Understanding Women's Journey of Recovering From Anorexia Nervosa

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Previous studies of recovery from anorexia nervosa (AN) have concentrated on discrete behavioral responses of individual women. Little is understood about the subjective process of women's recovery in the context of family, community, or society. In this feminist grounded theory study, the authors explored the perceptions of 12 women who considered themselves recovered or recovering from AN. They discovered a substantive theory of self-development that explains, within the current social context, women's journey from the perilous self-soothing of devastating weight loss to the informed self-care of healthy eating and problem-solving practices. The findings provide an urgently needed explanatory framework to inform women, clinicians, and health policy makers in their prevention and recovery efforts.

Keywords: *recovering; eating disorders; women's health; feminist theory; grounded theory*

Anorexia nervosa (AN) is a devastating problem for women. It creates fluid, mineral, and electrolyte imbalances that endanger cardiac, neurological, osteologic, endocrinologic, renal, and integumentary health and impairs psychosexual, social, academic, and occupational functioning (Fisher et al., 1996; Kaplan, 1990). Approximately one third of the anorectic population becomes chronically ill (Steinhausen, 2002), with as many as 16% to 20% dying from complications (Lowe et al., 2001; Theander, 1992). AN has a mortality rate greater than 12 times the mortality rate from all other causes of death for women 15 to 24 years of age (Eckert, Halmi, Marchi, Grove, & Crosby, 1995; Sullivan, 1995). Understandings of AN and recovery are limited to identification of discrete behavioral responses and explications of the meanings women assign to their health and illness. No holistic theory of recovery has been posited; moreover, present treatment strategies have uncertain outcomes. Given the high potential for death and chronicity, a new understanding

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of the process and meaning of recovery is vital for improved self-care and clinical intervention. In this article, we discuss the outcomes and implications of a feminist grounded theory study of recovery from AN.

REVIEW OF THE LITERATURE

Most of our knowledge of AN recovery is from the outside perspectives of investigators and clinicians who view recovering as behavioral responses, such as weight restoration, duration of symptom-free state, and improved scores on disordered eating clinical instruments. Specific variables found to predict recovery include having an increased percentage of ideal body weight at time of clinical presentation (Herzog, Minne, et al., 1993); shorter duration of illness before presenting for treatment (Steinhausen, 2002); biological factors of low serum creatinine level (Herzog, Schellberg, & Deter, 1993) and pituitary luteinizing hormone response to opioid blockade (Garcia-Rubi et al., 1992), which are associated with not vomiting; less psychiatric comorbidity (Strober, Freeman, & Morrell, 1997; Toner, Garfinkel, & Garner, 1988); higher satisfaction with family and social relationships (Bryant-Waugh, Knibbs, Fosson, Kaminski, & Lask, 1988; Casper & Jabine, 1996); and either family therapy if younger or individual therapy if older than 18 years (Dare, Eisler, Russell, & Szmukler, 1990).

Diversity in sample characteristics, constructs of recovery, length of follow-up, and methodological procedures makes it difficult to generalize across treatment outcome studies. We are left with uncertainty about what needs to occur for an individual woman to recover from AN.

Investigation of subjective experiences of recovering from the perspectives of women with AN has yielded personal interpretations of the meaning of AN and recovery. In these studies, women define recovering as psychological rebirth, whereby they stop doing what others expect (Beresin, Gordon, & Herzog, 1989) and as reconnection with self, others, and nature after having been strengthened through suffering the isolation of AN (Garrett, 1996, 1997). Women have attributed recovery to such personal elements as developing personality strength, being ready, and having faith (Hsu, Crisp, & Callendar, 1990); distancing self from unsupportive others and rebelling against expectations of others (Beresin et al., 1989), including rejecting authoritarian views of causality (Mukai, 1989); learning to trust self and others in relationships (Way, 1993); having therapy (Beresin et al., 1989; Hsu et al., 1990); and maturation (Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). These studies provide isolated elements with no clear understanding of the process. Further investigation is warranted, because the findings from both traditional and interpretive research traditions constrict the phenomenon of recovering into discrete variables. There is no agreement between definitions of recovery, no overall schema for how the various aspects of recovery connect, and no sense of movement over time. There is a need to go beyond description of individual experience to develop a theoretical understanding of subjective experience within social context. What is missing from the literature of how women recover is an understanding of the underlying basic social psychological process that, according to Glaser (1992), could "grab together so much into a conceptual grasp" (p. 35).

METHOD

We used feminist grounded theory to discover the central organizing process for how women recover. Grounded theory, a systematic approach to combining data collection and analysis, is guided by the fundamental question "What is going on here?" (Glaser, 1978; Glaser & Strauss, 1967). This enables consolidation of various isolated parts to make meaningful wholes (Chenitz & Swanson, 1986), grounding theory formulation in the concrete experiences of those studied. Research through a feminist lens seeks to describe women's everyday lives within their sociopolitical contexts (Allan, 1994; Thompson, 1992) and affirms a positive view of women as experts of their own health experiences (Keddy, Sims, & Stern, 1996; Wuest, 1995).

We recruited an initial sample of 7 women who identified themselves as recovered or recovering from AN through posters, newspaper advertisements, and a snowball approach. To gain the broadest possible spectrum of the phenomenon of AN recovery experiences, recovery was defined as whatever women said that it was rather than only by professional diagnosis. Data were collected from individual interviews with the women, the field notes of the primary author, and our ideas about relationships in the data. The primary author conducted all interviews.

We used constant comparative analysis (Glaser, 1978; Glaser & Strauss, 1967) to search for process by fracturing the data to look at it abstractly, assigning codes that captured the essence of the data, and clustering the data into categories that related to each other. Comparing each incident of data, codes, and categories with each other facilitated abstraction. Theoretical coding allowed us to weave the fractured story-as-codes and categories into an organized whole, thus climbing from disparate, descriptive data at the level of the interview and field note to a more abstract, inclusive view of the concept of AN recovering. Theoretical coding involved applying Glaser's (1978) various coding families to tease out properties and dimensions of categories. For example, we used types, strategies, consequences, and conditions to develop the category sheltering more fully. Types of sheltering are families sheltering women as daughters and women sheltering themselves. Sheltering strategies include isolating, conforming, and putting on a mask. A consequence of sheltering is not knowing myself. A precondition is power imbalance.

As the study progressed, the need to include data that could complete the emerging theory was accomplished by theoretical sampling,

> the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes . . . data and decides what data to collect next and where to find them, in order to develop . . . theory as it emerges. (Glaser & Strauss, 1967, p. 45)

Theoretical sampling directed further data collection and was informed by the ages of the women and the nature of treatment. For instance, because the initial sample consisted of mainly middle-aged women who had experienced AN during adolescence, we solicited younger and older women to understand if age of onset and length of time between onset and recovery influenced the theoretical construction. To examine the effect of the nature and availability of treatment on the recovering process, we sampled subgroups of women who had experienced different types of treatment as well as those who had not been professionally treated. Saturation was reached when categories were well defined and no new variation discovered (Glaser, 1978; Morse, 1995).

The final sample contained 12 women with varied AN and recovery experiences. They ranged in ages from 14 to 63, representing a mix of White and biracial heritages (one woman was of French and Aboriginal descent) and Catholic, Protestant, Jewish, and agnostic religious beliefs. These women were more highly educated than the general population. Half of the women in the sample were single, one quarter married, and one quarter divorced or separated. Four women had children. Nine of the 12 had been professionally diagnosed with AN; however, all would have met *DSM-IV* (American Psychiatric Association, 1994) criteria for AN. The onsets of AN ranged from less than 1 year to 30 years prior to the study. Participants agreed to multiple interviews, which allowed them to confirm or refine our explication of the emerging theory. The rights of participants were protected through adherence to principles of respect for persons, beneficence, and justice (Canadian Nurses Association, 1994). The study received full ethical approval from the University of New Brunswick Faculty of Nursing Ethics Committee.

RESULTS

From women's descriptions of their journeys in recovering from AN, we constructed a theory of self-development from perilous self-soothing to informed self-care. In Figure 1, we have presented the self-development model as a dynamic helix, not a linear progression, with an overall direction from left to right over time. Through self-development or ongoing self-refinement, women create learning paths that enable them to negotiate developmental and situational issues in their lives. The process contains threads of self-differentiation, self-awareness, and self-regulation winding through stages of perilous self-soothing and informed self-care. Self-awareness is acknowledging feelings, inner sensations, and perceptions; self-differentiation is maintaining sense of self while in relationships with others; and self-regulation is establishing control over uncomfortable affective states. Movement along self-differentiation, self-awareness, and self-regulation frame self-development as either perilous self-soothing or informed self-care. In perilous self-soothing, women struggle with not knowing their identity and place in society. AN helps them attain goals of recognition, acceptance, and stress reduction; however, it interferes with health and well-being. At a turning point called finding me, women begin to switch from perilous self-soothing to informed self-care. Women gain awareness of their strengths and limitations, are able to manage uncomfortable emotions and experiences, and maintain authentic relationships with self and others. For each woman, self-development is an individual journey that over time involves a series of changes influenced by reflectivity, developmental progression, and interactions within health care and larger sociopolitical systems.

Perilous Self-Soothing

Perilous self-soothing, the central problem, is characterized by women's use of unhealthy behaviors, including disordered eating, to attempt to feel better about themselves. Perilous self-soothing has two substages: not knowing myself and losing myself to the AN obsession.

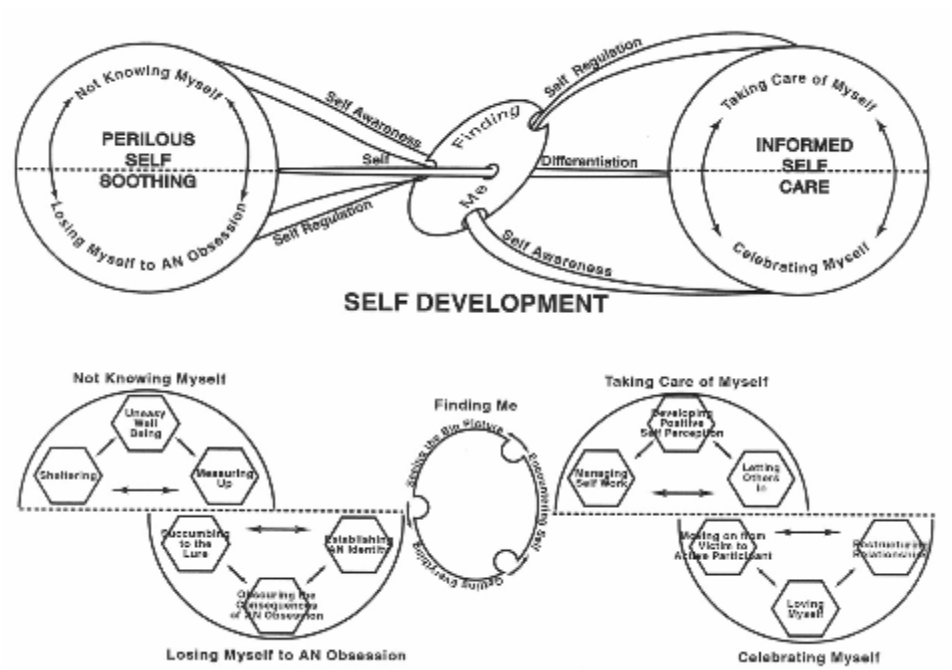

FIGURE 1: Self-Development Model of Anorexia Nervosa (AN) Recovering

Not Knowing Myself

"Not knowing myself" describes women before they develop AN. It is an uncomfortable state of going out of relationship with self to maintain relationships with others. Their intense focus on pleasing others keeps women from determining their own needs. Abby (all names are pseudonyms) summed up not knowing myself as "restricting all your needs: spiritual, personality, nurturing. You live for everybody else." Not knowing myself consists of interacting dimensions of uneasy well-being, sheltering, and measuring up. These dimensions predispose women to respond to life events with patterns of unhealthy behaviors.

Uneasy well-being. Women enter a state of uneasy well-being on perceiving their ives as "out of control" and unhappy, with "no comfort to be found." Their well-being is challenged by weight gain and altered role expectations associated with developmental transitions (i.e., entering adolescence, exiting adolescence, and entering middle adulthood) and negative life situations (e.g., abuse, harassment, and family stress, including fighting, adding or losing members, illness, and parental unemployment). This evokes uncomfortable feelings and creates for each woman a sense of uncertainty about "who I am, what I want, and where I fit in." At this time, a woman is unable to self-regulate. Her need to feel better about herself serves as rationale for initiating self-soothing behaviors. For example, Grace found that "running kept me going" after her husband's open heart surgery and mother's

death. Lori worked out several hours a day so that she did not have to "bother listening to my parents or fighting with them." Women who experience the most extreme uneasy well-being, as evidenced by attempting suicide, have been either overweight children or early pubertal "bloomers," suffered repeated abuse and/or harassment, and felt their emotional needs as young children were not met.

Sheltering. Women are sheltered by others as well as themselves. Sheltering is a strategy of protecting in response to a threat of being controlled or hurt. Families shelter daughters from social deviance and disapproval by denying the existence of real-world dangers and implementing behavior control measures (e.g., bribing weight loss and limiting food selection). Women are sheltered in their environments beyond their families by others, such as coaches who prescribe grueling training regimens to protect against athletic failure. Women learn to shelter themselves to avoid the pain of chastisement, difference, and abuse. They withdraw, conform to expectations, or "put on a mask" to conceal aspects of themselves that are either not valued or indicative to others that something is wrong. Sheltering stifles self-awareness, because in freezing their feelings and inner experiences, women lose valuable opportunities for self-expression, growth, and validation. Felicity pretended that all was well.

> I'd always been really, really, really private about my feelings and would never talk to anybody about anything. Everything was my own problem. If I had a problem I would deal with it myself. Nobody had to know. People would get so frustrated with me—my friends—because I'd always have this—I'd act like I was always in this constant same mood all the time and people would—if they knew something was bothering me—they would not even expect to get it out of me because I didn't talk. . . . Everyone used to call me the ice queen . . . I would never let anything show.

Measuring up. Women use measuring up to estimate personal worth by comparing themselves to external standards. Women measure up by comparing their physical appearance, popularity, or scholastic, athletic, or work efficiency with others. They reason that if others see them as doing a "good job now" or "look[ing] good now," then these others will be further pleased with additional work and appearance efforts. In measuring up, women limit their access of information about themselves to sources outside themselves. They neglect themselves in striving to measure up to unrealistic standards. They do not know how to differentiate their own needs and wants separately from what they perceive others expect of them; therefore, they design their interactions to seek approval from others.

Losing Myself to the AN Obsession

"Losing myself to the AN obsession" is the substage of perilous self-soothing when women develop AN to manage inner turmoil. The AN serves to interrupt developmental and situational crises, provide recognition from others, and distract from stresses of academic study, child rearing, abuse, harassment, neglect, or loss. Losing myself to the AN obsession is perilous: Women are unaware of the threat to health and do not care for themselves appropriately. Losing myself to the AN obsession involves succumbing to the lure, establishing AN identity, and obscuring the consequences.

Succumbing to the lure. Women succumb to the lure by initiating weight loss behaviors. They describe being passively engulfed by the attracting force of AN rather than consciously choosing to develop an eating disorder. They feel "powerless" and "weak" against the overwhelming external forces that have contributed to their uneasy well-being. AN initially provides a "short-term bubble" that makes women feel good because they receive compliments for losing weight, experience feeling "high" from starving and exercising, and perceive themselves as more "in control" of their life situations. Grace explained:

> When you come back from a run and your endorphins are high and everything, you don't feel hungry, you know. You just don't. So I wasn't hungry. I tend to eat more when I'm under stress . . . so because I wasn't having any stress because I felt good in my mind, you know, I wasn't eating as much. The more my hip bones stuck out, the more I liked it.

Succumbing to the lure enables women to convert their roles from passive victims of negative life events into active victimization by self-imposing food deprivation. AN helps women overcome personal ineffectiveness, because it is an indirect way to say with their bodies what they cannot say with words. For example, Cally Ann's emaciation showed her father "See what you did to me." Kelly's hospital admission allowed her to refuse to see her father.

Establishing AN identity. AN becomes central to women's well-being as their primary source of comfort, companionship, pride, and identity. It is considered a "best friend" and "security." Women come to define themselves by the AN, equating self-worth with weight loss. They feel good if able to attain their expectations for starvation and exercise; they define themselves as failures if they overeat or underexercise. Women see the AN as "taking control" of their minds. They identify having irrational thoughts, such as Felicity's fear that she would "balloon up to 400 pounds [from 93 pounds] if I ate one chocolate bar." AN becomes a "habit," a "way of life," "the only thing you know." They experience difficulty separating their identity from AN, for the AN provides them with identities that make them "special." Women develop satisfaction in doing what others cannot, that is, starving themselves. Kelly said she "never really had that search for who I was because who I was was the anorexia. It was something that I could do better than anyone." She saw her sense of self being threatened by the prospect of losing the AN. "If I give this up, then who the hell am I?"

Obscuring the consequences of the AN obsession. Women obscure the consequences to protect their anorectic identities. They use a strategy of baffling to convince others and themselves that they really do not have problems with eating. They baffle others by eating small portions in public, keeping exercise regimens private, hiding their emaciation by wearing loose-fitting or extra clothing, confabulating having eaten elaborate meals while actually starving, and refusing social engagements that conflict with planned exercise times. Women baffle themselves through exaggerating their actual intake. For instance, they "tack on" extra calories, so that an orange at 50 calories will "suddenly become 100 calories" to pretend they are eating more. They also minimize their fatigue and other AN symptoms. Prevailing social views about dieting and individual developmental level perpetuate obscuring. Lori

observed that most women see starving not as a problem but as the common occurrence of "Oh, I'm just dieting." Jill's concern about hair loss but not cardiac arrhythmia reflects her adolescent focus on physical appearance.

> It [my hair] was starting to fall out. Like I would brush my hair and it was coming out on the floor. It was really scary. I had really long hair and I thought that it would show when it was thinning out . . . I walked maybe four or five times a day. And I'd go on my mom's treadmill. And my heart—I could feel it just beating really, really fast. But I didn't pay much attention to it because I thought when you exercise; it's supposed to do that.

While obscuring, women dismiss the health costs of AN. They do not seek care for themselves but enter the health care system only when family, friends, and health providers uncover the eating disorder and enforce treatment. Women who receive treatment under these conditions feel (re)victimized by the health care system, experience treatment as controlling, and focus on surviving this "punishment."

Finding Me

"Finding me" is a turning point at which women begin to distance themselves from the AN to identify that it is no longer helping them attain life goals and aspirations. Erin reflected that with AN, "you're in a very short finite period and you're not thinking beyond who you are and what's important to you outside of that little bubble. And if you don't, there's no way you can get yourself out of it." Finding me involves concurrent shifts in self-awareness from seeing AN as a solution to recognizing it as a problem, in self-regulation from passivity to active participation in recovering, and in self-differentiation from disengagement to (re)connection with self and others. During finding me, women are "struggling to recover." Although they have glimpsed themselves beyond the AN and are working on "finding" themselves rather than "not knowing" or "obscuring," they are unhappy with their physical appearances and might secretly practice weight loss measures to feel better about themselves. They continue to hide their real selves in interactions with others and to measure themselves against internalized perfectionist standards. Finding me occurs over days to years depending on availability and acceptability of recovery resources and opportunity to reflect and learn recovery skills. Inherent in finding me are dimensions of seeing the big picture, encountering self, and getting everything on my shoulders.

Seeing the big picture. Women use perspective taking and "soul searching" to determine "Who am I?," "What do I want in life?," and "Where do I want to go?" Seeing the big picture begins with cognitive and affective dawning that "something's wrong." It is facilitated by reflection and perception of the severity of the AN symptomatology. Opportunities for reflection are either self-mandated (e.g., seeking the solace of a cottage on the ocean to relax from academic stress) or imposed by the consequences of AN (e.g., academic withdrawal, involuntary hospitalization). Women perceive the severity of the eating disorder by weighing the consequences, sensing mortality, and/or reaching bottom. Women weigh the consequences by determining how much the AN interferes with their current lifestyles, the lives of

their significant others, and their future goal attainment. Although Dawn had been hospitalized because of cardiac arrhythmia and electrolyte imbalance, she was able to identify AN as a problem only when she saw the toll it took on her parents (e.g., her mother developed chest pain and stress responses). Women sense mortality by envisioning their own dying and by confronting peers' deaths due to AN. Abby, at the age of 45, pictured that her "electrolyte balance could just go wacky overnight so rather than have that heart attack, I decided that I would go and get help." Reaching bottom involves experiencing severe health and social consequences, such as seizures, job loss, miscarriage, and academic failure. Although Lori had started to improve her nutritional intake when she learned she was pregnant, she lost the baby because her physical health was "so run down." This prompted seeing the big picture:

> What am I doing to myself? What the hell is going on here? Like because something's wrong. Before I didn't see it as a problem—me not eating and losing weight. I thought it [AN] was the greatest thing in the world.

Encountering self. The process of encountering self enables women to get in touch with previously unknown aspects of themselves, develop skill in self-expression and management of uncomfortable emotional and social situations, and acquire knowledge about eating disorders, self, and age-appropriate development. Women who identify the root of their problem as not having had their needs met at earlier times in their lives find learning about early childhood emotional needs and how to reparent self particularly helpful. Although there is discomfort associated with owning negative experiences and emotions that they have previously repressed, women are motivated to "figure out" themselves, to establish identities based on self, not AN or others' expectations. Abby recounted excitement while encountering herself.

> I went to [name of treatment centre in different province] so I could take the mask off and try to be me, whoever that was. . . . I had a lot of help finding me. And I came back with red hair! [Laughs] They, these two friends that were my age group would say, you know, "Abby you've got to get rid of that. That's not you." And whether it was certain jewelry or certain clothes, I don't know what, but they decided it wasn't me. So it was interesting that they almost knew me before I knew me. And they hadn't known me very long. But they saw different parts of me that I can't see. . . . And I had to go to gym class . . . it was the first time I realized that I was actually having fun. . . . I was always an athlete in high school, always as a kid . . . and this leisure person said, "You've played these sports before." And I said, "Oh yeah." . . . You know, when I talk about my sports, that's part of who I was. And still part of who I am.

Getting everything on my shoulders. Because each woman sees AN as something that she has permitted to happen in the first place and allowed to progress until health consequences result, she believes it is "up to me" to take responsibility for "fixing" the problem. In "getting everything on my shoulders," women commit to overcoming the victimization of perilous self-soothing. Some are motivated to escape what Dawn described as "harsh and inhumane punishment" associated with treatment such as being confined to bed rest for weeks for not meeting weight gain expectations. Others commit to recovery to end their guilt for having harmed their bodies through starvation and purging practices. Erin found it helpful to

recognize that her body had to work for her for the rest of her life. "I have to treat it as a temple and so I can't continue to do these horrible things." Women use their anger about being blamed for having AN, being told "what to do" with their bodies, being perceived as "selfish" by others, losing freedom with treatment choices, and difficulty accessing recovery resources to spark behavioral change. In getting everything on my shoulders, women rearrange responsibilities to prioritize recovery needs. They report that recovery is impeded by belittling comments such as "You don't want to get better" and "Plan your funeral" on the part of health professionals.

Informed Self-Care

Women enter the recovery stage of informed self-care by applying self-nurturing rather than the self-abusing strategies of AN to attain goals. They work intensively to manage eating, address underlying vulnerabilities, and develop authentic relationships. Informed self-care consists of substages taking care of myself and celebrating myself. Women who are taking care of myself no longer label themselves as "struggling to recover" but as "recovering." They are generally positive about their overall ability to care for themselves; yet, they continue to respond to episodes of increased stress in their lives by eating less and/or exercising more. They believe they will be "100% recovered" once others in their lives provide rationale and acknowledge responsibility for having inflicted abuse, neglect, or harassment. In this way, "recovering" women maintain some degree of victimization. In celebrating myself, women regard themselves as "recovered." They have addressed the underpinnings of the AN and now deal with life challenges directly through use of assertive communication, effective problem solving, and conflict resolution skills.

Taking Care of Myself

A woman is "taking care of myself" in using recovery-oriented skills rather than AN to meet physical, psychosocial, and developmental needs. This means she transfers the energy from the AN obsession into healthy eating and problem solving. Taking care of myself fosters self-nurturance, compassion, and confidence. It consists of managing self-work, letting others in, and developing positive self-perception. For Abby, taking care of myself was a novel idea.

> I'm learning how to take care of me. And I've never done that. And that comes along with meeting my own needs, identifying what my needs are, and having the courage and strength to go ahead and meet them. To try to do it, I can only do what I can do. And the thing is, if I don't meet it not to be really hard on myself. I'm very, very hard on myself. I've been hard on myself for years. And I am learning not to be so. So self-care, self-nurturing, I'm learning that. Some people call it selfish. I used to. But I don't anymore. I call it self-care.

Managing self-work. Women begin self-care by learning to function without the AN. To achieve physical and psychological stability, they engage in interfacing processes of staying on top in the real world and battling demons. Staying on top in the real world is healthy eating amid the stress of everyday role responsibilities. It requires normalizing eating (structuring daily intake to meet caloric requirements in such a way as to prevent starvation or bingeing) and self-monitoring (watching

over intake and activity levels). Battling demons is addressing the non-eating issues (e.g., esteem, power, and loss) underpinning the AN. To battle demons, women challenge negative self-talk and social definitions of beauty. They self-advocate to address injustices associated with any abuse and with stigmatization for having been treated on psychiatry units and perceived as having a mental disorder. They learn to manage their emotions by mentally distancing themselves from threats of abandonment, grieving losses, including the loss of AN, letting go of blame, and controlling anxiety and depression. Managing self-work is experienced as painful "reliving" of past hurts. It requires intensive, sustained effort. Women develop "replacing" behaviors to gain comfort. The replacing behaviors can include bingeing, purging, excessive shopping, drinking, smoking, overeating, Tylenol misuse, writing, and suicide attempts. The purpose of replacing is to provide instant relief (e.g., "It's a gratification . . . something that gives you the high, you know, you're trying to replace that high") and to create something familiar to which the women know how to respond (e.g., "I'm used to having havoc in my life [so] that when things start going good, I have to create some kind of problem for myself").

The challenge of managing self-work allows women to "get hold" of the AN. Replacing behaviors enable them to maintain their grip on recovering. Yet, the effort required might be abandoned to the resumption of perilous self-soothing behaviors, such as starving and excessive exercising. When "slip[ping] off the wagon" happens, women regain recovery progress through more determined adherence to the self-work of staying on top and battling demons.

Letting others in. Women recognize they need help from others to recover further. Letting others in is a strategy of talking about themselves and their AN experiences to access social support. According to Michelle, "you need support definitely because you're in a hole you can't get out of by yourself." Women access three main sources of social support: family, friends, and copatients or others with eating disorders. Women are selective about who, what, and when they tell others, initially speaking cryptically about their experiences to avoid rejection unless others demonstrated empathic responsiveness. Support from other women with eating disorders who have "been there too" is considered superlative, in that not only do women feel safe and accepted but they also are guided in naming and expressing their feelings. For Cally Ann, peer support provided an effective means to overcome her silence.

> It certainly helped me to eat with these people who had the illness. It helped me to hear them, their struggles. Slowly it was set up that "Ask Cally Ann" or "Pass it to Cally Ann" or "How does she feel about that?" [Laughs] And little by little, you know, your own little things start coming out. It gave you a voice that you never had before.

Letting others in also provides distraction from obsessive thinking about food and eating, validates women as people, not eating disorders, and counteracts the isolation of having AN. Felicity attributed her recovery to "opening up" to family and friends and gaining their support. Felicity's family and friends helped Felicity realize that "you don't have to be 90 pounds. We'll still love you." Women describe both affiliative (e.g., feeling heard, validated, and "of concern" and "of interest" to others) and instrumental (e.g., financial, child care, clothing, and transportation

resources) support as beneficial. They identify it as important to recovering, even if they have not experienced support. Belinda believed that lack of support unnecessarily lengthened her recovery.

> I don't think there was really any support. It was more or less in my own mind. I didn't want to go back to being seventy-four pounds. I really didn't have any support from the medical community or from any support group. My mother,—the kind of support was "You have to eat or you're going to get sick." And that was about the support I got there. Basically, I had to motivate myself . . . I don't think I fully recovered for a long time because I never really had the help.

Developing positive self-perception. Women develop positive self-perception by appreciating and nurturing themselves in nonperilous ways. They identify their strengths and practice being "good" to themselves. They undertake to appreciate their abilities, personal qualities such as generosity, and efforts to care for themselves in the areas of meal preparation and self-esteem. For example, Abby realized, "I cooked this meal, chopped vegetables and fish for me"; she learned to "pat myself on the back for what I do to care for me." Michelle papered the walls of her room with written positive affirmations, such as "I have a beautiful smile."

Positive self-perception is also developed via catching up on social development lost while in the stage of perilous self-soothing. Women catch up on what they missed by engaging in developmentally earlier level activities like experimenting with dating, drinking, and wearing make-up. Forty-year-old Hope played with dolls and coloring books to "fulfill what was missed" as a child. Women learn to give themselves approval to choose what they want (e.g., sports and social activities) rather than what they perceive others want for them. Developing positive self-perception is facilitated by natural progression from adolescent to adult developmental tasks. For instance, part-time jobs helped Jill become "more mature" and Erin to be a more effective role model to children. As a result of developing positive self-perception, women feel more comfortable with themselves and optimistic that they can successfully find their niches in life.

Celebrating Myself

"Celebrating myself" is the final recovery substage of informed self-care during which a woman becomes happy with herself and knowledgeable about how best to meet her needs in situations and relationships. She has made meaning from the AN experience, living within any of its residual limitations. Celebrating myself consists of processes of moving on: from victim to active participant, restructuring relationships, and loving myself. Women who complete celebrating myself are "recovered." They are no longer vulnerable to the "lure" of AN, because they proactively and consistently meet their self-care needs. They are not victims but active participants. Erin summarized celebrating myself as having a better understanding of herself.

> I think I'm definitely not egocentric like I used to be. I know myself, whereas back then I didn't stop long enough to get to know who I was and what I wanted in life and where I saw myself fit in as a puzzle piece in this huge spectrum of life. So I think that I was in a big race back then. Now I'm not. Now it's a small little race in life. It's not a race but it's—you work with what you have. And you work with nature, work

> with the community, work with how you fit in. And that puzzle piece that you are right now, you know, definitely changes over time. I've slowed down a lot . . . I don't think I have to prove myself now. I'm proving myself as I exist. . . . You know, you just have to go with the flow and do your best and hope your cards fall in the place where you're happy and where they haven't, they haven't. You can't judge yourself so harshly. You have to continue on. I've made errors. I make errors as a parent. The big thing is you learn—I've learned—to say "sorry" and recognize those errors.

Moving on: From victim to active participant. A women moving on: from victim to active participant learns to overcome the vulnerabilities that have influenced her to develop AN in the first place. She recognizes that she is the one oppressing herself regardless of familial, situational, and social predisposing circumstances. After demarcating the aspects of her life over which she realistically can have autonomy, she lets go of her belief that she can control and be controlled by others. This allows her to stop blaming others. She works to overcome passivity with power figures (e.g., health professionals) by expressing her needs and viewpoints assertively and rehearsing her action plan to overcome performance anxiety. She says "no" to others when she does not want to do something. She refuses to listen to the voice of her anorectic "inner critic." She enacts appropriate life style changes to manage any long-term health consequences from the AN. For example, Lori watches dietary protein to aid kidney function permanently impaired from the AN. In moving on, women employ strategies of breaking free, redefining, and reframing. They break free by "acting for me." They no longer obsess about calorie counting, aspartame consumption, frequent weighings, competitive workouts, and laxative and diet pill use. They break free from "everything the illness [AN] started with, what brought it on," including their sense of obligation to live up to others' expectations and to restrict their own happiness. Women redefine by viewing themselves from "the inside out" rather than "the outside in" to determine their worth in ways other than being anorectic. They redefine themselves as "strong," "independent," "pig-headed," and "stubborn" for having lived through "something [AN] that kills people" and for "surviving treatment." They reframe the AN as a catalyst "to make me who I am," "a gift" that provides better skills with which to live life, "a blessing in disguise," and a "building block to a healthy being . . . [that has] pushed me to a deeper thinking process and a deeper respect for others."

Restructuring relationships. Women restructure relationships to invest in relationships that meet their needs and detach from those that do not. They restructure work, family of origin, friends, marital, church family, and sexual relationships to accommodate their self-care and support needs. For instance, they might switch to regular daytime hours instead of night shifts to normalize eating. Women restructure relationships because they are "different" persons now (i.e., authentic, self-aware, assertive). Felicity, who had lost touch with her friends when anorectic, rebuilt authentic relationships no longer wearing her mask of superficiality. Women, previously engaged in sexual relationships because they did not know their own needs and were trying to please others, are now able to discontinue these relationships. Women stop investing in abusive relationships. A milestone is reached when women establish satisfying relationships that include sexual interactions. A consequence of restructuring relationships is rejection of cultural prototypes. Women accept being larger sized, because it means they are "healthy,"

"stronger," and "better." They recognize that they do not need to be "good wives" or "good daughters" to be worthwhile in society.

Loving myself. Women's process of loving myself or responding with compassion to self and world entails appreciating their human imperfections. They learn to acknowledge perceived personal shortcomings, become comfortable with body image, and accept failures as opportunities for growth and self-discovery. They now appreciate the common human threads connecting them to others, whereas before loving myself, they would view little foibles such as dropping change and holding others up in checkout lines as "something terribly wrong with me." Women respect themselves and others by adopting "love myself first" philosophies (e.g., "Every person I meet is my teacher so that I may learn from them," "Nobody can make me feel inferior without my permission"). They develop respect for their bodies, as evidenced by practicing healthy behaviors, not to maintain weight recovery or to break free from the AN obsession but because they love themselves and want to look after themselves as well as possible. Women believe they cannot love others unless they love themselves. The effects of loving myself include improved quality of life from having a healthy outlook, diet, and exercise regimen; finding "absolute happiness within myself"; being "honest with" and "true to" self; feeling "free" and in control; and developing pride and optimism in self. For Cally Ann, "life is just beginning because I've been dying for 16 years." In loving myself, women discover beauty in self and everyday phenomena such as sunrises, wildlife, and quiet moments. They no longer feel suicidal, as they see themselves connected to a larger beauty and power. They offer themselves as resources to educate, support, and prevent others from "going through" what they did.

DISCUSSION AND IMPLICATIONS OF THE SELF-DEVELOPMENT MODEL

The self-development model is a valuable contribution to knowledge of AN and recovery because it provides a process and language for comprehending individual experiences within larger social contexts. It captures the complexity of women trying to live their lives in relation to cultural and developmental expectations. The construct of perilous self-soothing offers a nonjudgmental, insightful picture of the dynamics of AN not available in clinical concepts such as denial and noncompliance. Informed self-care is an ongoing process of development and creation. Recovering is depicted as self-awareness, self-differentiation, and self-regulation.

In this study of women's recovering from AN, the comforting and mediating function of AN is highlighted. AN is portrayed as a means for negotiating difficult transitions. It eases the pain and stress related to control via cultural expectations for female appearance and role. For the women in the study, alterations in their shape (e.g., pubertal breast and hip development, weight gain during middle age) and talent (e.g., attending university, competing in sports) attracted the notice of others. According to the objectification theory of Frederickson and Roberts (1997), a woman recognizes that others will appraise her "as a body" (p. 194). The control exerted by others also included weight loss interventions that intensified the woman's unease, her need to shelter and measure herself, and her succumbing to

the lure of AN. There is a need to determine women's knowledge and understanding of the meaning of weight gain and self-worth during transitions to help interpret the changes in a normative way rather than as measurements of defectiveness and difference. In keeping with study findings, prevention programs need to reach women before the onset of pubertal and midlife transitions to be effective. The findings also point to a need for a health policy shift directing prevention programs to target others in addition to the women. Most eating disorder prevention programs are geared to female adolescents in school classrooms (Graber, Archibald, & Brooks-Gunn, 1999). Interventions are not included for older women at risk and others such as parents, educational authorities (e.g., coaches), and husbands, who might react negatively to changes in weight, shape, and talents and might encourage extreme weight loss practices.

The finding that both perilous self-soothing and informed self-care arise from women's interactions within social structure and not as individual intrapsychic processes underscores the inappropriateness of relying on personality characteristics, discrete behavioral responses, and single events to evaluate AN and its recovery, as these factors and their impact are understandable only when context is taken into account. This suggests that improving general social conditions for women might not only aid their recovering but also might prevent them from developing AN in the first place. The larger system needs to monitor for situations such as teasing and harassment, which put women at risk. Anticipatory guidance is critical for vulnerable women who have been isolated or different in their development, such as women who are sheltered, overweight, or early pubertal "bloomers." This might be a particular challenge given the high prevalence of abuse and harassment reported in Canadian and American high schools (Fineran & Bennett, 1999; Ontario Secondary School Teachers' Federation, 1994) and in the eating-disordered population (Jasper, 1994; Sundgot-Borgen, Fasting, Torstveit, & Berglund, 2003). Gender harassment has been found to increase in frequency from Grades 6 to 8 and to be associated with developing sexuality and mixed-gender socialization (McMaster, Connolly, Pepler, & Craig, 2002).

A strength of this feminist grounded theory is its rich description and comprehensive explanation of women's experiences with AN and recovery. Everyday strategies women use to recover are revealed. Women were found to begin to recover once they engaged in finding me, a complex process of learning about self, recognizing the problematic nature of AN, and preparing for behavioral change. Women become self-aware through reflection and getting in touch with inner experiences. They self-differentiate by evaluating their own role in relationships and building a repertoire of assertiveness skills better to address their needs and perspectives. They learn to self-regulate stress and painful affects. The discovery of finding me indicates that it is not appropriate for others to try to change women's behaviors. Rather, women can be helped to recognize their actions as information depicting and affecting their whole experience of health. Interventions could be designed to help women make connections and see patterns beyond their current life situations.

The self-development model provides gestalt for understanding various levels of self-soothing, including perilous, replacing, relapsing, and catching-up behaviors that when seen as isolated events might be misinterpreted. The meaning of these behaviors is dependent on the woman's position in her journey of awareness, differentiation, and regulation. Replacing (substituting activities that offer a high

and recreate disorder), relapsing (abandoning recovery skills), and catching-up (advancing social development) behaviors occur during the recovery stage of informed self-care, when a woman learns to practice taking care of myself skills. Perilous behaviors are eating disorder symptoms during the stage of perilous self-soothing. Perilous self-soothing and relapsing consist of similar behaviors involving extreme weight loss activities plus baffling strategies. They differ in scope and timing. Perilous self-soothing might include behaviors other than eating disorder symptomatology. Relapsing does not occur unless the woman had engaged in managing self-work. Replacing behaviors are actions other than restricting or exercise (e.g., bingeing, smoking, writing, and suicide attempts) that bring relief. The replacing behaviors women in this study used were all harmful to health except writing. Suicide attempts are considered self-soothing, because they represent the woman's best solution to managing emotional turmoil (Everett & Gallop, 2001). The phenomenon of replacing has not been explicated in previous research of recovering from AN. Catching-up behaviors, which function to restore the interruption of emotional and social development, have been described in extant literature (e.g., Crisp, 1997; Garrett, 1998). Previous studies, however, consider catching up only from the onset of the AN. The difference that this study makes is linking catching up to the developmental stage when the woman's uneasy well-being, not the AN, began.

Women's self-development was found to be adversely affected when their environments lacked social or therapeutic support. This suggests that the type and degree of support offered by family, friends, and health professionals be further investigated. The finding that women had difficulty progressing in their recoveries unless those who had contributed to the development of the AN acknowledged culpability calls for exploration of the role family and friends in women's recovery experiences. The finding that women use AN to express with their bodies what they can not say more directly must be kept in mind in program planning. Treatment programs modeled on deprivation (e.g., denial of activity privileges) to exert control over eating might serve to recreate conditions of neglect and denial and might traumatize and silence women by preventing them from using the only way they know to express themselves (Sesan, 1994). Programs that facilitate autonomous self-definition and skill development might be of greater benefit to women than those that define women's bodies for them (e.g., setting weight goals and monitoring meal plans).

The theory of women's self-development illuminates an additional area for research and advancement of more formal theory to explain women's recovery from AN. The finding that the majority of women in the study perceived treatment as traumatic and subsequently defined recovering from AN to some extent on their ability to "survive" treatment is alarming. There is an obvious need to explore further women's subjective experiences with institutionally based treatment to inform future decisions about content, structure, and allocation of formal recovery resources. Health professionals' responses to caring for women with AN needs to be explored further. Women reported receiving the most help when others were open to women's perspectives and concentrated on listening to and looking carefully at what was being revealed in the women's suffering rather than approaching with preconceived notions of needs and responses. Clearly, interventions must not focus on caring for the AN at the expense of ignoring the woman. King and Turner's (2000) phenomenological study and Ramjam's (2004) naturalist inquiry of the experiences of registered nurses caring for adolescent anorexic females found that caring

for anorexic female adolescents challenged nurses' core values of trust, equality, and respect. In both studies, nurses wanted greater involvement in the care of AN patients but felt unprepared and unsupported in implementing treatment protocols that limit caring.

We see a risk in having presented the finding that recovering is possible without treatment. Might this lead to policy makers' withholding programs and perhaps worsening women's situations? We recommend that the findings serve as a base for further research exploring treatment for AN and that they be considered for their ability to stimulate thinking about critical health reform in the area of caring for women with AN. The study invites reflection and dialogue by those who design and implement care for women with eating disorders.

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