reclaimed her elderly horse (refer to chapter VI) from hired keepers. He now lives on her newly acquired farm. Lynn is also making plans to enter graduate study in the social sciences. After moving to her farm, Lynn wrote that she is discovering “a greater connection to others.”

One dimension of the women’s recoveries was the discovery of meaning through creative endeavors and interpersonal connectedness. Another dimension was discovering ways of validating themselves that excluded acquiring the perfect body.

The Feminist Paradigm

Although feminist theorists offer diverse thoughts on the causes and cures of gender subjugation, they have a collective commitment to rectify the sex/class oppression of women. The feminist perspective, in its broadest sense, offers a framework for studying the women’s stories of bulimic practices and recoveries. Bartky (1988), Brownmiller (1984), Chernin (1982), Dworkin (1989), Seid (1989), Wolf (1991), and others write about the construction of female beauty as a reflection of patriarchal domination. In determining to be more than “physical creatures,” the women struggled to move beyond defining themselves by the patriarchal standards of beauty. Although the women did not identify themselves as feminists, they spoke feminist thought as they recalled the social contexts that fostered their bulimic practices (refer to chapter V). Most of
the women grasped the relationships of their gender socialization to their drives to be thin and bulimic practices. As discussed in chapter V, most of the women expressed anger and/or sadness for living in a society that pressures women to define themselves through their measurements and weights. Bartky (1988) and Dworkin (1989) described dieting and exercise as forms of oppression that women submit to in order to transform themselves into the physically perfect women that win male approval. Although the women in this study did not indicate that they understood their drives to be thin and their bulimic practices to be aspects of a larger order of female subjugation, they did view the “disciplinary practices” (Bartky, 1988, p. 71) of beauty as gender specific and oppressive.

Because the women’s recovery stories across themes called attention to multiple understandings and practices of bulimic recovery, the final theme emerging out of the women’s stories is described as “no one way.”

Postmodern Philosophy

Postmodern thought offers a conceptual framework for studying the women’s phenomenological understandings, and practices of recovery. Postmodernists find logocentrism problematic (Sands & Nuccio, 1992). They celebrate differences and multiplicities and argue against the search for universal truth and deny the possibility of value free knowledge (Fraser & Nicholson, 1990; Sands & Nuccio, 1992). Postmodernists reject the positivist tenant that there is a single reality, an essential innate truth that is objective, measurable, and separate from the people experiencing it. Rather, they view phenomena as having multiple meanings. That is, they understand meaning as constructed through human interactions in political, historical and social contexts.

The women in this study discussed their personal ways of facilitating and supporting their bulimic recoveries in interactive interviews and through a loosely structured writing assignment. Although similarities emerged, the particularities of each recovery story added complexity and variations to recovery viewpoints and practices.
Self Reflexivity And Methodology

Throughout the research process I kept descriptive fieldnotes and a reflexive journal. The fieldnotes were my thoughts, impressions, and reactions to completed interviews. Heeding Bogdan and Biklin’s (1992) advice, I sometimes wrote fieldnotes during interviews, but always immediately after interviews. These fieldnotes, considered supplements to each interview, were kept with the interview transcripts in the participant’s binder. The participant’s binder held all materials pertaining to each participant. The fieldnotes were divided into six content areas as recommended by Bogdan and Biklen (1992, pp 120-121). They were: Portraits of the subjects, reconstruction of dialogue, physical setting descriptions, accounts of particular events, depiction of activities, and observer’s behavior. Writings in the sixth content area (observer’s behavior) was very beneficial in helping me evaluate ways in which I might have influenced the participant.

Being the human instrument (Lincoln & Guba, 1985) meant that I needed to keep vigilance on my subjectivity (values, viewpoints, positions) and sources of bias that could have threatened the trustworthiness of the research study (LeCompte, 1987). I also needed to record accurately on emergent design and analysis. My “reflexive journal” (Guba & Lincoln, 1982, p. 248) or “field diary” (Bogdan & Biklen, 1992, p. 122) served these purposes. It was an introspective diary in which I wrote out my feelings, impressions and problems regarding any aspect of the project. It was a strategy manual in which I recorded future, and often speculative, research plans. Finally, it served as a progress report of the “evolution of the design and analysis” (Bogdan & Biklen, 1992, p. 121). The reflexive journal, categorized on Bogdan and Biklen’s five part model (1992, p. 122-127), contained reflections on analysis, methods, ethical issues, frame of mind, and clarifications.

Self reflection did not lead to any changes in the study’s orientation or in the methods of collecting data. However, the practice of introspective writing helped me
identify and resolve countertransference issues, and concerns regarding the welfare of participants. These concerns will be discussed in the next section of this chapter.

Research Issues

Countertransference

Research issues clustered around countertransference, ethical concerns and the effects of participating in the study. Countertransference is the term that describes the feelings that a therapist may develop towards a client because the client reminds the therapist of a person from his or her past. Succumbing to countertransference results in the therapist responding to a client as if the the client was a person from the therapist’s past. In the research setting, the process of connecting and interacting with participants, made it especially important to remain alert to ways in which I might project persons from my past unto the participants in the study. Through self reflexive journaling and peer debriefing with a practicing clinician, I remained attentive to ways in which my inner subjectivity and past relationships could distort the interviewing process. Furthermore, as discussed in chapter III, clinical training and extensive clinical social work experience in the mental health field working with women having problems with substances afforded me previous opportunities to work through personal conflicts and to attain a better understanding of my subjectivity.

Welfare of the Participants

A concern throughout the interviewing process centered on what I consider privacy invasions. That is, to what extent should participants be encouraged to tell more than they meant to or even wanted to? The balances between gathering rich data and protecting participants remained a concern throughout the interview process. When one of the participants described sensitive memories as being “ouchy,” she underscored the need to protect participants from speaking about that which they were reluctant to share. Writing in
my reflexive journal/field diary helped me explore ways to facilitate storytelling without enticing any of the women to go beyond their thresholds of comfort and well being.

The invasion of privacy concern was best exemplified by one woman’s ambivalence towards discussing a relationship that may have related to her bulimic practice. Although she approached the subject on several different occasions, she always retreated from it prior to full disclosure. Her body language on these occasions indicated psychological discomfort. In this incident, and others, the balance between gathering rich data versus protecting participants always sided in favor of participant well being.

A related ethical issue that I call “interpretative transgressions,” dealt with writing up the findings. Because the study fostered collaboration, the participants, in the second formal membercheck (refer to chapter III), were asked to read my interpretations of their stories. The concern for protecting the participants presented itself when I realized that several speculations that I harbored regarding the recovery stories of a few of the participants might be damaging to the participants in question if included in the findings chapters. Because my hunches were not based on any direct information given by participants I determined that omitting these speculations from my writings did not compromise the research accuracy of the study but did protect participants psychological well being. This discussion of invasion of privacy and interpretative transgression issues is not to be construed as hindering the collection of data or distorting the presentations of the findings. Rather, this section of the chapter is presented to remind clinically inexperienced researchers of at least some of the issues that introspective writing brings to our attention. In the final analysis, my concern for the protection of participants did not in any meaningful way limit the data collection process nor weaken the trustworthiness of the findings. Rather, my concern for the women’s well being, over time, built trust and rapport between us that resulted in their decisions, on their terms, to share “ouchy” experiences that related to their bulimic recoveries.
Effects Of Being In The Study

Prior to entering the field I was concerned that exploration of bulimic recovery might result in some distress for at least a few of the participants (refer to chapter III). However, the women’s comments during and after the completion of the study highlighted the positive nature of the participatory experience.

The women talked and wrote about the effects of speaking out. They also commented on the impact that reading the findings chapters (chapters IV-VII) had on their lives. The women, at the close of interviews and in the open-ended questionnaire that accompanied the findings chapters (appendix I), were asked What did you get out of being in the study? The women responded with comments pertaining to self affirmation, a sense of connection to others (by reading the findings chapters), and the opportunity to help practicing bulimics.

Mary: I feel it’s real important to have a voice...I’m keeping in mind here that I wanted to do this, what I’ve been through, if I can make any kind of positives out of it, and it’s one of the reasons why I’m supportive of what you’re doing because I think it’s great, and, um, my feeling has been just, it’s kind of good to talk about it...This feels a lot to me like it did when I was a senior member in a group. You know, I’d been there a while and new people would come along, and it would give a chance for me to share some of my experience, to feel better about myself, to be able to share what’s worked for me and what didn’t work for me, and um, so, probably that’s what I’ve gotten out of this.

Joan: I have learned more than I realized I’ve learned. It’s very difficult to go back. It really helped me realize that I’ve come along farther than I sometimes give myself credit for.

Ann: [I got] more a sense of community, less shame.

Alex: Being in this study gave me an opportunity to examine my views of recovery. It’s important for me to still hold some relationship with my eating disorder because it was my life for so long. I’m proud to be on the other side.

Beth: The most beneficial part was reading my story. You pulled it all together and somehow it all made sense. Seeing how my story was the same as well as different from the others was interesting. It was useful to talk about my experiences and not revert back to bulimic behaviors. It just reinforced that I have gained strength through my recovery.
Lynn: Discussing my recovery, seeing my words in print helped solidify, in my mind, the progress I have made. It has been easy, over the years, to dwell on the progression of the illness, rather than the progression out of it. Through being involved in the study I can acknowledge and appreciate the growth I've achieved... Through involvement in this study and through personal exploration I've found a greater connection to others. My thoughts of I'm the only one have been challenged. I felt alienated from others. I'm beginning to feel part of. By sharing our personal stories we can bond as women.

However, the impact of being researched is only known in the short term. How the six womens' participation in this study will affect them in the long run is not presently known. Because listening to womens' recovery stories is a form of intervention it leads me to question when the impact of a qualitative researcher ceases to play itself out in the lives of women who have disclosed so much in her presence. Through self reflexive journaling I wrestled with the time frames regarding when my clinical responsibilities for the well being and future of persons who have relived their experiences in my presence should come to an end. My decision was to remain responsive to those women who wished to keep in touch over time and to continue to maintain a reference list of competent mental health specialists with expertise in eating disorders to whom I could refer participants if professional help was warranted in the future. It should be added that five of the six women in this study have positive relationships with their own past or current therapists and would, in all probability, turn to them if the need arose.

Limitations Of The Study

Although “the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who would make that transfer than with the original investigator” (Marshall & Rossman, 1989, p. 145), a number of cautions are advised by the original investigator.

The power of transferability of findings is narrowed by the degree of homogeneity in the sample of women who participated in this study. All six women are Caucasian, middle class and heterosexual. Second, all but one of the women are under forty years of
age. Third, anyone wishing to transfer this set of findings to another context should be cognizant that investigator triangulation (Patton, 1990) did not occur in this study. Although interactive interviews and multiple memberchecks minimized misinterpretations, anyone evaluating the feasibility of transferability should remember that if interviewing and analysis had been conducted by several investigators, different findings might have emerged from the data.

**Recommendations For Further Study**

Expanded understandings of what supports bulimic recoveries will be forthcoming when former bulimics are encouraged to tell their stories, in their own voices, without the restrictions of closed-ended questionnaires. The stories told by the women in this study point to several areas warranting qualitative investigation.

As previously mentioned, the recovery stories of former bulimics where limited to Caucasian, heterosexual women living outside of poverty and working class contexts. Naturalistic inquiry into what facilitates bulimic recoveries might result in expanded understandings if participants were chosen from racial, socioeconomic and/or sexually oriented contexts other than those represented in this study.

Furthermore, and related to the above, the findings emerging out of the six women's stories indicate a need to examine the environments and practices that facilitate bulimic recoveries in older women and in minority women. Future study should also examine the role of animals in some women’s recoveries.

Finally, naturalistic inquiry into men’s understandings of their bulimic recoveries might expand our understandings of recovery from the former bulimic’s point of view and might offer a richer understanding of the role of gender on the recovery process.
Implications For Social Work

As previously discussed (refer to chapter III), the congruence of qualitative methodology and social work values encourages qualitative investigation into what former bulimics have to say about what supported and hindered their recoveries. Studies that are designed to encourage recovered persons to tell their own stories, in their own voices, may contribute to our clinical understandings of what facilitates the recovery process. Furthermore, studies that focus on the recovered person’s point of view may contribute to our treatment of many conditions and situations. When social workers choose methods of intervention dependent on the unique needs of an individual in a particular situation (Anderson, 1988), they will benefit from reading the stories of those who have recovered. Reading qualitative studies on what former bulimics say about their journeys into recovery may help social workers to understand that the “subjugated knowledge “ (Hartman, 1992, p. 483) of those who lived the experience often challenges universal truths propagated by the experts.

In light of the findings regarding the participants’ will to meaning (Frankl, 1984, 1988), practitioners would serve their clients by adopting an existential perspective on the recovery process. Without imposing their own values on their clients, practitioners need to support bulimic clients in their attempts to discover meaning in living. Practitioners, in facilitating clients' will to meaning, will help them to reduce their meaning vacuums and bulimic symptoms that occupy their inner emptiness (Lantz & Pegram, 1989). Sensitivity to the diverse avenues of endeavor that practicing bulimics will travel in discovering meaning is an important therapeutic attribute in helping practicing bulimics discover their individualistic and present-oriented meaning in living (Frankl, 1984; Krill, 1986, 1988).

Additionally, the diverse turning point experiences and multiple environments and practices that emerged out of this study reminds us to listen to the voices of our clients as they tell us of the meanings that they discover in their situations and relationships.
Furthermore, the women’s discussions of their struggles to detach themselves from seeking affirmation through physical shape remind us of the macro implications of disordered eating.

Finally, the women’s views that their bulimic practices were rooted in meaning vacuums and patriarchy remind us that our profession’s dual commitment to helping people resolve their problems and to challenging oppressive conditions is well suited to supporting women in their bulimic recoveries.
APPENDIX A
DESCRIPTION OF THE STUDY

I am a Ph.D. candidate in the College of Social Work at The Ohio State University. For my dissertation I am conducting a qualitative study on women's personal experiences with bulimic recovery. My study is under the direction of my dissertation advisor, Dr. Virginia Richardson, Professor of Social Work at The Ohio State University. The purpose of this study is to ascertain what women who have recovered from bulimia believe were the most helpful aspects of their recovery.

I will be interviewing six women who have recovered from bulimia in order to hear their stories regarding how they were able to recover from bulimia. The intention of this study is to develop and advance new theory regarding what contributes to bulimia recovery in women that is grounded in the accounts of women who are former bulimics. Confidentiality of all participants is protected. Data will be handled and reports written so as to mask the identity of all participants in the study.

I plan to interview women over the age of 21 who meet the following criteria:

1. Women in bulimic recovery for a minimum of two years. Bulimic recovery, as defined by this study, allows for a minimal number of short term bulimic relapses during the recovery process.

2. Women who participated in bulimia while retaining weight in a relatively normal range.

3. Women who when practicing bulimia used self-induced vomiting as their primary purging method.
This study will utilize the accounts of women who have recovered from bulimia as the data for analysis, relying on their recall of what supported them as they learned to eat without resorting to bulimic behaviors. The phenomenological orientation of this inquiry respects the unique perspective of each woman and it is expected that multiple ways of interpreting recovery experiences will emerge.

I hope that you will want to encourage women that you believe to be in bulimic recovery to contact me for further discussion about their possible participation in this study. Enclosed is a letter to give to those women that you believe would be likely candidates for this study. Please call me if you have information or questions.

Thank you for your interest in this study.

Sincerely,

Lee S. Shillito, L.I.S.W., A.C.S.W.
APPENDIX B

LETTER FOR INFORMENTS TO GIVE TO POTENTIAL PARTICIPANTS

I am a Ph.D. candidate in the College of Social Work at The Ohio State University. For my dissertation I am conducting a study on women’s personal experiences with bulimic recovery. My study is under the direction of my dissertation advisor, Dr. Virginia Richardson, Professor of Social Work at The Ohio State University. I am interviewing six women who have recovered from bulimia in order to hear their accounts of how they were able to recover from bulimia. I believe that your participation and insights will produce information that will be a valuable part of an improved understanding about bulimic recovery.

My objective is to interpret your story of recovery and the stories of other recovering women to develop a theory about what helps women to give up bulimic behaviors. Parts of the finished product are likely to be published in professional journals, presented at professional conferences, shared with the popular media and/or published as a book. Confidentiality of all participants is protected. Data will be handled and reports written so as to mask the identity of all participants in the study.

I plan to interview women over the age of 21 who meet the following criteria:

1. Women in bulimic recovery for a minimum of two years. Bulimic recovery, as defined by this study, allows for a minimal number of short term bulimic relapses during the recovery process.

2. Women who participated in bulimia while retaining weight in a relatively normal range.
3. Women who when practicing bulimia used self-induced vomiting as their primary purging method.

I hope that you will want to be involved in this study. If you believe that you meet the project's criteria and would like to contribute information that may help practicing bulimics recover from their eating disorder please telephone Lee S. Shillito so that we can discuss both the study and the eligibility criteria more fully.

Sincerely,

Lee S. Shillito, L.I.S.W., A.C.S.W.

Phone (home phone)
(work phone)
APPENDIX C

EXPLANATORY LETTER TO POTENTIAL PARTICIPANTS

[Date]

Dear [Name of potential participant]:

Thank you for your interest in being a participant in my study of women in bulimic recovery.

I am a Ph.D. candidate in the College of Social Work at The Ohio State University. For my dissertation I am conducting a study on women's personal experiences with bulimic recovery. My study is under the direction of my dissertation advisor, Dr. Virginia Richardson, Professor of Social Work at The Ohio State University. I am interviewing women who have recovered from bulimia in order to hear their accounts of how they were able to recover from bulimia. The purpose of this study is to find out what you believe were the most helpful aspects of recovery. I believe that your insights on how you recovered from bulimia will inform women who are still bulimic about approaches to recovery that worked. Your story about how you recovered from bulimia will also contribute to the therapeutic community's understanding of treatment strategies that help bulimic women recover from their eating disorder. I hope that you will want to participate in this exciting study. It is my expectation that your participation in this study will provide you with a rewarding and insight-gaining experience.

This research project will consist of two in-depth individual interviews and one written assignment. There may arise an occasion with a particular participant where a third interview might be beneficial. Third interviews will be conducted, if deemed necessary and appropriate, with the agreement of the participant(s). Each interview will last one and a half to two hours. The second interview will be scheduled approximately four weeks after the first interview. I will audiotape record each interview and, if you wish, you may have a transcript of the interview to keep. At the end of the first interview you will be asked to do an at home assignment. This task consists of writing about persons and events that were
important in your recovery process. The information obtained from the individual interviews and the written assignment will be part of the research material for the study.

Participation in this research study is voluntary. Please note that I will carefully maintain confidentiality. What you share with me in interviews and through the written assignment as well as my written reports will be handled so as to mask the identity of all participants in this study. Names and/or identifying data will not appear in any part of the study. All audiotapes will be destroyed at the completion of the research project. In addition, no audiotaping will be conducted without your written consent. You may choose not to answer any questions, choose not to do the written assignment, withdraw consent and discontinue participation at any stage of the project.

It is anticipated that the exploration of your bulimic recovery will be an affirming experience because it will connect you to those personal strengths that underpin your recovery from bulimia. However, there is always the possibility that you might experience some distress as a result of discussing and exploring your former bulimic experiences. I will maintain a reference file of competent mental health specialists with expertise in eating disorders to whom I may refer you should you request such a referral and/or if the need arises.

I plan to interview women over the age of twenty one who meet the following criteria:

1. Women in bulimic recovery for a minimum of two years. Bulimic recovery, as defined by this study, allows for a minimal number of short-term bulimic relapses during the recovery process.

2. Women who participated in bulimia while retaining weight in a relatively normal range.

3. Women who when practicing bulimia chose self-induced vomiting as their primary purging method.

If you believe that you meet the project's criteria and would like to contribute information that may help practicing bulimics recover from bulimia please complete the data sheet enclosed in this packet. Mail this form back to me in the self-addressed envelope at your earliest convenience. When I receive your completed data sheet I will promptly determine whether or not your particular circumstances and bulimic background match the specific criteria required by this research project. I will then inform you (by phone) of my
decision and, if appropriate, we will schedule an appointment for the first interview. At the first interview you will sign a consent form for participation in this study prior to beginning the interview.

Feel free to call me with any questions or concerns you may have about the project. Your willingness to help is greatly appreciated. I look forward to meeting you.

Sincerely,

Lee S Shillito, L.I.S.W., A.C.S.W.
APPENDIX D
DATA SHEET

NAME:

ADDRESS:

TELEPHONE NUMBER:

AGE:

MARITAL STATUS:

WHAT IS YOUR PRIMARY ROLE (CHECK ONE):

Wage earners_____ Homemaker_____ Student____

Other (specify)

HIGHEST LEVEL OF FORMAL EDUCATION:

HOW LONG HAVE YOU BEEN IN BULIMIC RECOVERY?
BULIMIC RELAPSES

Although you consider yourself in bulimic recovery, have you experienced any bulimic relapses (binging and purging, just binging or just purging) during your bulimic recovery?

yes__ no__

If you have experienced bulimic relapses during your recovery please briefly describe the characteristics of your relapses (i.e., binging and purging, just binging, just purging, etc.), how often these relapses occurred, the average length of bulimic relapses (i.e., two days, one week, several months, etc.) and when you experienced your last bulimic relapse?
APPENDIX E
CONSENT FORM

I consent to participate in research entitled: The Voices Of Recovery: A Qualitative Investigation Of Women Recovering From Bulimia. The authorized representative (Lee S. Shillito) for the principle investigator (Dr. Virginia Richardson) has explained the purpose of the study, the procedures to be followed and the expected duration of my participation.

I have been told that individual interviews and the written assignment on bulimic recovery charting are part of a research study on bulimic recovery in women. I have been informed that the study is being conducted as a doctoral dissertation at The Ohio State University in the College of Social Work. Furthermore, I have been informed that the study is to articulate and describe women's personal experience with recovery from bulimia.

I have been told that individual interviews will be audiotape recorded. I have been informed that these tapes and information obtained from the written assignment will be part of the research material for the study. The principle investigator's authorized representative, Lee S. Shillito, guarantees that my identity will be kept confidential and will not be revealed in any reports originating from the study. Names and/or identifying data will not appear in any part of the written report. All tapes will be destroyed at the completion of the research project.

I have been informed that my participation in this study is voluntary. I have been told that I may ask questions about the study, refuse to answer any question during an interview, terminate the interview, choose not to do the written assignment, withdraw consent, and discontinue participation at any stage of the project.

I have been informed that there is the possibility that I might experience some distress as a result of exploring my bulimic experiences. I have been informed by the principle investigator's authorized representative, Lee S. Shillito, that she will maintain a reference file of competent mental health specialists with expertise in eating disorders to whom she may refer me should the need arise.

I acknowledge that I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: ____________________________

signed: ______________________________________________________
(participant)

signed: ______________________________________________________
(principle investigator)

signed: ______________________________________________________
(authorized representative for the principle investigator)
APPENDIX F

INTERVIEW GUIDE

Opening and Reserve Questions for Phase One: Individual Interviews

First Interview (first level interview)

Opening question:

Could you please describe your own bulimic recovery. Describe the beginning of recovery and what has helped you in your ongoing recovery process?

Reserve questions (to elicit information not generated by the opening question).

1. What was going on in your life at the time you stopped being bulimic (i.e., interpersonal relationships, work related issues, therapy)?

   Describe key people and/or incidents that contributed to your stopping your bulimic behaviors.

2. How have you stayed away from bulimic relapses?

   Tell me about the most difficult times for you.

   Tell me about those key incidents (people and/or activities) that threatened your recovery. How did you overcome those threats to your recovery?

   Tell me about those people who contributed to your recovery. How have they contributed to your recovery?

   Tell me about those activities that contributed to your recovery. How did these activities help you recover from bulimia?

3. If you've experienced bulimic relapses during your recovery, what do you think were the key incidents (people and/or activities) that contributed to that (those) bulimic relapse(s)?

4. If you have tried before to recover from bulimia and were not successful, what was different during your recovery this time?

5. How has not being bulimic affected you? How are you different as a result of not being bulimic? What meaning does not being bulimic have for you?

6. What kinds of things have replaced bulimia?
Are you involved in something that you view as a substitute for bulimia?

Is it a substitute that you like? Why?

Is it a substitute that you don't like? Why?

7. Is there anything about your life as a bulimic that you miss now that you are in recovery?

8. Do you consider yourself fully recovered?

   If so-why?

   If not-why?

9. Is there anything you would like to add that could improve my understanding of your bulimic recovery?

   Anything that you have not talked about?

Second Interview (second level interview)

Clarify issues particular to individual stories and build on the particulars of individual stories shared during first interviews.
APPENDIX G

BULIMIC RECOVERY CHARTING ASSIGNMENT

INSTRUCTIONS FOR THE BULIMIC RECOVERY CHARTING ASSIGNMENT

At the end of the first interview you will be requested to return home and construct a chart (map, graph) that specifies important events and persons in your recovery process. You will be instructed to write up why these identified specific events and specific people were important in your bulimic recovery process. If you have experienced bulimic relapses please identify and discuss why these events and persons triggered your bulimic episodes.

I will be sensitive to the personal and unique way in which you will chose to do this assignment. Therefore, specific instructions on how to do this assignment will not be given. However, you are encouraged to discuss concerns and issues about the assignment prior to doing it and also encouraged to telephone me to discuss concerns about the assignment in the process of doing the bulimic recovery charting.

You are requested to return your bulimic recovery charting within one week of being given the assignment. Such a short turnaround allows for immediacy of recall following the first interview and protects you from making too much of the assignment.
APPENDIX H

FORMAL MEMBER CHECK EXPLANATORY LETTER

June 29, 1993

Dear [participant]:

Enclosed, for your keeping, is the final draft of the four findings chapters of the dissertation, The Voices of Recovery: A Qualitative Investigation Of Women Recovering From Bulimia. These chapters are my analysis of the findings that emerged out of the participants stories of their bulimic recoveries.

In order to protect participant identity, names and identifying data do not appear in any part of the study. For your information, you are [name] in this written document.

Your responses and reactions to these chapters are important to me and will be included in the last chapter of the dissertation. In order for your responses to be represented in the last dissertation chapter, I will need to have you fill out and mail back to me the enclosed questionnaire by (postmarked) July 9th, 1993. If I do not hear from you I will assume that your experiences are represented accurately in theses chapters. Please do complete the questionnaire and mail it back to me in the stamped self addressed envelope by July 9th.

I will be doing my oral defense in August and expect to be able to mail you the final chapter of the approved dissertation in September.

If you have any questions or concerns please call me. I am always glad to hear from you.

Sincerely,

Lee S. Shillito L.I.S.W., A.C.S.W.
APPENDIX I

FORMAL MEMBER CHECK QUESTIONNAIRE

QUESTIONNAIRE

1. Do you feel that your experience is represented accurately in this analysis?

2. If you do not feel that your experience is represented accurately how would you change it?

3. What did you get out of being in this study?
# APPENDIX J

## CODING ILLUSTRATION

### Phase One: Participant Text

**Alex:** ... whether I just eat popcorn and coffee or orange juice or something, I mean, I have to eat something and so um, you know, or toast or whatever. *I have to eat something in the morning.*

**Mary:** For one, *I would not weigh myself*, for me that was a trap, to weigh myself, because I would obsess about the weight.

**Beth:** *I wouldn’t weigh myself* because if I weighed myself, that would control my whole day...

**Joan:** *I don’t have forbidden foods, I don’t have forbidden eating times.* The way I control my weight, well. there are two ways. One is with activity, *exercise*. And the other is *I only eat when I’m hungry.*

**Lynn:** *I got on the prozac*, and he gave it to me just during PMS time, because I’d realized that, I know now that it’s a time when I do crave carbohydrates and feel like binging.

### Phase One: Emergent Codes

**Eating patterns in recovery**

**Not weighing herself**

### Phase Two: Participants Emergent Codes

**Alex:** Eating patterns in recovery

**Mary:** Not weighing herself

**Beth:** Not weighing herself

**Joan:** Eating patterns in recovery

**Exercise**

### Phase Two: Category

**Bulimic recovery strategies**

145
Ann: Not weighing herself

Lynn: Medication

**Phase Three: Category**

Bulimic recovery strategies

**Phase Three: Core category/theme**

Practices of recovery
REFERENCES


