The Presence and Search for Meaning Among Women in Remission and Recovery from Anorexia Nervosa

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Dedication

To the love and support of my mother, Debra Lynn Currier. My best friend, advocate, and role model. She is a true testament to recovery, inspiration, resiliency, as well as a kind and loving soul.

To the memory of my Poppa, Bernard Joseph Currier.
A loving role-model, teacher, advocate, as well as a kind, loving soul, and supporter.

For Liesel, Lotus, Rose, Stephanie, and Geraldine. I hope that your stories and experiences of remission and recovery from anorexia nervosa shared in this thesis will be received with reverence, as well as touch the lives of many readers.

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Abstract

In recent years, there has been a growing interest in understanding the role of meaning in people's efforts to deal with serious negative life events. In the realm of eating disorders (EDs), however, research on the presence of, and search for, meaning in life for women with anorexia nervosa (AN) is scarce. The objectives of the study, therefore, are fourfold and seek to explore how women in remission and recovery from AN experience: (1) the presence of meaning; (2) the search for meaning; (3) meaning in life, and; (4) the existential givens and significance of recovery and remission. The study employs the three-interview series of semi-structured interviews with 5 to 6 participants, who are in remission and/or recovery from AN. Interpretative Phenomenological Analysis (IPA) was used as the methodology of choice to describe and interpret the data.

This study presents findings, which are the superordinate themes and subsequent subsets that correspond to "clearly related other themes" abstracted via subsumption that developed from the Interpretative Phenomenological Analysis (Smith et al., 2009, p.97). The presentation of the findings is an integration of description and interpretation, which is proposed by the IPA methodology and divided into two parts. Part 1 introduces the reader to each of the five participants. The focus of this section is to delve into the phenomenological core of their experience as it relates to each of the seven superordinate themes: (1) Diagnosis of Anorexia; (2) Experience of Anorexia; (3) Anorexia Treatment Process; (4) Experience of Remission and Recovery Process; (5) Metaphors for Anorexia, Remission and/or Recovery Process; (6) Spirituality, and; (7) Meaning-Making Process and Sense of Purpose.

While recent evidence has emerged concerning the functional and existential significance of AN (e.g., Fox & Leung, 2009; Marco et al., 2017), these studies are quantitative in nature, and thus they do not explore the experiences or understandings of the women with AN. In many ways, AN is not only a functional syndrome (e.g., coping with life stressors, modulating emotions, and fostering a sense of control), but it is also an existentially meaningful one (Eli, 2015; Schnackenberg, 2016). Therefore, perspectives used to elucidate findings of the current study include existentialism, as well as psycho-spiritually based. Accordingly, the findings will have implications for furthering our current knowledge and understanding of AN, as well as remission and recovery, which in turn can have an impact on the focus of treatment and the strategies used.

Introduction

Anorexia nervosa (AN) is a highly complex eating disorder (Wilson & Fairburn, 2002; Wilson, 2005), characterized by an avid pursuit of thinness, coupled with distorted thoughts about body shape and weight (5th ed.; DSM-5; American Psychiatric Association [APA], 2013). While the prognosis of AN varies, Steinhausen (2002) showed in his review of 119 outcome studies of 5.590 male and female patients that only 46% of patients fully recovered from AN, a third improved with only partial or residual features of the disorder, and 20% remained chronically ill for the long term. Despite the "relatively poor global outcome" (Steinhausen, 2002, p. 1288), this review points to the lack of clarity and uniformity regarding how to best define relapse, recovery, and remission. Moreover, this perspective is reiterated by a literature review of remission in eating disorders (e.g., Ackward, Richter, Egan, & Cronemeyer, 2014), which reveals that the terms 'relapse,' 'remission,' and 'recovery,' as well as the associated rates, vary considerably. According to the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*), recovery from AN is understood as requiring individuals to attain a sufficient body weight in accordance with an appropriate body mass index (BMI) and experience the resumption of menstruation. However, many recovered women – according to the *DSM-5* criteria – continue to experience existential issues such as finding meaning in life and purpose outside of the syndrome (Fox & Leung, 2009; Knapp, 2003).

While some theories have been proposed about the role of meaning in life when coping with serious life stressors (e.g., Frankl, 1963; Janoff-Bulman, 2004; Yalom, 1980), empirical research has only recently explored this area. For instance, meaning in life has been linked to psychological well-being in healthy adolescents (e.g., Brassai, Piko, & Steger, 2011) and adults (e.g., Steger, Kawabata, Shimai, & Otake, 2008). Conversely, a lower presence of meaning (i.e.,

a person's comprehension of their life experiences, coupled with a sense of overarching purpose they are striving toward) has been linked to increased depression and anxiety (Steger, Mann, Michels, & Cooper, 2009). Furthermore, meaning in life has been shown to be a protective factor against trauma and suicidality (MacDermott, 2010).

In the realm of eating disorders (EDs), research on the presence of, and search for, meaning in life is scarce. However, there appears to be a growing interest in how this construct might impact ED psychopathology and possibly ameliorate it. In their quantitative study, Fox and Leung (2009) found that two groups of women with AN (those aged between 18 and 30, and those aged over 30, respectively) appeared to experience lower existential well-being (i.e., defined by beliefs and feelings of meaningfulness, purpose and satisfaction with life progress) compared to their non-eating disordered peers. Moreover, these authors suggest that women with AN have limited skills and coping mechanisms for dealing with existential anxiety (i.e., a term given to the feelings associated with the recognition of meaninglessness, responsibility, and death) and that AN may be one way of imposing meaning on their world.

In another quantitative study comprised of two groups (247 participants diagnosed with EDs according to *DSM-5* criteria and a nonclinical sample comprised of 227 participants), Marco et al. (2017) found that meaning in life (i.e., defined by the web of connections, interpretations, aspirations, and evaluations that make experiences coherent and provide a sense that life matters and is valuable) was highly and positively correlated with greater satisfaction towards body appearance, and thus suggest that meaning in life could be a protective factor for various dimensions of body image, including overweight preoccupation, body dissatisfaction, and ED psychopathology. In the same way, the authors discovered that meaning in life was highly and negatively correlated with borderline symptoms and suicide ideation.

Despite the possible relationship between meaning in life and ED psychopathology, there is no study that the present author is aware of concerning the association between meaning in life and the recovery process for women with AN. Moreover, the existing studies (e.g., Fox & Leung, 2009; Marco et al., 2017) are strictly quantitative in nature, and thus do not consider the view or understanding of recovery from the perspective of the individual with AN. According to Carter et al. (2012), the highest risk of relapse occurs during the first year (i.e., typified by a BMI less than or equal to 17.5 for 3 consecutive months and/or at least one episode of a binge-purge behaviour per week for 3 consecutive months) and often as early as 3 months post-treatment. Therefore, meaning in life could serve as an important protective factor during the early phases of post-treatment. Similarly, it could improve current psychotherapeutic modalities for women with AN by offering interventions focused on finding, and creating meaning, both inside and outside of the syndrome.

The thesis deliberately refers to AN as a 'syndrome,' defined as a collection of signs and symptoms that characterize a condition (Pike, 1998; Russell et al., 2019). The rationale for this terminology stems from the present author's premise that the symptoms of AN are both complex and multifaceted in nature, and thus not solely psychological. As the subsequent sections reveal, AN has a lengthy history that touches on various dimensions of the affected individual, including, but not limited to, psychological, emotional, familial, spiritual, and existential.

It is also critical to note that there is no single definition of the concept of recovery for people with mental health problems (Anthony, 1993; Jacob, 2015); however, psychiatry has proposed concepts like relapse, recurrence, remission and recovery based on symptoms profiles over time (Jacob, 2015). A common definition, according to Slade and Longden (2015), is that "recovery comprises full symptom remission […]" (p 3). They also make an important

distinction between 'clinical recovery' (i.e., an outcome or a state that is observable and objective, rated by the expert clinician) and 'personal recovery' (i.e., a process or a continuum that is subjectively defined by the person themselves, rated by the person experiencing the mental health problems). In contrast to personal recovery, the definition of clinical recovery does not vary across individuals, meaning it can be defined, measured, and investigated in empirical studies (Slade & Longden, 2015). Personal recovery, on the other hand, focuses on the centrality of hope, identity, meaning, and personal responsibility (Slade & Longden, 2015).

The clinical conceptualization of recovery seemingly parallels the criteria found in the *DSM-5*, whereby recovery from AN is largely determined by body weight, accompanied by several other clinical symptoms such as symptom severity, eating attitude(s), and menstrual cycle for "a sustained period" (APA, 2013, p. 329). Although these measures are important for research purposes, they give little, if any, attention to the person's view of recovery from AN or the potential meaning they might derive from it. As Schnackenberg (2016) explains:

> There is a danger […] of missing the story, the person, the emotional suffering behind the diagnosis. When we talk about someone with anorexia […] we are talking about a person who meets the DSM criteria, which includes losing a dramatic amount of weight and exercising excessively. However, anyone who has ever been given this label will be quick to point out that such criteria are extremely limiting and reductionist (p. 44).

Schnackenberg (2016) points to the inhibiting, and perhaps insensitive, nature that diagnostic labels can have on women with AN. Zerbe (2001) also echoes this idea, stating that "behind every symptom of disordered eating lies a story that is longing to be told" (p. 305). For this reason, the study will refer to clinical recovery from AN (i.e., no significant disturbance in eating

or weight control behaviours or body image disturbance, etc.), while also giving attention to indicators of personal recovery.

Since recovery is usually defined in relation to remission and relapse, it is also important to consider how remission and relapse are defined. Relapse commonly occurs during recovery from AN (D'Abundo & Chally, 2004). According to the *DSM-5*, relapse is defined as returning to a level of disordered eating after a period of full or partial remission from those behaviours (e.g., failure to maintain body weight range, cessation of menstrual periods, resumption of purging or restrictive behaviour, and/or resumption of maladaptive attitudes regarding diet and food). In medical terms, 'remission' refers to a temporary or permanent decrease or subsidence of manifestations of a disease or syndrome (D'Abundo & Chally, 2004). The *DSM-5* identifies two phases of remission for AN: (1) 'partial remission,' obtained after full criteria for AN was formerly met, but not all of the criteria has been met for a sustained period of time, and; (2) 'full remission', obtained after full criteria for AN was formerly met, yet none of the criteria have been met for a sustained period of time (APA. 2013).

Finally, it is necessary to acknowledge that the study focused on women with AN and not men. Historically, male presentations of AN have been perceived as uncommon and rare (Murray et al., 2017), but research suggests the prevalence and incidence of EDs is increasing in males (Sweeting et al., 2015). For example, the male-to-female ratio for AN is estimated at approximately 1:10 to 1:15 (Herpertz-Dahlmann, 2009). Unfortunately, males are grossly underrepresented in ED research, which is largely due to the unreported cases and accompanying stigma that males frequently experience with ED syndromes (Murray et al., 2017). The intention of excluding males from the study was neither to disregard nor collude with the notion that AN

does not affect them. Rather, the present author was cognizant about keeping the study and recruitment of participants within the practical time limitations of a doctoral research program.

The thesis explored women's experience of remission and recovery process with the hope of understanding both the holistic and existential essence of their treatment process. The research objectives are to explore how women in remission and recovery from AN experience:

1. The presence of meaning
2. The search for meaning
3. Meaning in life
4. The existential givens and significance of recovery and remission.

The following research questions were explored:

1. How do women in recovery and remission from AN experience the presence of meaning?
2. How do women in recovery and remission from AN experience the search for meaning?
3. How do women in recovery and remission from AN experience meaning in life?
4. What are the existential givens and significance of recovery and remission for women with AN?

With the aim of helping the reader, the objectives and research questions were also repeated on pages 76, and 280-281.

The thesis is organized into different chapters. The first chapter explores the historical overview, how did this topic emerge? Specifically, the first chapter will discuss the historical origin of AN, including the syndrome in its modern context, which shifted away from religious/spiritual connotations toward medical and psychological interpretations. The second chapter encompasses theories on meaning in life and meaning-making processes. The third chapter covers existential themes in AN. The fourth chapter presents the methodology and the

procedures for conducting an interpretative phenomenological research design, accompanied by aspects highlighting validation process, personal disclosure and reflexivity, research permission and ethical considerations of the present study. The fifth chapter presents the analysis of findings within (vertically) and across (horizontally) participants, comprised by a partial discussion. The sixth chapter discusses the findings in greater depth to elicit rich accounts of their experiences. The seventh and final chapter includes: (1) model and therapeutic implications, and (2) study limitations and implications for future research.

1. Anorexia Nervosa

1.1 Historical Overview of Anorexia Nervosa

EDs are defined by eating practices that involve either insufficient or excessive food intake, all which impact on daily functioning, and are characterized by maladaptive attitudes and behaviours around eating, weight, and body image (APA, 2013). EDs are neither a benign nor a novel group of psychiatric illnesses. AN is a serious psychological disorder characterized by a relentless pursuit of thinness (Walsh, 2005), accompanied by distorted thoughts about body shape and weight, described as far back as the 13th century (Pearce, 2004). Early accounts of religious asceticism and fasting behaviour, such as that seen in St. Catherine of Siena, are considered examples of AN (Bell, 1985). Moreover, two cases of adolescents with core features of AN were first described as an illness entity in the 17th century by the English physician, Richard Morton (Brumberg, 1988; Pearce, 2004). In 1689, Morton published the influential volume "*Phthisiologia, seu Exercitationes de Phthisi*," translated into English five years later, and subtitled, "A Treatise of Consumptions," in which he outlined the first medical account of AN, which he referred to as "a Nervous Consumption," caused by "sadness, and anxious cares" (Morton, 1689, as cited in Silverman, 1985, p. 2830). However, the syndrome was only formally

identified and labelled almost simultaneously by Charles Lasègue in 1873 and William Gull, who named the condition 'anorexia nervosa' in 1874 (Madden, 2004).

Awareness of EDs was largely limited to the medical profession until the latter part of the 20th century, when German-American psychoanalyst, Hilde Bruch, published her influential book *Eating Disorders* in 1973, which described both anorexia nervosa and bulimia nervosa (BN) to the lay reader (Brumberg, 1988). Awareness of EDs continued to dramatically increase during the 1980s with the death of singer Karen Carpenter, who died of cardiac complications due to AN (Tenore, 2001). Furthermore, this was the first time the media focused on the fact that EDs can have serious, life-threatening consequences (Tenore, 2001). Although the contemporary emphasis on the Western ideal of beauty has been frequently cited for increases in the prevalence of EDs across the last several decades (e.g., Bordo, 1993; Bruch 1978; Wolf, 1992), a closer examination of history reveals that disordered eating has been present in other eras.

1.1.1 Asceticism

In medieval Europe, particularly between the 13th and 16th centuries, prolonged fasting was considered "a female miracle" (Brumberg, 1988, p. 41), which belonged to ascetic practices intended to circumvent evil influences and to achieve spiritual perfection (Griffin & Berry, 2003). Asceticism, according to Huline-Dickens (2000), sought to respond to a way of life that included voluntary abstinence from sensual and physical pleasures. From the religious viewpoint, asceticism (from the Greek *askesis*, exercise) has been referred to as "spiritual exercises (self-denial, renunciation of immediate or sensual gratifications) in the pursuit of virtue, its object being the attainment of perfection" (Fassino et al., 2006, p. 601). Self-starvation is one such form of self-renunciation in attaining spiritual perfection, which emerged from

dualistic ideals of the early church and grew into a prominent form of asceticism, particularly for women (Bemporad, 1997).

The initial cases of self-starvation in Western countries have been recorded as developing from the widespread movement of Gnostic philosophy and Christianity (Bemporad, 1997), both of which promoted a dichotomy between the soul and the body that corresponds to other religious dichotomies such as: God and Satan, good and evil, light and dark, righteous and sinful (Dell'Osso et al., 2016). Griffin and Berry (2003) explain that "This dualism functioned as a device for the medieval church to maintain social control over human behaviour and concurrently led Western philosophical [and] theological traditions to renounce the body in order to become closer to the soul" (p. 44). They continue to clarify that, "The concept of original sin and the unworthiness of humanity (and especially women) in the eyes of God, increased the appeal of self-renunciation" (Griffin & Berry, 2003, p. 44). There are many hagiographies detailing female saints who engaged in ascetic practices (e.g., Bell, 1985; Bynum, 1984; Sukkar, Gagan, & Kealy-Bateman, 2017; Weinstein & Bell, 1986), including fasting and restrictive eating of "earthly fare" (Brumberg, 1988, p. 41). The most renowned of these saints, Catherine of Siena (1347-1380), ate only a handful of herbs each day (Brumberg, 1988) and reported stomach pains that did not permit her to eat anything but the Eucharist (Sukkar et al., 2017). Other female saints reportedly covered their faces in the presence of food and refused to partake in family meals (Brumberg, 1988).

Although fasting and restrictive eating was a commonly documented characteristic of medieval spirituality (Brumberg, 1988), it did not involve both genders in the same manner or to the same degree (Weinstein & Bell, 1986). There are few cases of male saints who claimed or were claimed by others to be incapable of eating (Brumberg, 1988; Bynum, 1984; Weinstein &

Bell, 1986). In their examination of 864 saints who lived between 1000 and 1700, wherein 151 of 864 (17.5%) of the saints in the sample were women, Weinstein and Bell (1986) maintain that "women were more rigidly confined to a particular kind of holiness than were men" (p. 220). Additionally, the authors explain that men and women did different things in their holy lives, and different values were placed on what they did both by the faithful and by the church (Weinstein & Bell, 1986). For instance, renunciation of the body was a means for women to achieve spiritual perfection through complete self-discipline that resulted in independence from physical needs (Griffin & Berry, 2003).

In the context of the medieval and Renaissance-era hagiographies, Bell (1985) and Bynum (1987) have both contended that religion informed the food refusal of women in history. More specifically, Bell (1985) provided evidence in his widespread study of the writings of medieval women, suggesting that 'holy anorexia' was a rebellion against patriarchy, whereas Bynum (1987) described how women rejected both body and family through food practices to control both themselves and their circumstances. In his study of 170 holy women, Bell (1985) concluded that almost 50% could be diagnosed as suffering from AN. By his own admission, however, he acknowledges that the documentation needed to support a comprehensive psychological and physiological study of these holy women is inconsistent because the surviving information is primarily folkloric rather than documentary (Bell, 1985). Other authors have accentuated the parallels among the saints' asceticism and some psychological traits of anorexic's (diagnosed according to *DSM-IV* criteria; American Psychiatric Association [APA], 1994), particularly self-discipline, self-denial, rituals, frustration of physical needs, closeness to death, control over instincts, and aspiration to immortality (Lawrence, 2008).

Despite these similarities, researchers posit that the asceticism of modern anorexics is different from that of the saints in core features that deem it as pathological (e.g., Maître, 2001); that is, "the modern anorectic strives for perfection in terms of society's ideal of physical, rather than spiritual beauty" (Brumberg, 1988, p. 41). Additionally, Behar and Arancibia (2015) contend that asceticism in saints was oriented to attaining "the divine encounter," whereas the pursuit for thinness in modern anorexics is seemingly associated with sociocultural aesthetic ideals (p. 231). Nonetheless, this conceptualization of AN could be perceived as limited; namely, it is not simply a matter of vanity, pursuing thinness to meet an aesthetic ideal imposed by Western cultural standards. On the contrary, as Macleod (1982) explains, it can be understood as a "strategy aimed at establishing autonomy and resolving what would otherwise be unbearable conflicts in the life of the sufferer" (p. 11). These conflicts are also considered existential in nature (Schnackenberg, 2016), especially as they relate to "being-in-the-world" (Macleod, 1982, p. 11). If AN is, in part, a quest for finding a sense of meaning and identity, then it is important to provide other strategies or frameworks for women to replace this and facilitate change (Fox & Leung, 2009). Accordingly, the study seeks to investigate the role of meaning among women in remission and recovery from AN, investigating its role and possible alternatives.

1.1.2. Anorexia as a 'Modern Disease'

It is important to examine the emergence of AN in its modern context, as it reveals how understandings of self-starvation and food refusal shifted away from religious/spiritual connotations toward medical and psychological interpretations. The trend toward medical explanations of AN gradually increased, particularly in the 18th century (Brumberg, 1988; Madden, 2004). Although a description of AN was first provided by Morton in 1689, it was Lasègue and Gull in the 1870s who independently described the clinical entity of AN as we

recognize it today (Goldbloom, 1997). Gull's article '*Anorexia Nervosa'* published in 1874 not only highlighted many of the clinical features of AN, but it also coined the term "anorexia nervosa" to distinguish the disorder from the term "hysteria," which resulted in the syndrome being considered a psychological disorder (Madden, 2004). Towards the end of the 19th century, AN had become formalized as a psychiatric condition (Hepworth, 1999). After its formal recognition, there were few reports of AN until the 1930s, which, in part, is explained by the associations made with the discovery of an endocrine disease (Dell'Osso et al., 2016; Hepworth, 1999). This disease was first described by Simmonds in 1914, characterized by pituitary cachexia (physical wasting) that involved patients significantly abstaining from food (Hepworth, 1999). By the 1930s, however, the distinction between Simmonds' disease and AN was reconsidered (MacSween, 2013).

Following World War II, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) was created by the American Psychiatric Association (APA) in 1952, in part, to deal with "the chaotic state" of classification in the United States, and to provide mental health professionals with a common language for clinicians to diagnose, communicate, study, and treat individuals with mental disorders (Blashfield, Keeley, Flanagan, & Miles, 2014, p. 28). Since the preliminary publication of the *DSM,* there have been five subsequent editions of this manual published (Blashfield et al., 2014).

AN was placed in the first edition of the *DSM-I* (1952), acknowledged as a psychophysiological reaction and neurotic illness (Dell'Osso et al., 2016). While the *DSM-I* included negligible clinical observations of AN, the second edition of the *DSM-II* (1968) situated AN under special symptoms feeding disturbances (Dell'Osso et al., 2016). Interestingly, this category was reserved for "the occasional patient whose psychopathology is manifested by a

single specific symptom," in which AN was used as an example (APA, 1968, p. 47-48). At the time, AN was seemingly considered a consequence of other motives and not weight phobia, which, in part, can be explained by the preference for somatic explanations in medicine at the time (Habermas, 2015).

In the third edition of the *DSM-III* (1980), as well as its revised version *DSM-III-R* (1987), EDs were classified under disorders of childhood or adolescence, which included AN, BN, pica, rumination disorder of infancy, and atypical eating disorder. The *DSM-III* (1980) was also the first to define patients who did not meet the full criteria for AN or BN, but who did have clinically significant ED pathology as "atypical" (APA, 1980; Peterson, Berg, Durkin, & Jappe, 2015). Additionally, binge eating was acknowledged in the *DSM-III* (1980) and recognized as bulimia. It was only until the revised version of the *DSM-III* (*DSM-III-R*) that the term 'bulimia nervosa' (BN) was formally adopted (APA, 1987).

In 1994, the fourth edition (*DSM-IV*) was released with many more psychological disorders, including the category of 'Eating Disorder Not Otherwise Specified' (EDNOS) that merged all other clinically significant EDs symptoms into this residual category (APA, 1994). As a result, binge eating in the absence of purging fell under EDNOS until the latest *DSM-V* published binge-eating disorder (BED) as a separate disorder in 2013 (Dell'Osso et al., 2016). In addition to AN, BN, BED, pica and Avoidant/restrictive food intake disorder (ARFID), the *DSM-5* (2013) chapter for EDs provides a section named "Other Specified Feeding or Eating Disorder" (OSFED), which includes some other unusual pathological eating patterns (e.g., atypical AN, in which all other criteria for AN are met, but weight is in the normal range, as well as BN or BED with lower episode frequency). This section also includes purging disorder (e.g., characterized by recurrent purging behaviour to influence weight or shape, without binge eating)

and night eating syndrome (e.g., characterized by recurrent episodes of night eating or extreme food consumption after the evening meal) (Dell'Osso et al., 2016).

AN was only presented and accepted as a modern, medical condition a century and a half ago, although many of the symptoms were recorded much earlier (Leff, 2017). Throughout each publication and revision of the *DSM*, the psychiatric community has accentuated specific symptoms of EDs, systematically organizing them into their own diagnostic divisions (Leff, 2017). Present descriptions of AN are still largely influenced by those proposed by *DSM-5* (APA, 2013), as well as the *ICD-10* (World Health Organization, 1993). Common features that are central to these descriptions include the refusal to maintain or gain weight above a minimal developmentally normal level, intense fear of weight gain and a severe disturbance of body image, as well as underlying hormonal abnormalities (e.g., amenorrhoea). The following section examines some of the clinical features of AN in greater depth, drawing on the *DSM-5*, as well as other clinical accounts.

1.2 Clinical Features of Anorexia Nervosa

AN is characterized by a relentless pursuit of thinness and an "intense fear" of the consequences of eating (APA, 2013, p. 338). This intense fear of eating and subsequently gaining weight results in a deliberate restriction of food intake that can lead the affected person to become significantly underweight or dangerously emaciated (Steiger & Bruce, 2009). The fear of gaining weight is so intense that actual (or perceived) weight gain, in an already thin or emaciated person, can provoke profound anxiety, irritability, and/or feelings of loss of control (Fairburn & Harrison, 2003). People with AN often eat a restricted range of foods, may avoid social situations involving food, may consume their food in a prescribed order, or in painstakingly calculated, hypocaloric amounts (Steiger & Bruce, 2009).

1.2.1 Subtypes. In some cases, anxiety manifests so strongly after eating that an individual may purge through vomiting or misuse of laxatives to appease fears of overeating (APA, 2013). Given the presence of binge-eating/purging behaviours that may accompany AN, the *DSM-5* created a distinction between two anorexic subtypes: (1) Restricting type – there is severe restriction of food intake but no binge eating or purging; (2) Binge-eating/purging type – binge and purge episodes are recurrent (i.e., self-induced vomiting or the misuse of diuretics, laxatives, or enemas). Crossover between the subtypes over the course of AN is not unusual; therefore, subtype descriptions are used to specify current symptoms rather than longitudinal course (APA, 2013).

1.2.2 Course and development. AN typically manifests in females during mid to late adolescence (age 14-18 years), a period of "dramatic psychological and physical development" (Walsh, 2013, p. 480). The onset of AN is generally associated with dieting behaviours that may evoke little, if any, concern, especially given the presence of reinforcing compliments (Walsh, 2013). With time, however, the commitment to dieting increases, coupled with several secondary features such as physical adverse effects, social withdrawal, rigidity and perfectionism (Walsh, 2013). Recovery from AN is typically determined by body weight, symptom severity, eating attitude(s), and menstrual cycle for "a sustained period" (APA, 2013, p. 339). As such, recovery outcomes from AN vary – some affected by this disorder recover fully, while others continue to experience patterns of great fluctuation between weight gain and significant weight loss cycles. Further, some individuals experience a progressive decline of health from AN, lasting several years (APA, 2006). Mortality rates in AN are among the highest in psychiatric disorders and thus early detection and appropriate treatment are crucial (APA, 2006).

1.2.3 Epidemiology. The actual prevalence of EDs is an issue of dispute because of methodological weaknesses in many of the conducted epidemiological studies, including periodical modifications in the diagnostic criteria for EDs and the study of limited samples (Ghaderi & Scott, 2001; Hsu, 1996). Based on their review of epidemiologic studies from the United States and Western Europe, Hoek and van Hoeken (2003) report that the incidence of AN ranges in studies from 4.2 to 8.3 per 100,000 person-years. Incidence rates for AN are highest for females aged 15 to 19 years, and within the 15 to 24-year-old female age group, the incidence of AN has increased from 1935 through 1999 (Hoek & van Hoeken, 2003). While late-onset of AN rarely occurs in females over 40 years of age, recent findings suggest an increase in the prevalence of inpatient admissions among middle-aged women (Ackard et al., 2013; Cumella & Kally, 2008; Jenkins & Paul, 2018). The average point of prevalence rate of AN in young females is 0.29% (Hoek & van Hoeken, 2003), whereas estimates of lifetime prevalence of AN range from 1.2% to 2.2% (Bulik et al., 2006; Keski-Rahkonen et al., 2006).

1.3 Etiology of Anorexia Nervosa

The literature on the etiology of AN attempts to elucidate why some women struggle to fulfill the basic human need of eating or place such prominence on weight and physical appearance that renders them more significant than anything else in life (Stein & Latzer, 2012). The existing literature demonstrates “an uneasy balance” between studies exploring the role of alleged factors and theories that attempt to integrate such factors into a comprehensive whole (Polivy & Herman, 2002, p. 190). To remediate this situation, research and literature often cite an integrated, multidimensional etiology perspective. These theories generally postulate that AN implicates a constellation of social pressures (e.g., encouraging slenderness), biological and neurobiological factors (e.g., genetic influences, structural changes in brain physiology),

psychological tendencies (e.g., issues with temperament and certain personality traits), and developmental processes (insecure attachment processes or dysfunctional family patterns) (APA, 2013; Polivy & Herman, 2002).

It is important to recognize, however, that these theories frequently neglect the existential and spiritual dimensions that are suggested to contribute to the development and perpetuation of AN (e.g., Fox & Leung, 2009; Patching & Lawler, 2009; Redenbach & Lawler, 2003; Richards & Bergin, 2005). Given that the definition of recovery from AN is habitually associated with the diagnostic criteria provided by the *DSM-5*, it is no surprise then, that recovery criteria do not include spiritual and/or existential dimensions. For this reason, the following section includes an overview of the spiritual and existential dimensions considered to contribute to the development and maintenance of these syndromes. Furthermore, the study seeks to address this gap in the research by considering how these areas can serve as protective factors for women with AN.

1.3.1 Sociocultural Factors

Western social values to some degree associate slimness with cultural ideals of success, beauty, and power. According to some theorists, AN is regarded not as an individual psychological or behavioural disorder but as a cultural disorder, an expected corollary of consumer capitalism and sexism (Bordo, 1993; Wolf, 1992). For instance, Hall & Cohn (2011) maintain that extreme dieting regimes have become normalized in American society. The pervasive media in Western societies bombards women with digitally enhanced images of models with protruding collar bones and emaciated frames, seemingly sending one distinct message: life would be better if you were thinner. Several theorists and researchers have little doubt that internalization of such values directly contributes to the development of body-image preoccupations (e.g., Bordo, 1993; Wolf, 1992).

Paradoxically, the present emphasis on thinness in Western culture is also accompanied by a focus on the imperative of health (Schnackenberg. 2016). This is evidenced in the recent emergence of the condition referred to as "orthorexia nervosa" (ON), in which people restrict their diet based not on the quantity of food they consume, but based on its quality (Dunn & Bratman, 2016). Although ON is not in the *DSM-5*, this obsession with healthful eating has been referred to as "healthy anorexia" (Musolino, Warin, Wade & Gilchrist, 2015). In their mixed methods approach that included ethnographic fieldwork, Musolino et al. (2015) studied 25 women, who had not been given an ED diagnosis, or had been diagnosed but had delayed seeking treatment or did not wish to pursue it. The study revealed how participants used a '*habitus'* of healthism (i.e., a concept derived from French sociologist, Pierre Bourdieu, characterized by the physical embodiment of cultural capital that extends to the deeply ingrained habits, skills, and dispositions that individuals possess due to life experiences), and 'care' to rationalize and justify their disordered eating practices (Musolino et al., 2015). More specifically, they demonstrated how "eating and bodily practices entailing 'natural', medical and ethical concerns (in particular, the new food regime known as orthorexia) are successfully incorporated into participants' eating disorder repertoires and embodied as a logic of care" (Musolino et al., 2015, p. 18). Indeed, the message disseminated in Western society, therefore, would appear to be that women must be thin *and* healthy, in order to be desirable.

Although the cultivation of a specific body type ideal and the promotion of thinness through media and the diet industry have been repeatedly shown to account for the prevalence of AN in western culture (e.g., Garner, Garfinkel, Schwartz, & Thompson, 1980), research suggests that AN occurs in a wide range of ethnic, cultural, and socio-economic groups (e.g., Lee, 1991). An extensively published study of Fiji Islanders seemingly challenges and exemplifies that AN is

not as culturally bound as was once thought. According to Becker (1995), prior to the introduction of television in 1995, the island had no reported cases of AN or weight concerns: however, within three years of American and British programming, more than two-thirds of Fijian girls had attempted dieting, and three-quarters of them felt too heavy. Given the emergence of AN in non-western societies, the notion of cultural specificity of EDs has been challenged (e.g., Becker, 1995; Markey, 2004; Nasser, 2009). More recently, research by Yan et al. (2019) demonstrated how online forums and social media websites encourage ED behaviours, and how they have become a growing concern in recent years, which are thought to promote "pro-anorexic" and "pro-bulimic" lifestyles. Moreover, they contended how online communities such as these may advocate "thinspiration" (e.g., pictures or quotes that serve as motivation for an individual trying to achieve or maintain a very low weight), as well as suggestions and techniques for promoting thinness and maintaining disordered eating behaviours (Norris et al., 2006; Yan et al., 2019).

The following part of this subsection, integrates and reviews both the sociocultural and socioeconomic factors that impacts the development of AN. The concept of medicalization in sociology originated within a particular societal—political— historical context characterized by the dominance of professionalized (bio)medicine. The concept describes the processes and effects of medicine's link to social regulation and control (Correia, 2017). According to sociologist Peter Conrad et al., (2010), an underlying theme in research and literature is the concern about "overmedicalization."

More specifically, they contend that "Medicalization is a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad et al., 2010, p. 1943). They proceed to identify how examples include

menopause, attention deficit hyperactivity disorder, post traumatic stress disorder, anorexia, infertility, obesity, sleep disorders, erectile dysfunction among others (Conrad et al., 2010). The major focus has been on verifying and documenting the increase in medicalization, debating conditions which constitute medicalization, and identifying the implications for patients, medicine, and society. As a result, they maintain that there has been growing concern with the probability that medicalization is driving increased health care cost (Conrad et al., 2010). While the study did not evaluate whether medicalization is good or bad for health and society, it conveys the need for understanding the societal and economic impact of growing medicalization (i.e., the economic, social, and political dimensions of health and health care). Although medicalization describes a social process (i.e., defense or criticism od medical power), empirical studies have demonstrated that medicalization has largely been achieved not only through the work of medical professionals or scientists, but also increasingly through the efforts of patients or citizens seeking to legitimize their distress through defining it as a "medical" problem (Correia, 2017, p. 1).

1.3.2 Psychological Factors

There is wide-ranging research on psychological risk factors postulated to contribute to the onset and maintenance of AN, including temperamental, cognitive, behavioural, and emotional factors (Bakalar et al., 2015; Steiger & Bruce, 2009). In terms of temperament, there have been several personality variables receiving attention as potentially significant in the development of AN. The construct of perfectionism has long been a focus in both theoretical models and empirical investigations (Bakalar et al., 2015). For example, perfectionism is highlighted in both the transdiagnostic model of EDs (i.e., according to this model, the fundamental cause of all EDs is the same set of dysfunctional self-worth beliefs, referred to by

Fairburn as “core psychopathology”; Fairburn, Cooper, & Shafran, 2013, p. 516) and the cognitive-interpersonal maintenance model of AN (i.e., according to this model, cognitive, socio-emotional and interpersonal factors act together to both cause and maintain EDs; Schmidt & Treasure, 2006). There are also various studies demonstrating a link between AN and anxious personality traits (e.g., Amianto et al., 2011; Lilenfeld et al., 2006). In a recent sister-pair study comprised of 157 females (AN = 94; BN = 63), Taborelli et al. (2013) discovered that individuals with AN manifested temperamental anxiety, including increased harm avoidance, less self-directedness, less reward dependence, more persistence, and lower levels of novelty seeking, compared to their non-eating disordered sisters.

In addition to temperament factors and personality traits, self-esteem and body-image disturbances have received considerable attention as potential psychological risk factors (Polivy & Herman, 2002; Steiger & Bruce, 2009). Disturbances in body-image or excessive self-evaluation on perceived body-shape constitute a defining characteristic of AN, which are speculated to play a central role in its onset and maintenance (APA, 2013; Steiger & Bruce, 2009). Moreover, severe disturbance of body image and intense fear of weight gain lead anorexic individuals to engage in a variety of behaviours with the intention of losing weight (Polivy & Hernan, 2002). For instance, they are often intensively busy preparing their meals, in an effort to control and to avoid high-calorie foods. Similarly, they weigh themselves multiple times a day and follow strict, gruelling diets (Steiger & Bruce, 2009).

In terms of emotional risk factors for AN, research suggests that difficulties with emotional regulation (i.e., the capacity to understand one’s emotions, as well as modulate emotional experience and expression) may constitute a significant psychological risk factor in the onset and maintenance of AN. Schmidt and Treasure (2006) discuss the role of anorexic

symptoms in facilitating avoidance of intense negative emotions in their maintenance model of AN. Specifically, they propose that the exclusive mental focus on food and eating is associated with emotions becoming "less salient" and anorexic individuals describing themselves as emotionally "numb" (p. 347). Likewise, Espeset et al. (2012) revealed that different emotions were managed by means of specific ED behaviours in their qualitative study of 14 women with AN. For example, sadness was linked to body dissatisfaction and was managed through restrictive eating and purging, whereas anger was avoided by means of restrictive eating and purging and/or released through anorectic self-control, self-harm and exercising (Espeset et al., 2012).

1.3.3 Developmental Factors

Research suggests that AN risk factors differ across development (e.g., parent-perceived child overweight predict early ED onset such as AN, BN, binge eating disorder; BED), while puberty appears to be a period of significantly higher risk for ED onset in adolescents), and thus individuals who develop the syndrome at different ages seem to have different risk factors (Bakalar et al., 2015). Developmental periods of particular importance in the onset of AN are puberty and the transition from adolescence to young adulthood (Bakalar et al., 2015; Bulik, 2002; Steiger & Bruce, 2009). Puberty is a complex and challenging stage of development, in which adolescents experience many physical and psychosocial changes that must be negotiated (Bulik, 2002). Several theories highlight the role of body dissatisfaction in initiating increased dieting, which in turn, reportedly leads to AN (e.g., Bulik, 2002; Fornari & Dancyger, 2003). Adolescent females who mature earlier are also believed to be at particular risk of developing AN given that they experience physical changes earlier than their peers, and may, therefore, experience even more body dissatisfaction (Bakalar et al., 2015).

According to Bruch's (1988) psychodynamic formulation of AN, the syndrome has an adaptive value and role in dealing with the demands of puberty and adolescence. That is, Bruch maintains that the young anorexic is overwhelmed by feelings of ineffectiveness and emptiness, which is coupled, and amplified by an inability to access her own thoughts, feelings, and beliefs. Therefore, she retreats to a rigid preoccupation with food and eating, providing her with the illusion of control and competence. This retreat, according to Bruch, serves to protect the young adolescent from anxieties and fears that she feels she cannot control. Indeed, the developmental consequences are complex and manifold, as Bulik (2002) explains:

> Many young women who recover from eating disorders in their twenties or thirties find themselves either addressing for the first time or readdressing basic adolescent developmental tasks such as establishing independence from family, developing trust in friendships, and dating and romantic relationships (p. 44).

Emerging research demonstrates, however, that AN is no longer restricted to the young adolescents. Rather, qualitative reports suggest that midlife women, similar to their younger counterparts, use AN to cope with developmental challenges, identity issues, and psychological stress (Maine, 2010; Maine & Kelly, 2005).

Although women of all ages are often prone to anxiety regarding body image (Tiggeman & Lynch, 2001), research suggests that women aged 45-60 years become more conscious of this concern (Saucier, 2004). Moreover, there is increasing evidence suggesting that this group of women experience substantial life stress and depression (Midlarsky & Nitzburg, 2008) and that they experience different psychological and developmental issues than women entering adolescence and early adulthood (Midlarsky & Nitzburg, 2008; Zerbe, 2003). For instance, Zerbe (2003) maintains that loss is an important variable in the development and maintenance of EDs

such as AN, BN, and BED among middle-aged women; specifically, coping with issues such as empty nest syndrome, the death of a loved one, loss of youthfulness and a changing appearance have all been implicated as precipitants of AN.

Family systems have also been implicated not only in the maintenance of AN, but also in its development (e.g., Minuchin, Rosman, & Baker, 1978). Likewise, key developmental changes in the attachment system are believed to be connected to the early onset of AN (e.g., Gander, Sevecke, & Buchheim, 2015; Ward, Ramsay, Turnbell, Benedettini, & Treasure, 2000). These aspects will be discussed in greater depth in subsequent sections, which provides an overview of the family systems theory of AN (see section 1.4.2).

1.3.4 Biological and Neurobiological Factors

Research has highlighted a range of potential genetic, physiological, and neurobiological factors that appear to play a role in the onset of AN (Bakalar et al., 2015). According to these approaches, structural brain abnormalities (e.g., reduction in gray matter, greater cerebrospinal fluid volume, altered white matter integrity) and disruptions in brain circuitry (e.g., dopamine and serotonin) may be contributing factors in AN (Bruce & Steiger, 2009; Kaye, 1999; Kaye, Fudge, & Paulus, 2009).

Research shows, for example, that individuals with AN have disturbances of dopamine (DA) and serotonin (5-HT) systems (Kaye et al., 2009). In their review article, Kaye et al. (2013) explain that “5-HT might play a role in altered satiety, impulse control, and mood, while DA may be implicated in aberrant rewarding effects of food, motivation, or executive functions (inhibitory control, salience attribution, and decision-making)” (p. 112). Similarly, brain imaging studies suggest that individuals with AN may have an imbalance between circuits in the brain that regulates reward and emotion and circuits that relate to consequences and planning ahead

(Kaplan, 2010). Indeed, brain imaging studies consistently show that when compared with healthy subjects, individuals with or those who have recovered from AN have an imbalance between enhanced 5-hydroxytryptamine (serotonin) receptor 1A (5- HT1A) and diminished 5-HT2A receptor binding potential (Kaye et al. 2013). For instance, a PET study of a mixed group of subjects with recovered AN showed a significant positive correlation between 5-HTT and DA D2/D3 binding for the dorsal caudate, antero–ventral striatum, medial caudate, ventral putamen, and dorsal putamen (Bailer et al., 2012). Malnutrition in AN is associated with changes in brain structure (e.g., reduction in gray matter, altered white matter integrity) and profound metabolic, electrolyte, and endocrine disturbances (Kaye et al., 2013). It is important to note, however, that studies of AN must consider the impact of malnutrition on brain function. Specifically, Kaye et al. (2013) remind readers that, "malnutrition in AN is associated with changes in brain structure and profound metabolic, electrolyte, and endocrine disturbances" (p. 117).

In addition to neurobiological factors, there is increasing evidence for an inherited predisposition of EDs (specifically, AN, BN, and BED), suggesting that these syndromes are biologically inherited and tend to run in families (Striegel-Moore & Cachelin, 2001). Family studies, for instance, have provided strong evidence for the familial nature of EDs. Strober et al. (2000) found that first-degree relatives of individuals with AN are 11 times more likely to have AN during their lifetime than relatives of unaffected controls. Although family studies are typically the initial step in verifying genetic etiology, family studies are unable to explain whether a disorder aggregates within families due to genetic or environmental factors (Baker, Janson, Trace, & Bulik, 2015).

1.3.5 Biopsychosocial Factors

The most widely accepted approach in attempting to understand and conceptualize the etiology of AN is the biopsychosocial (BPS) model (Phillip et al., 2003). The biopsychosocial model is largely based on Engel's model of BPS (Engel, 1977), which is often employed in psychiatry and is multi-dimensional in nature as it endeavours to examine the individual from a holistic perspective, involving "the complex interaction among biological, psychological, and social factors in the formation and maintenance of psychiatric disorders" (Erwin-Grabner, 2006, p. 4).

The biopsychosocial model of AN etiology postulates that biological vulnerability, psychological predisposition, and sociocultural influences precipitate the dieting and weight loss in vulnerable and susceptible persons (Steiger & Bruce, 2009). This view suggests that weight loss, in turn, leads to malnutrition that inevitably contributes to the physical, emotional and psychological changes in women with AN. Many researchers support this model and the notion of a complex interaction among many factors that increase a woman's risk for developing AN (Leung, Gellar, & Katzman, 1996; Polivy & Herman, 2002; Striegel-Moore & Cachelin, 2001). Even this 'wholistic' view of AN seemingly overlooks the spiritual and existential dimensions of the syndrome. Although these areas were briefly mentioned at the beginning of the study, the subsequent section provides greater detail about the role of spiritual and existential dimensions in the development and perpetuation of AN.

1.3.6 Spiritual and Existential Factors

The role of spirituality in human development and functioning is becoming more widely recognized in the field of mental health (Pargament, 2007; Pargament & Exline, 2022; Plante & Sharma, 2001). Despite the widespread literature delineating the benefits of spirituality and

religiosity in various domains of mental health (Plante & Sharma, 2001), EDs have received little attention in this regard (Akrawi, Bartrop, Potter, & Touyz, 2015). Although agreement on definitions for 'religion' and 'spirituality' do not exist (Richards & Bergin, 2005), it is important to clarify and define these terms.

In their systematic review on the relationship between aspects of religiosity, spirituality and disordered eating, psychopathology and body image concerns, Akrawi et al. (2015) defined religiosity as "a system of organized beliefs, practices, rituals and symbols designed to facilitate closeness to the transcendent," whereas they defined spirituality as "the personal quest for understanding answers to ultimate questions about life, meaning, and a relationship with the transcendent" (p. 2). Spirituality, according to Pargament (2007), is understood as "a search for the sacred" (p. 32). Pargament et al. (2013) explain that spirituality also includes not only "concepts of God and higher powers, but also […] other aspects of life that are perceived to be manifestations of the divine or imbued with divine-like qualities" (Pargament et al., 2013, p. 15), whereas religion is "the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality" (Pargament et al., 2013, p. 16-17). For the purpose of the study, spirituality refers to the quest of seeking meaning and understanding in life (Akrawi et al., 2015), as well as strength and connection with the transcendence (Pargament, 2007; Pargament & Exline, 2022).

The theistic understanding of ED etiology, defined primarily by Richards and Bergin (2005), suggests that human development and personality are influenced by an array of systems and processes (e.g., biological, cognitive, social, psychological), but places spirituality as the core of identity and personality. The foundation of this approach is grounded in the worldview of the major theistic world religions (Christianity, Judaism, and Islam) and stresses the belief in a

personal and transcendent God, who is intimately and actively engaged in the lives of human beings and in the history of the world (Richards & Bergin, 2005). Furthermore, the theistic approach suggests that several of the core struggles of AN are spiritual in nature (Richards, Hardman, & Berrett, 2007).

In their clinical work, for example, Richards et al. (2007) discovered several recurrent spiritual issues or dysfunctional beliefs that manifest in women with AN and/or BN: (1) EDs provide control over life and emotions, (2) EDs effectively communicate pain and suffering, (3) EDs insinuate perfection, (4) EDs facilitate approval and acceptance from others, and (5) EDs can provide a sense of identity, meaning, and purpose in life. These erroneous beliefs are often at the expense of women's relationship with God, with themselves, and with other people in their lives (Richards et al., 2007). As Richards et al. (2009) explain:

> Women suffering from eating disorders often feel distant and far removed from God's influence and love. They often feel unworthy, unlovable, and incapable. They lose their ability to feel connected to family and friends. As their relationship with God and with family and friends deteriorate, they rely ever more exclusively on their eating disorder as their way of coping with pain and problem (p. 174).

Consequently, these unhealthy beliefs become "the objects of their faith and attention," and so they rely ever more exclusively on their ED as their way of coping with pain and problems (Richards et al., 2007, p. 47). These dysfunctional beliefs and feelings of spiritual unworthiness affect the spiritual lives of women with AN and/or BN in a variety of ways, particularly as they signify themes of perfectionism, worthlessness, remoteness, and lifelessness (Richard et al., 2007). In a spiritual and religious sense, these pursuits become "false idols" that demoralize women's spiritual identity and thwart genuine expressions and experiences of connection with

God and others in their lives (Richards et al., 2007, p. 47). This idea is further evidenced by Patching and Lawler (2009), who discovered in their qualitative study of 20 women (6 with AN; 2 with BN; 12 with AN and BN) that, although many women initially used ED behaviours as an attempt to fit in and connect with others (e.g., family and peers), their behaviours intensified their feelings of disconnection from themselves and others. Interestingly, the women in this study shared that experiencing this level of disconnection eventually prompted them to pursue their longing for an enhanced lifestyle, which involved re-engaging in life and reconnecting with themselves and others (Patching & Lawler, 2009).

It is important to note that recurrent spiritual issues or dysfunctional beliefs identified by Richards et al. (2007) are based solely on their clinical observations in working with ED patients affected by AN and/or BN. Moreover, they examine the ED population in a general manner, and thus they do not specifically focus on women with AN. While there are some similarities in ED psychopathology among women with AN and BN (please refer to the transdiagnostic model discussed in 1.4.1), there are also marked differences (e.g., symptom manifestation and expression, as well as eating attitudes). These limitations, therefore, represent another major gap in the existing research on the spiritual needs of women with AN, which the study seeks to address.

In addition to spiritual (and religious) dimensions of AN, there is emerging evidence that suggests existential dimensions may play a role in the development and maintenance of the syndrome (e.g., Fox & Leung, 2009; Marco et al., 2017; Redenbach & Lawler, 2003). Therefore, Fox and Leung's (2009) study examines the relationship between existential well-being (i.e., beliefs and feelings of meaningfulness, purpose, and satisfaction with life progress) and ED symptoms in women with AN. The authors identified that individuals with symptoms of AN

appear to experience lower existential well-being than their non-eating disordered peers, although it is unclear how this may be related to psychopathology (Fox & Leung, 2009). However, the authors surmise that it I s possible the reason AN is so resistant to treatment is that the symptoms function as maladaptive attempts to distract attention away from existential concerns. In which case, the authors stated they would expect anorexic symptoms to increase in line with existential concerns, in an effort to reduce anxiety: "This result may offer some explanation as to why anorexia nervosa is so resistant to treatment efforts" (Fox & Leung, 2009, p. 25). Likewise, the authors Marco et al. (2017) results propose that interventions with patients with severe ED should not focus only on symptom reduction (binge eating, laxative abuse, purging, normal weight), but also that a more global intervention should be considered, including quality of life.

Before delving into these dimensions, however, it is necessary to differentiate existentialism from spirituality to provide greater clarity concerning these two terms in the study. While existentialism and spirituality are both concerned with the role of meaning making as a fundamental part of human experience (Thompson, 2007), existentialism also raises important questions about death and dying and the finite nature of human existence, as well as freedom, responsibly and the necessity to choose (Yalom, 1980). Additional themes common to descriptions of existentialism include meaning or purpose (or lack thereof), thoughts about the dying process, struggles around the state of being, personal choice and commitment, autonomy, and temporality (Thompson, 2007). To avoid confusion with the various terms (e.g., the interchangeable use of the terms 'existential dimensions' or 'factors'), the present author will refer to existential givens for accentuating the various existential themes formerly mentioned (Tomès, 2005).

As previously stated, Fox and Leung's (2009) quantitative study examined the "existential salience" or significance of anorexic behaviours, including how they may serve as a maladaptive coping mechanism for mitigating existential anxiety (p. 29). The authors stated that "it would be surprising" if AN developed solely out of a specific need for meaning; nonetheless, they argue how their findings suggest "it is possible that it is a factor in their development" (p. 29). Although research on existential givens associated with the development and perpetuation of AN is scarce, there is emerging conceptual literature that applies existential theory as a framework, accompanied by second wave positive psychology (PP2.0), for understanding and addressing EDs in the therapeutic milieu (e.g., Sigg & Armstrong, 2017; 2018). Moreover, this conceptual literature highlights how AN may be a mechanism for coping with profound "existential chasms" or voids (Sigg & Armstrong, 2017, p. 145) such as loneliness (Levine, 2012; Stewart, 2004), despair and anguish (Manley & Leichner, 2003).

Previous theorists, such as MacLeod (1981), suggest that the self-denial of food is itself related to an existential crisis of identity. More specifically, she maintains that women with AN struggle to accept the world as it is, and thus they must learn to find new meaning for living in it accordingly. More expressly still, MacLeod (1981) expresses finding "a paralyzing sense of ineffectiveness" to be a central area of disordered functioning: "The anorexic experiences herself as a passive vessel" (p. 8).MacLeod also emphasizes how AN is above all an attempt to assert one's identity. Furthermore, MacLeod (1981) means by identity what Erikson means by ego identity and she quotes him (p. 54-55):

> Ego identity is more than the mere fact of existence, it is as it were, the ego quality of this existence Ego identity then, in it subjective aspect is awareness of the fact that there is self sameness and continuity to the ego's synthesizing methods, the style of one's

> individuality, and that this style coincides with the sameness and continuity of one's meaning for significant others in the immediate community (p. 54-55)

Additionally, MacLeod (1981) contends that, "If anorexia is about identity in general, it is also specifically and most importantly about autonomy" (p. 55). Others, such as Pettersen and colleagues (2012), propose that as symptoms of AN diminish, the more challenges emerge at the psychological and existential level such as coming to terms with grief about previous losses and taking responsibility for creating the future.

It is critical to acknowledge that, although the studies highlighted in the preceding paragraph touch on existential givens in relation to AN, they do not explicitly identify or classify them as such. It should be noted, therefore, that highlighting various studies that examine apparently existential themes in relation to AN – loneliness and isolation, as well as anguish and despair – risks adhering to a reductionist approach, in which certain parallels are stressed and discrepancies overlooked. For this reason, it is apparent that additional research is required concerning the existential givens of AN, especially in providing data to accompany existing conceptual work on the topic.

1.4 Overview of Theoretical Frameworks of Anorexia Nervosa

The previous section presented several approaches concerning the etiology of AN, including sociocultural views, psychological and developmental accounts, as well as biological and neurobiological models. Similarly, it provided an overview of some spiritual factors and existential givens posited to contribute to the development and maintenance of AN. In addition to these etiological factors, there are a variety of theoretical frameworks that seek to conceptualize and treat AN. Given that it is beyond the scope of the study to discuss all existing theories in detail, descriptions of several major theoretical perspectives that are frequently used

to conceptualize AN are presented in the subsequent section, including cognitive-behavioural, family systems and attachment theories, as well as psychodynamic and interpersonal. Finally, an existential-phenomenological framework is also presented and explored.

1.4.1 Cognitive Behavioural

Cognitive-behavioural therapy (CBT) focuses on identifying maladaptive thought patterns and linking these to feelings and resultant behaviours (Arch & Craske, 2009). The origins of cognitive-behavioural descriptions of AN can be found in the clinical accounts of Hilde Bruch (Fairburn, Cooper, & Shafran, 1999). Though a psychoanalyst in orientation, Bruch (1973) highlighted the significance of the anorectic's thinking style, accentuating the "paralyzing sense of ineffectiveness, which pervades all thinking and activities of anorexic patients" (p. 254). Bruch's ideas were consequently refined by Garner and Bemis (1982), in which they applied the principles of Beck et al. (1979) cognitive theory and therapy of depression to AN (Fairburn et al., 1999).

In their seminal article, Garner and Bemis (1982) identified the characteristic cognitions and accompanying distortions of AN, centered on weight, shape, food and eating concerns, as well as on control (Cooper, 2012). Garner and Bemis (1982) also identified the key cognitive disturbance as the belief that "thinness is a value of inestimable worth" (Cooper, 2012, p. 205). Once this belief is accepted, according to Garner and Bemis (1982), the typical beliefs and behaviours seen in AN subsequently follow (Cooper, 2012). For this reason, Garner and Bemis (1982) promoted treatment focused on modifying the cognitive distortions and challenging the assumptions related to concerns with food, eating, weight and shape. Similarly, they outlined various techniques for developing motivation in anorexic patients for psychotherapy, coupled with strategies for monitoring weight gain and food intake.

Various authors have modified the cognitive-behavioural therapy of AN, while retaining its fundamental premise that the extreme concerns about shape and weight are the core feature that maintains the syndrome (e.g., Fairburn et al., 1999; Wolff & Serpell, 1999). More recently, Fairburn et al. (2003) developed a transdiagnostic model for EDs, which is intended not only for AN and BN, but also a wide spectrum of clinical issues associated with eating (e.g., atypical EDs or EDNOS).

According to the transdiagnostic model, the underlying cause of all EDs stem from the same set of dysfunctional self-worth beliefs, described by Fairburn as "core psychopathology" that involves the overestimation of body weight, appearance, and their control (Fairburn et al., 2003, p. 516). The theory also suggests that, although people usually derive their self-worth based on their achievements in various spheres of life (Dudek, Ostaszewski, & Malicki, 2014), those with AN seemingly derive their self-esteem from their weight and figure, as well as their ability to control them (Fairburn et al., 1999; 2003). Subsequently, they engage in behaviours that reinforce core psychopathology outlined in the model (Dudek et al., 2014; Fairburn et al., 1999; 2003). Some of the mechanisms that maintain core psychopathology include weight and body checking (i.e., frequently weighing oneself, using measuring tape, comparing oneself with others) and/or weight and body avoidance (i.e., avoiding mirrors and weighing oneself), as well as preoccupation with thoughts about food, weight, and appearance (Dudek et al., 2014; Murphy, Straebler, Cooper, & Fairburn, 2010).

In terms of a treatment approach, the transdiagnostic model provides a comprehensive manual based on the theory previously described, which is referred to as CBT-enhanced (Cooper, 2012; Fairburn, 2008). It is described as enhanced cognitive behavioural therapy (CBT-E) because it utilizes a wide range of strategies and procedures, as well as modules to address

certain barriers to change that are considered external to the core ED such as clinical perfectionism, low self-esteem, and interpersonal difficulties (Murphy et al., 2010). Moreover, CBT-E is designed to treat ED psychopathology rather than a specific ED diagnosis (e.g., AN, BN, BED), which is delivered on an individual basis to adult patients with any ED of clinical severity who are deemed suitable to treat on an outpatient basis (Murphy et al., 2010). Treatment typically involves in-session weighing, reviewing homework assignments and case formulation, self-monitoring of ED actions, urges, and emotions, as well as recording behavioural and weight trends, and collaboration between the therapist and patient to determine barriers and overall treatment progress (Murphy et al., 2010; Fairburn, 2008).

Though CBT and CBT-E have been shown to account for success (i.e., typically defined by weight restoration, the cessation of symptoms, particularly binging and purging) in women with BN (Murphy et al., 2010), AN has not been met with the same successful outcome (Cooper, 2012). For example, in a meta-analysis conducted by Bulik et al. (2007) that searched six databases for literature published between 1980 and 2005 on the efficacy of treatment for AN, they determined that the effectiveness of CBT in treating patients diagnosed with AN is still unknown. Additionally, they identified several weaknesses in the literature on AN treatment to date, including small sample sizes and high attrition rates, as well as a lack of consistent definitions for terms such as relapse, recovery, and remission (Bulik et al., 2007). An alternative explanation is that CBT and/or CBT-E for AN has some considerable shortcomings, particularly as it remains focused on inciting motivation in patients, addressing dietary rules and increasing BMI. If this is correct, then it suggests that a limiting factor is our current knowledge and understanding of AN, which in turn has an impact on the focus of treatment and the strategies used.

1.4.2 Family Systems and Attachment

Over the past few decades, clinicians and family therapists have highlighted the significance of family dynamics and interactions in the development and maintenance of EDs (e.g., Dare & Eisler, 1995; Minuchin, Rosman, & Baker, 1978; Schwartz, Barrett, & Saba, 1985). According to family systems theories, eating disturbances such as AN and BN are best understood within the framework of the family (Dare & Eisler, 1995; Schwartz, Barrett, & Saba, 1985). Based on family-based treatment (FBT) approaches, families are evaluated as a unit, in which members are interconnected, and family organization can impact the behaviour of all family members (Laghi et al., 2017).

Family systems concepts concerning AN have been most clearly delineated in the psychosomatic family model of Minuchin, Rosman, and Baker (1978), who ascertained that certain family patterns contribute to both the development and maintenance of AN. Specifically, they identified a cluster of characteristics understood as typical in families of anorexics: (1) excessive enmeshment, characterized by a lack of clear boundaries in family interactions; (2) rigidity, or the tendency to keep the status quo; (3) overprotectiveness, characterized by highly intrusive interactions and the high degree of concern for each other's well-being, and lastly; (4) conflict avoidance. Family systems with these features, according to Minuchin et al. (1978), are designated as 'psychosomatic,' because the symptoms of a family member are conceptualized as an expression of the discomfort of the entire family; specifically, the child or adolescent's symptoms of AN, in this context, serve as a "regulator in the family system," particularly in relation to parental conflict (Minuchin et al., 1978, p. 32).

According to the psychosomatic family model, the task of the family therapist is to examine feedback processes by which the young anorexic and her family influence each other

(Laghi et al., 2017). The therapist takes an active stance, enabling the parents to take charge of their daughter's eating, and thus, inviting them to adjust the structure of the family (Laghi et al., 2017). This is exemplified in Minuchin et al. (1978) family therapy lunch session technique, in which eating lunch with the family is intended to provide the therapist with an opportunity to observe family members' transactions around eating, and to make therapeutic interventions to change the patterning of those transactions. Furthermore, the collaborative efforts of the parents are meant to reinforce the boundary between marital and sibling-subsystems, while also preventing conflict avoidance and becoming less enmeshed with their child (Minuchin et al., 1978; Rosman, Minuchin, & Liebman, 1975).

Family systems theories have historically ascribed the development of AN to dysfunctional family patterns (e.g., rigid, enmeshed, conflict avoidant), but empirical evidence rarely supports or promotes a family etiology model (Ciao et al., 2015; Dare & Eisler, 1995; Dring, 2018). Rather, current research tends to focus more on the influence of AN on the family system instead of the influence of family on the etiology of the syndrome (Dare & Eisler, 1995; Levine, 1996). By the late 1980s, for example, Dare et al. (1995) challenged the premise of Minuchin et al. (1978) approach that family dysfunction was culpable for the development of AN. Instead, they took the view that family relationship problems might arise because of the AN, and thus become a maintaining factor (Dare et al., 1995). Subsequently, families began to be viewed as a significant resource and included in intervention programs (e.g. le Grange, 2005; Lock, le Grange, Agras & Dare, 2001) This is perhaps best exemplified and demonstrated in the Maudsley family therapy (MFT) approach and treatment of AN, developed by Dare et al. (1985) at the Maudsley Hospital in London and manualized by Lock et al. (2001) for adolescents with AN and their families.

MFT uses the family as a key resource for facilitating recovery by "mobilizing the parents to take control of the young person's anorexic behaviours" (Rhodes, 2003, p. 191). MFT incorporates theoretical concepts from several established FBT approaches including strategic, structural, Milan systemic, and narrative (Lock et al., 2001). A central principle of MFT is that the anorexic has "regressed and is not functioning at her or his appropriate developmental level, with normal adolescent behavior arrested by the presence of anorexia" (Hurst, Read & Wallis, 2012, p. 341). Therefore, she is not viewed as being in control of AN and the accompanying behaviours; conversely, the illness controls her (Hurst et al., 2012). To address this, the narrative therapy technique of externalization is used to separate the client from the AN (Hurst et al., 2012; White & Epston, 1990). Through this separation, the family can begin to observe the AN without blaming and/or judging the anorexic for her behaviours (Hurst et al., 2012).

It is striking that FBT/MBT inadvertently silence the voice of the anorexic, who may defer to AN, in part, to create some semblance of control in her life. It is arguably more appropriate then, to refer to what Dring (2018) considers "family work" as opposed to "family therapy": specifically, "the goal should not be to change the family relationships, but only to overcome the anorexic behaviour, and its effects on the family, and only then normal development will re-assert itself" (p. 2). Conti et al. (2017) also reaffirm the importance of prioritizing the voice and preference of the anorexic and her family, particularly when a manualized FBT approach does not work. In their in-depth qualitative case study, for instance, Conti et al. (2017) explored the lived experience of MBT/FBT for one female adolescent, Hayley, (14-years old) and her family over a 3-year period (ages 11-14). They discovered that, although MBT/FBT is the most commonly used treatment for adolescent AN, it was not 'the roadmap' for Hayley and her family. Specifically, they argued that the rigid application of

FBT/MBT formula, including the high prioritization of eating and weight restoration, seemingly obscure other therapeutic objectives (e.g., engagement in therapeutic conversations, maintaining a non-blaming therapeutic stance, assisting adolescents toward recovering their voice and a sense of identity from AN) (Conti et al., 2017). However, they acknowledge that their critique of FBT/MBT does not refute the necessity of weight restoration in AN; instead, "[w]hat is being questioned is the assertion that therapy be confined to weight gain through a highly manualized method […]" (Conti et al., 2017, p. 423).

Research concerning the efficacy of FBT and MBT in adolescents with AN has varied results. In their controlled trial comparing FBT with individual supportive therapy in 80 patients with EDs (57 with AN; 23 with BN), Russell, Szmukler, Dare, and Eisler (1987) discovered that FBT was particularly effective (i.e., based primarily on weight restoration and menstrual functioning) for adolescents less than 18-years of age with a short duration of illness. However, the study also found that individual supportive psychotherapy was more successful than FBT in patients 19-years or older. In another 5-year follow-up of MFT for AN (n=18), Eisler, Simic, Russell, and Dare (2007) found that of those families who completed the treatment, 72.2% of adolescents were described as having "good outcome," 5.6% had "intermediate" and 22.2% "poor outcome" with results measured by weight restoration and improvements in AN symptomatology (Eisler et al., 2007, p. 555). Given the varied results of FBT/MBT, treatment for AN has recently integrated attachment-based therapy as an adjunct to FBT (Wagner et al., 2016). The following section briefly examines attachment theory, based on the work of Bowlby (1969; 1973; 1980), as well as its role in the development, maintenance of treatment of AN.

Attachment refers to "a system which is linked primarily to the search for safety and protection and for which the focus is placed on the child's confidence in a caregiver's

availability and responsiveness" (Ringer, 2000, p. 63). More broadly, attachment "reflects one's degree of confidence that significant others, usually family members, will provide support and protection and will remain within emotional proximity" (Little & Schwartz, 2002, p. 456). Secure attachment relationships offer emotional support, comfort and availability, particularly during stressful situations and times of marked change (Gander et al., 2015; Ringer, 2000; Wagner et al., 2016).

A major concept of attachment theory is the notion that children's patterns of attachment are carried into adult life (Bowlby, 1969; 1973; 1980). As children grow older, according to attachment theory, they begin to internalize daily interactions and experiences with their parents. In other words, they develop what Bowlby (1969) labelled 'internal working models of attachment' which originate from variations in how caregivers respond to their child's attachment behaviour. In securely attached children, Bowlby maintained that attachment events have led them to anticipate their caregivers' availability, understanding and responsiveness. Consequently, they will experience themselves as competent and valuable. Conversely, when caregivers show a rejecting or inconsistent response to the signals of their children, they tend to experience themselves as incompetent and unlovable (Gander et al., 2015; George & West, 2012).

Attachment in the field of EDs has received considerable attention from researchers and clinicians alike (e.g., Bruch, 1973; Tasca et al., 2006; Ward, Ramsay, Turnbull, Benedettini, & Treasure, 2000; Zachrisson & Skarderud, 2010). In their meta-analysis of 29 articles, Zachrisson and Skårderud (2010) revealed that there is greater prevalence of insecure attachment (i.e., dismissing or preoccupied types) among patients with EDs (e.g., avoidant attachment tended to be more represented in patients with restricting AN, while patients with BN displayed a

higher incidence of attachment preoccupation). However, in another quantitative study of 127 patients (50 had AN, 52 had BN, 30 had anorexia with bulimic features, 12 were obese, and 9 had EDNOS), Ward et al. (2000) determined that attachment patterns did not differentiate the various subgroups of EDs, suggesting that similar attachment difficulties may underlie both AN and BN. Additionally, they discovered a basic "pull-push" dilemma was enacted in the reciprocal attachment relationships of ED participants: "patients were most characterized by the apparently contradictory attachment styles of compulsive care-seeking (anxious) and compulsive self-reliance (avoidance)" (Ward et al., 2000, p. 374).

With greater focus on relationships, rather than behaviours, attachment-based family therapy (ABFT) seeks to assist adolescents in using their parents as a resource and source of support, to assist them in improving their ability to emotionally regulate themselves (Wagner et al., 2016). ABFT aims to improve the family's capacity for problem solving, affect regulation, and organization (Diamond et al., 2010). Similarly, it seeks to repair ruptures in the attachment relationship between parents and adolescents to establish (or restore) the secure base to strengthen family cohesion, and therefore, reduce family stress or buffer against stressors outside the home (e.g., bullying, academic pressures) (Diamond et al., 2010; Wagner et al., 2016). While FBT focuses on food and eating and using 'externalization' to unite the family in their efforts to overcome AN (Lock et al., 2001; Rhodes, 2003), ABFT focuses on the quality of parent-child attachment relationships (Wagner et al., 2016). Likewise, ABFT addresses and repairs long-standing interpersonal ruptures in the attachment relationship with attachment ruptures serving as the central topic of conversation (e.g., abuse, neglect, abandonment, divorce, parental criticism and control) (Wagner et al., 2016). ABFT is often introduced when the progress of FBT has

stalled, which typically occurs when nutritional stability has been achieved and other interpersonal problems begin to surface within the family (Wagner et al., 2016).

Wagner et al. (2016) explain that ABFT is comprised of several 'treatment tasks' that guide the therapeutic process, wherein the first task is focused on establishing improvements in family relationships. This naturally leads into the second task that consists of the adolescent alone, which seeks to help him or her in identifying and articulating their perceived experiences of the attachment ruptures, while also preparing him or her to discuss these with their parents. The third task involves the parent(s) alone, which encourages them to consider how present stressors and/or their own intergenerational attachment legacies influence their parenting style. The intent of this task is to motivate parents in wanting to be different with their children, increasing their receptiveness to emotion-coaching skills. The fourth task involves both the adolescent and parent(s) discussing, validating, and attempting to address and resolve these past attachment ruptures. As the parent(s) acknowledge the adolescents' thoughts and feelings, their adolescents become more self-reflective and emotionally regulated. Finally, the fifth task involves focusing on using the parent(s) as a secure base to support the adolescent's exploration of competency and autonomy (Wagner et al., 2016).

ABFT has shown to be effective for adolescents with depressive disorders (Diamond, Diamond, & Levy, 2014) suicidal ideation and behaviours (Diamond et al., 2010). While research is still in its infancy for ABFT and EDs, Wagner et al. (2016) conducted an in-depth qualitative case study of Charlie (a 17-year-old adolescent female with AN) to demonstrate that, although FBT helped Charlie's parents understand AN and develop the skills to help their daughter achieve nutritional restoration, the attachment ruptures prevented Charlie from accepting her parents' help. Therefore, ABFT served to enable Charlie to use her parents as a

secure base to obtain support and comfort while managing her ED and building autonomy (Wagner et al., 2016).

In contrast to ABFT, as well as CBT and MBT/FBT approaches to treating AN, psychodynamic psychotherapy does not have a linear or manualized approach to treatment. Instead, it has key principles that guide the treatment process and view the individual as a unique person (Zerbe, 2012), whose symptoms arise from a variety of factors that include, but is not limited to attachment disruptions in infancy, childhood maltreatment, deprivation, trauma, family dynamics and conflicts, difficulties in modulating affect, unconscious conflicts, and impediments to moving successfully through the essential and characteristic phases of development (Banker, 2012; Brody, 2002; Farrell, 2000; Zerbe, 2010). The subsequent section provides a broad overview of the underpinnings of psychodynamic theory and its relation to AN. The intention is neither to dilute nor deprecate its richness or relevance to the field of EDs. On the contrary, psychodynamic theory and practice offer a thoughtful, albeit complex, examination and understanding of AN (Caparrotta & Ghaffari, 2006; Zerbe, 2001, 2008, 2012).

To further summarize some findings regarding attachment in AN, it is worth noticing that insecure attachment (dismissing or preoccupied types) is frequent among individuals with EDs: in particular, avoidant attachment tends to be more represented in individuals with restricting AN, while individuals with BN show a higher prevalence of attachment preoccupation (Gander et al., 2015). The high incidence of the unresolved attachment pattern in ED samples is significant, especially for individuals with AN (Gander et al., 2015). Unresolved attachment (U) refers to a group of individuals who are not able to contain and reorganize stories including features that evidence danger, helplessness, failed protection or isolation (Gander et al., 2015). Unresolved individuals become momentarily overwhelmed by their attachment fears that cannot

be reorganized in the narratives (George and West, 2012). Before launching into characteristics of the unresolved attachment, it is necessary to underline the role of trauma for AN in general. It is well known that sexual and physical traumatization represent non-specific risk factors for the later development of an ED (Lejonclou et al., 2014). Practitioners who treat patients with AN often encounter histories of various traumatic and abusive experiences (Gander et al., 2015). With regard to the whole spectrum of traumatic experiences, individuals with AN frequently report interpersonal trauma and adverse childhood circumstances like emotional abuse, mental health problems in parents or parental divorce during their upbringing (Lejonclou et al., 2014).

1.4.3 Psychodynamic and Interpersonal

Psychodynamic theory has a rich and nuanced history, developed from Sigmund Freud and expanded upon by his followers throughout the 20th century into the present (Caparrotta & Ghaffari, 2006; Zerbe, 2001). Contemporary psychodynamic theory and practice integrates insights derived from several schools of psychoanalytic thought, including drive theory, ego psychology, object relations, self-psychology, relational and attachment theories, and intersubjectivity (Zerbe, 2001). Some of the main premises of contemporary psychodynamic theory include: (1) "the role that the dynamic unconscious plays in emotional life; (2) the re-enactment of psychological and behavioural themes created on the dynamic unconscious that ensnare the individual in increasing, obstinate, and self-defeating patterns of living, and; (3) the importance of the therapeutic relationship in understanding the patient and guiding the treatment" (Zerbe, 2012, p. 254). Other areas of focus include patients' subjectivity and defense mechanisms, unconscious meanings of symptoms, the potential link between current and past interpersonal relationships and conflicts, as well as the influence of the internal representation of

relationships on the meaning patients attribute to their own experience (Abbate-Daga et al., 2016).

Classical psychoanalytic thinking has viewed AN as a refusal of female sexuality by means of starvation (Dare & Crowther, 1995). That is, the refusal to eat allowed the anorexic to not only lose weight, but also her sexual characteristics, and therefore, become childlike again (McIntosh et al., 2000). Early psychoanalytic theory also viewed AN as an oedipal level disturbance (Lawrence, 2001), in which jealousy and rivalry between the individual and parents or siblings is theorized to be a key issue in the development of the syndrome (Winston, 2006). It has also been proposed that AN has the function of creating what to the patient may be the only effective form of expressing anger or aggression (Dare & Crowther, 1995). However, later psychodynamic thought abated its focus on drive theory by reconceptualizing AN within object relations theory (McIntosh et al., 2000). Several schools began to focus on the interpersonal context in which AN developed and identified how the psychology of the individual is influenced by the way he or she experiences relationships (Bruch, 1973). Accordingly, AN came to be understood as a syndrome of interpersonal relationships, as well as the organization of the self (Kaufman & Heiman, 1964).

Psychodynamic psychotherapy draws from a variety of tools and techniques that includes empathic understanding and clarification, assessing potential transference and countertransference patterns, as well as confrontation and interpretation of one's suffering, which has seemingly entrapped them in often "beguiling and intertwining symptoms that thwart full engagement in life" (Zerbe, 2012, p. 243). Psychodynamic treatment of AN focuses primarily on assisting patients in understanding symptoms as they are manifest in the present context to find ways to master maladaptive modes of coping and to improve overall quality of life (Zerbe,

2001). More specifically, it looks at the anorexic's symptoms as an expression of emotional suffering that she resists becoming conscious of and addressing directly, evidenced by her tendency to defer to restriction, binging and/or purging. As Zerbe (2012) explains, "Few individuals wish to face what is painful and potentially dysregulating to the personality structure, so they resist doing so" (p. 257). Psychodynamic theory upholds, therefore, that "the way out of what causes emotional pain is to face it directly in the context of a safe and sustaining relationship with the therapist" (Zerbe, 2012, p. 257). Furthermore, it contends that ED symptoms have meaning and, although behavioural methods and approaches may temporarily help regulate them (e.g., CBT through its methods of monitoring ED actions, urges, and emotions) it is only by addressing the anorexic's internal conflicts, developmental deficits, traumatic events, and abandonments that her psychological development and overall well-being can ultimately be restored (Zerbe, 2012).

In practicing from a psychodynamic approach, the clinician will give particular attention to what emerges in the patient-therapist relationship (Zerbe, 2012). More expressly, the therapist will assist the patient in observing what is enacted within the therapeutic milieu, including how it is another version of what has occurred in past or current relationships (i.e., analysis of the transference relationship) (Zerbe, 2012). Moreover, the therapist will encourage the patient to bring their thoughts and feelings about the therapeutic relationship directly to the session for mutual examination and understanding (Zerbe, 2012). The therapist will also make use of her or his own countertransference, which refers to the feelings, thoughts, and fantasies that emerge when working with the patient to garner additional understanding of the patient's unique conflicts, strengths, deficits, and defenses (Caparrotta & Ghaffari, 2006; Chassler, 1994; Kernberg, 1995; Winston, 2012; Zerbe, 2008). An excerpt from Lawrence's (2008) case study of

'Patient F' exemplifies the therapeutic relevance of countertransference, although she does not classify it as such in her text:

> I found myself sighing inwardly, fearing this would be a long illness. Here is a patient who tells me that I cannot come in, cannot be allowed to see or understand her, while at the same time forcing me to see something terrible. She tells me that there is simply nothing to see […] And yet her body, which I cannot but see, tells me she is mortally ill. If I had persisted in attempting to elicit an acknowledgement of this, the result would have been a fruitless cat-and-mouse interaction (p. 79).

Chassler (1994) also accentuates the importance of the therapeutic relationship, including how it informs the interpretative work of psychodynamic practice: "Regardless of the clinician's psychoanalytic orientation in working with starving anorexic patients, only when a solid therapeutic alliance has been established, which takes a substantial period of time, can the interpretative work begin" (p. 411).

Research on the efficacy of psychodynamic psychotherapy in the treatment of AN is limited (Zerbe, 2012), but gradually growing (e.g., Bachar, Latzer, Kreitler, & Berry, 1999; Cross, 2013; Tobin 2012; Zipfel et al., 2014). In their comprehensive meta-analysis of existing literature on the effectiveness of psychodynamic psychotherapies in EDs, Abbate-Daga et al. (2016) examined 47 studies published between 1980 and 2015 on psychodynamic treatments delivered to adults with AN, BN, and binge eating disorder (BED); specifically, 15 studies were available for AN, 9 for BN, 12 for BED, and 11 for samples with mixed diagnoses. After examining the various studies and publications, Abbate-Daga et al. (2016) determined that, although some of the studies suffered from methodological limitations (i.e., psychodynamic interventions are not typically manualized, require a long time to be completed, and are strongly

personalized to each patient), current data provides support concerning the efficacy of these interventions, particularly for AN. They also discovered that psychodynamic therapies are as effective as CBT and family therapy. Furthermore, they found that patients preferred psychodynamic treatments, conceivably because treatments with tailored and personalized plans are highly valued (Fassino & Abbate-Daga, 2013).

In another randomized control trial study conducted by Zipfel et al. (2014), they sought to assess the efficacy of two manual-based outpatient treatments for AN – focal psychodynamic therapy (FPT) and CBT-E – as opposed to 'optimized treatment as usual' (i.e., outpatient psychotherapy and structured care from a family doctor). Specifically, 242 participants were randomly allocated to 10 months of treatment with either FPT (comprised of 80 patients) or CBT-E (comprised of 80 patients), or optimized treatment (comprised of 82 patients). They discovered that FPT proved to be beneficial in terms of recovery at 12-month follow-up (i.e., based on a combination of weight gain and ED psychopathology), while CBT-E was more effective with respect to speed of weight gain and improvements in ED psychopathology than optimized care. Indeed, this study alludes to how psychodynamic psychotherapy strives towards generating more insight within the patient/anorexic, compared to swift changes in behaviour or cognition that other approaches seek to attain.

It is worth noting that, although psychodynamic psychotherapies are sometimes criticized for lacking a manualized approach and/or requiring a longer duration of treatment (Abbate-Daga et al., 2016), findings from Carter et al. (2011) randomized control trial study comparing specialized psychotherapies in the treatment of AN (cognitive behaviour therapy and interpersonal psychotherapy, as well as supportive psychotherapy) revealed that psychotherapy focusing on interpersonal aspects (e.g., interpersonal therapy and focal psychodynamic therapy)

might require a longer timeframe to produce effects, thereby creating better long-term results. As Zerbe (2012) poignantly summarizes: “Psychodynamic treatments aim to make the life of the person more vital and meaningful […] This process only transpires over time” (p. 264). Given that the anorexic’s preoccupation with her weight “often serves as a mask for other, more intricate sources of discomfort” (Knapp, 2003, p. 17), it is understandable that she requires additional time to glean the meanings of eating and body image, along with the role food may itself play in her life. The subsequent section examines an existential-phenomenological approach to understanding AN, conveying how themes of meaning, relationships and agency accompany the syndrome.

1.4.4 Existential-Phenomenological

The prevailing conceptualization of AN is based on the medical model, and a positivist and empirical epistemological position (Botha, 2015). For this reason, it is not uncommon for women with AN to feel pathologized, isolated, and alienated (Rich, 2006). The medical approach seemingly reduces the anorexic’s experience to objective symptoms without regard to the context and/or personal meaning of them (Morgan, 2015). Moreover, the *DSM-5* definition of AN focuses mainly on the nature of physical symptoms, promoting the notion of AN as solely a matter of weight loss and/or gain (Botha, 2015; Rich, 2006). In the face of this medical discourse, a qualitative study conducted by Rich (2006) revealed how many young women with AN want “others to understand the pain, anguish and emotional difficulties that lie beneath the surface features of the ‘body’” (p. 290). Therefore, an existential approach to understanding AN considers themes such as personal meaning and agency in conceptualizing the anorexic (Maine, 1985), while a phenomenological position explores the personal lived experience of AN.

In an in-depth and classic case study, Binswanger (1958) provides a detailed examination of the existential dilemmas inherent in AN. More specifically, his account of a young woman, 'Ellen West,' provides a glimpse into the inner world and experience of a woman suffering from anorexic symptoms. In his work with Ellen West, Binswanger employed various existential concepts and techniques, including existential analysis – a school of thought that seeks to understand people in a deeper, more philosophical way rather than a strictly scientific way – in his attempt to understand her symptoms and propensity to dread gaining weight (Dittmar & Bates, 1987). In order to develop an understanding of AN using Binswanger's existential framework, his modes of being-in-the-world are briefly explained, followed by a brief summary of Ellen West's case.

Binswanger's (1958) distinguishes three modes of world (derived from Heidegger's concept of 'Dasein' or being-in-the-world) that describe the existence of each individual: (1) 'Umwelt,' literally meaning "world around," signifying the environment; (2) 'Mitwelt,' meaning "with-world," constituted by our interpersonal relationships and; (3) 'Eigenwelt,' the "Own-world," which refers to or subjective, personal experience and mode of relating to one's self (Dittmar & Bates, 1987; Ghaemi, 2001; Hoeller, 1990).

The being-in-the-world model – the existential worlds – was extended upon by several psychologists comprising of Yalom (1980), May, (1983), and Van Deurzen (1988; 2012). These worlds are universal dimensions in which we must exist as human beings: (a) we all must breathe and eat (physical/Umwelt); (b) we all must live in a cultural human world (social world/Mitwelt); (c) we all have inner thoughts and inner lives (psychological world/Eigenwelt); (d) we all have some fundamental beliefs about the world, and all make meaning of matters (philosophical/spiritual world; Überwelt).

Indeed, a fourth world, Überwelt (spiritual/philosophical world) was established by Emmy Van Deurzen (1988) during the late 1980s. The Spiritual World (Überwelt) is German for "over world" Van Deurzen's definition: "Person's connection to the abstract and metaphysical aspects of living" (Van Deurzen, 1988; 2012, p. 86). Van Deurzen (1988, 2012) proceeds to clarify that "the spiritual world is the domain of experience where people create meaning for themselves and make sense of things" (Van Deurzen 1988; 2012, p. 87).

For individuals to realize their full existential possibilities, according to Binswanger (1963, as cited in Dittmar & Bates, 1987), they must be able to successfully harmonize the various existential worlds to form a meaningful unity or Gestalt. The absence of this unity or "Gestalt-loss" therefore, leads to fragmentation of the self and a paralyzing state of "existential dread," in which one becomes so closed within themselves they are no longer able to exert any control over him or herself (Dittmar & Bates, 1987, p. 62).

It is now necessary to provide a brief overview of Ellen West, in order to appreciate her struggle with disordered eating, as well as Binswanger's existential conceptualization of her. It is also important to recall that Ellen West was born in 1888; therefore, medical explanations of AN were only beginning to emerge at the time (as previously discussed in section 1.1.2). However, her journal entries certainly represent the experience of a young woman suffering from anorexic and depressive symptoms, as well as obsessive-compulsive tendencies (Ghaemi, 2001). From her childhood, it was noted that she was stubborn, defiant, and intelligent, as well as frequently unhappy with "days when everything seemed to empty her" (Ghaemi, 2001, p. 59). As a young adult, at around 20-years old, she reportedly experienced fluctuations in her weight that contributed to her "dread of getting fat," which also overlapped with the end of a romantic relationship (Ghaemi, 2001, p. 59). Over the next several years, she continued to alternate

between periods of binging and starvation, accompanied by compulsive exercising and laxative misuse. At 25-years old, she married her cousin and tried to become pregnant, but she miscarried and continued grappling with disturbed eating habits and behaviours: "[S]he was obsessed with being thin, and, at the same time, distressed by this obsessive idea and wished that she could eat food normally" (Ghaemi, 2001, p. 59). Attempts to reform Ellen's eating disturbances produced meagre results, which lead to increased suicidal ideation and her ultimate demise; tragically, she committed suicide at 33-years old (Ghaemi, 2001).

In his existential analysis of Ellen West, Binswanger (1958) provides an overview of her "Eigenwelt" (i.e., "own world"), along with her "Mitwelt" (i.e., "with world") and her "Umwelt" (i.e., "surrounding world"). According to Binswanger (1958), Ellen West's mode of existence was characterized by a withdrawal during childhood into her Eigenwelt from her Umwelt and her Mitwelt. Moreover, he noted that she also experienced several failed relationships as a young adult, which he seems to mention in passing, and thus implies that they were unavoidable and expected (Ghaemi, 2001). However, as a result of these expected setbacks, her interest in others in the Mitwelt began to progressively dwindle (Dittmar & Bates, 1987). Subsequently, her interest in her existence in terms of her future deteriorated, and her existence became gradually identified by her past, a painful recollection of failures and unfulfilled aspirations:

> Her failure to realize 'the old plans and hopes' transforms the world into boundless desolation, soundless stillness, and icy cold, in which the Eigenwelt shrivels to an infinitely tiny point […] Thus her existence, spatially conceived, moved from being a line pointing toward the future to a circle imprisoned in the past. By her early twenties, her existence was held up in this "vicious circle" which she would never break until the end

> of her life. Thus, at the age of 21, her existential development had ended, just as her psychopathological symptoms would begin (Ghaemi, 2001, p. 61).

Binswanger (1958) suggests that Ellen West was already dead, existentially speaking, since her early twenties once her being-in-the-world was perverted into that vicious circle: "The rest of her life was a mere waiting for her physical death" (Ghaemi, 2001, p. 62).

A perusal of Ellen West's case study – and tragic demise – reveals the importance, perhaps necessity, of integrating a phenomenological approach in understanding the anorexic's experience of the syndrome from 'the inside' (Botha, 2015; Dittmar & Bates, 1987; Rich, 2006). At various points in her treatment, for example, she was scrutinized by other psychoanalysts (e.g., Bleuler), in which she received labels ranging from "obsessive neurosis" to "a progressive schizophrenic psychosis" (Ghaemi, 2001, p. 61). At one point, she recorded in her diary that: "The analysis was a disappointment […] I analyzed with my mind, and everything remained theory […] The wish to be thin remained unchanged in the center of my thinking" (Ghaemi, 2001, p. 61). Perhaps even more disconcertingly, she was dubbed with "a poor prognosis," discharged from the hospital, and three days later, following one day of "a positively festive mood" and an unusually healthy appetite, she committed suicide (Ghaemi, 2001, p. 61). Although Binswanger's existential therapeutic approach (or arguably lack thereof) had its limitations (e.g., he reportedly overlooked a period of one month when Ellen West made at least four serious suicide attempts), his phenomenological approach accentuates the importance of not merely providing the anorexic with explanations of the syndrome from "the outside," but rather the importance of sharing her perceptual world and striving to mutually construct a new identity from "the inside" (Dittmar & Bates, 1987, p. 63).

1.5 Recovery, Remission, and Relapse in Anorexia Nervosa

Navigating the literature on recovery, remission, and relapse from AN is wrought with ambiguity. Most notably, the lack of consensus regarding what constitutes each of these respective terms is apparent and not only points to the complexity of the syndrome, but also the existent gaps in our knowledge and understanding. A growing body of research on the course of AN has emerged that seeks to comprehend how far astray the anorexic might wander and whether she will ever arrive to the path of recovery and regain a course that is freed from the clutches of the syndrome (Khalsa et al, 2017; Pike, 1998). The course of a disorder, as Pike (1998) elucidates, refers to "the progression of core features of the syndrome over time in terms of their duration, severity, variability, and impact on the general health and suffering of the individual" (p. 447-448). Additionally, he explains that predicting course and outcome is a vital part of describing any clinical syndrome; yet such prediction in the case of AN is particularly challenging given its variable course and outcome (Pike, 1998). Some treatment outcome studies concerning the course of AN reflect optimism (e.g., Keski-Rahkonen et al., 2007) usually in early onset though (Eisler et al., 1997), whereas others produce less hopeful results and show associations with chronicity (e.g., Hay, Touyz, & Sud, 2012; Steinhausen, 2002) reluctance to recover and poor treatment adherence (e.g., Nordbø et al., 2008), as well as comorbidity and mortality (e.g., Herpertz-Dahlmann, 2009).

The literature on treatment outcome reveals a contentious dispute of how narrowly or broadly recovery for AN should be defined (Couturier & Lock, 2006). Some authors, for example, suggest complete symptom abatement is required in order to categorize someone with AN as recovered (e.g., Helverskov et al., 2010), while others suggest that recovery should be determined by weight restoration and menstruation (e.g., APA, 2013; Eisler et al., 2007). In their

systematic qualitative review of 27 studies addressing relapse, remission, and recovery following treatment of AN, Khalsa et al (2017) concluded how definitions of recovery can be divided into the following categories: (1) remission/recovery based solely on weight measurement; (2) remission/recovery based solely on symptom reports, and; (3) define remission/recovery based solely on weight and symptom reports (i.e., diagnostic criteria available at the time). Similarly, they maintained that definitions varied substantially in the literature, and consequently, resulted in different estimates of prognosis. In another treatment outcome study, Ackard et al (2013) examined women from inpatient and partial hospital ED programs (N = 195; 94 AN; 24 BN, and; 77 EDNOS) to compare and evaluate a broad spectrum of remission definitions. In doing so, they discovered "markedly varying remission rates" that depended on the definition used, and thus, emphasized the need for widespread adoption of consistent criteria (Ackard et al., 2013, p. 17).

Another probable source of disparity in recovery and remission rates results from the broad range of time spans used in the definitions (Couturier & Lock, 2006). Several authors, for example, require the remission period to be maintained for at least 8 weeks before patients are considered as recovered (e.g., Strober Freeman, & Morrell, 1997; Herzog et al., 1999). Other authors have suggested that full remission is defined as an absence of all symptoms or only "residual symptoms" for at least 12 weeks, and partial remission is defined as a reduction of symptoms to a "sub-diagnostic level" for at least 12 weeks (Helverskov et al., 2010, p. 455). Additionally, studies typically describe recovery and/or remission outcomes in terms of BMI and menstruation, applying terminology such as "good," "intermediate," "poor" (e.g., Eisler et al., 2007, p. 555), or more perhaps even more apathetically, "died" (Lowe et al., 2001, p. 884).

In the context of these discrepancies, Duncan, Sebar, and Lee (2015) tersely state that "the apogee of decades' worth of scientific inquiry thus appears more successful in identifying what we do not know, rather than what we need to know" (p. 178). Accordingly, they stress the "marked pressure to further our understanding of the recovery process," particularly if clinicians are to counsel individuals more effectively with AN towards it (Duncan et al., 2015, p. 178). Moreover, they maintain that it demands novel ways of exploring the syndrome, including "expansion beyond the reductive, dominant medical framework through which eating disorder research has been traditionally conducted" (Duncan et al., 2015, p. 178). Indeed, there is an increasing shift towards examining anorexic's lived experience with the syndrome using qualitative methods to identify themes relevant to recovery (e.g., D'Abundo & Chally 2004; Duncan et al., 2015).

In their qualitative study, D'Abundo & Chally (2004) employed grounded theory to explore the experiences of recovery from 20 women (i.e., participants described symptoms of both AN and BN, and thus, the authors did not reference them as anorexic or bulimic in this analysis). In doing so, they developed a model for comprehending the experience of recovery that they referred to as a 'circle of acceptance,' comprised of thoughts, actions or behaviours that described participants' process of gaining self-worth. In a similar vein, Duncan, Sebar, and Lee's (2015) meta-ethnography study sought to do the synthesis of existing qualitative research on the phenomenon of recovery from AN from the perspective of those who had identified as experiencing it. They discovered two core categories related to recovery that included empowerment and self-reconciliation; namely, recovery is "a complex and consuming journey, entailing a self-determined search for identity and truth, and the repossession of personal control and power" (Duncan et al., 2015, p. 187).

In another phenomenological study that examined 32 women with AN in different stages of the recovery process, Garrett (1996a) described the participants' recovery as "a spiritual quest" that involved a re-discovery or connection between inner self, others, and nature (p. 1491). Interestingly, Garrett's (1996a) findings seemingly reflect, and reaffirm, the relevance of the existential concepts of Mitwelt, Eigenwelt, Umwelt and Überwelt. In many ways, these qualitative studies illuminate the personal meaning, and implicit existential givens, entrenched in recovery for women with AN.

2. Theories on Meaning in Life and Meaning-Making Processes

2.1 Theories on Meaning in Life

The definition of meaning in life differs throughout the literature, ranging from coherence in one's life (e.g., Reker & Wong, 1988) to goal directedness or purposefulness (e.g., Park & George, 2016) to "the ontological significance of life from the point of view of the experiencing individual" (Crumbaugh & Maholick, 1964, p. 201). Regardless of the differences in definitions of and pathways to meaning in life, "theorists uniformly regard meaning as crucial" (Steger, Frazier, Oishi, & Kaler, 2006, p. 80). The significance of meaning in life has been conversed about in philosophy, religion, and literature and is widely acknowledged to be a central human concern (George & Park, 2016; Park, 2010a; Yalom, 1980). Many existential philosophers have contended that a crucial component of the human condition is an incessant pursuit of meaning (Heine, Proulx, & Vohs, 2006). As described in section 2.2.4, there are various types of meaning an individual can develop or 'make' (e.g., global and situational), and thus, there are some useful categorizations for understanding some of these common processes (e.g., automatic versus deliberate; assimilation versus accommodation; searching for comprehensibility versus searching for significance, and; cognitive versus emotional) (Park, 2010a). The following section provides

an overview of theories of meaning in life, coupled with an examination of meaning-making processes.

2.1.1 Existentialism

Existentialism is a philosophy that was founded by 19th century philosophers Soren Kierkegaard and Friedrich Nietzsche, and further developed by prominent 20th century philosophers such as Jean-Paul Sartre, Paul Tillich, Martin Heidegger, Martin Buber, and Rollo May (Burston, 2003; Breitbart et al., 2004). Existentialism is concerned with the inevitable aspects of human existence that correspond to existential givens and confronts the tenacious questions of human struggles (Wong, 2017). More expressly, it is concerned with questions pertaining to existence that includes, but is not limited to: "What am I doing here? What is the point of striving toward a goal, when death is the inevitable end? How can I live a worthwhile life? How can one find happiness is a world full of suffering?" (Wong, 2017, p. 1375).

Existentialists, as Chen (2010) explains, "are extremely occupied in finding meaning in human existence," in addition to "explaining the need to define themselves relative to an absurd universe because in the end, we all die" (p. 366). Meaning in life fulfills a fundamental role for individuals and can be traced in all human experiences, including inescapable experiences that involve suffering (Frankl, 2006). For this reason, existentialists hold that meaning in life can be discovered by "revealing the positive in that which is negative," and by finding meaning in suffering (Chen, 2010, p. 366). According to this view, the responsibility of all human beings is to make their lives meaningful (Chen, 2010; Frankl, 2006).

Renowned existential scholar, Irvin Yalom, also deemed meaning-in-life as an important psychological construct; one that relates deeply to all human beings, to the point of being a matter of life and death: "To live without meaning, goals, values, or ideals, seems to provoke

considerable distress" and "in severe form it may lead to the decision to end one's life" (Yalom, 1980, p. 422). According to Yalom (1980), when one is incapable of finding a coherent pattern or reason, feelings of dysphoria are experienced; that is, one feels exasperated, dissatisfied, and helpless. At the same time, he maintained that there is an inherent dilemma and paradox in our human need to have meaning in life because we exist in a universe that has no inherent meaning (Yalom, 1980). Yalom (2000) acknowledged the difficulty human beings experience in the attempt to find meaning in the absence of comforting external structures such as religion. Therefore, he provocatively questioned, "Perhaps we can forgo the question, why do we live? But it is not easy to postpone the question, how shall we live?" (1980, p. 427).

Existential humanistic psychology postulates certain challenges inherent in the human condition, and studies how people come to terms with these 'givens' (May, 1983; Greening, 1971; Yalom, 1980). By "givens" (i.e., existential givens) Yalom (1980) refers to certain facts of human existence which he calls concerns: death, isolation, freedom, and meaninglessness (Krug, 2009). In other words, Yalom (1980) refers to "The individual's confrontation with these facts of life constitutes the content of the existential dynamic conflict" (p. 8).

In a similar manner, Viktor Frankl (1963), a distinguished Austrian psychiatrist, stressed that people are dominated neither by will-to-pleasure (Freud) nor by the will-to-power (Adler/Nietzsche), but rather by what he calls, *the will-to-meaning*, that is to say, the "deep seated struggle for a higher and ultimate meaning to [their] existence" (Ruffin, 1984, p. 41). Frankl believed that an important aspect of human nature is the striving to search for and to possess a meaning or a purpose for one's life; therefore, it is said to be "the primary motivational force in man" (Frankl 1977/2006, p. 104). Therefore, he maintained that an individual's will to meaning could not only preserve his or her mental and physical health, but also assist them in

surviving adverse conditions of pain, suffering, and grief (Frankl, 1977). Frankl (1962) was confronted with many questions about his own meaning of life, which later led to his development of existential analysis. Although Frankl (1977/2006) mentioned meaning as a primary motivational aspect in man, Wong (2020) describes personal meaning as cognitive-affective system that brings a subjective satisfaction resting on the person's values, and the way the person interprets the environment and moments in his/her life. More concisely, Wong's (2020) definition of meaning applies four criteria: (1) "a meaningful life is purposeful [..] A sense of mattering or significance imbues our lives with meaning; (2) A meaningful life is understandable or coherent; (3) A meaningful life is a responsible one. We must assume full responsibility for our life or for choosing our life goal. Self-determination is based on the responsible use of our freedom; (4) A meaningful life is enjoyable and fulfilling" (p. 573).

Existentialists have also conceptualized meaning as relation (Heine et al., 2006). Baumeister (1991) refers to meaning as a "mental representation of possible relationships among things, events, and relationships […] Thus, meaning *connects* things" (p. 15). In a similar manner, Camus (1955) maintains that people are meaning-makers, compelled to make connections, discover signals in noise, recognize patterns, and establish associations in places where they may not intrinsically exist. As Heine et al. (2006) explain, "People are meaning-makers insofar as they seem compelled to establish mental representations of expected relations that tie together elements of their external world, elements of the self, and most importantly, bind the self to the external world" (p. 89). Consequently, when elements of perceived reality are experienced that do not seem to be part of people's existing relational structures "or that resist relational integration," these inconsistent elements provoke a "feeling of the absurd," a puzzling sense of incongruity that compels people to re-establish a sense of uniformity and coherence in

their lives (Heine et al., 2006, p. 89). In other words, people are compelled to comprehend their experiences and identify meaningful pursuits and themes in their lives (Steger & Kashdan, 2007).

2.1.2 Spirituality and Religion in Meaning-Making

It is appropriate to mention the role of spirituality and religion in meaning-making. Religion can be defined as "a search for significance in ways related to the sacred" (Pargament, 1997, p. 32), is central to the meaning systems of many people, although its centrality varies greatly from individual to individual (Park, 2005). Religiosity and spirituality are distinct, but with overlapping experiences; as such, we begin with clear definitions of each of these terms. Following from Mattis (2000) and Zinnbauer et al., (1997) "religiosity" is defined as the degree to which individuals adhere to the prescribed beliefs and practices of an organized religion. "Spirituality" refers to an individual's belief in the sacred and transcendent nature of life, and the manifestation of these beliefs in a sense of connectedness with others (Pargament, 2007).

In a qualitative study, Mattis (2002) examined the ways in which 23 African American women use religion/spirituality to cope and to construct meaning in times of adversity. The research question posed for the study: What do Black women's narratives help us to learn about the role of religion/spirituality in meaning-making? The findings of the study indicated that religion/spirituality help women to interrogate and accept the reality of their circumstances; identify, confront, and transcend limitations; engage in spiritual surrender; identify and grapple with existential questions and life lessons; recognize their own purpose and destiny (and the purpose of others' lives); act in principled ways; achieve growth; and accept transcendent sources of knowledge. As articulated in Mattis' (2002) final discussion: "These themes do not

suggest a hierarchy through which individuals must travel in the effort to construct meaning. Instead, they simply name critical parts of a process of meaning-making" (p. 317).

2.1.3 Presence and Search for Meaning

Meaning in life (MIL), as defined by Steger et al. (2006), refers to "the sense made of, and significance felt regarding, the nature of one's being and existence" (p. 81). Likewise, Steger et al. (2006) distinguish two important dimensions of MIL: (1) presence of meaning (POM), and; (2) search for meaning (SFM). The first component, POM refers to whether people perceive their lives as significant and purposeful. Moreover, it refers to the comprehension of oneself and the surrounding world, as well as the understanding of how one fits into the world (Steger, Mann, Michels, & Cooper, 2009). The second component, SFM refers to the strength and activity of people's efforts to create or increase their understanding of the meaning and purpose of their lives (Steger et al., 2009). In other words, POM is concerned with a valued outcome ("my life is meaningful"), whereas SFM is concerned with an important process ("how can I make my life more meaningful?") (Steger et al., 2009, p. 661).

According to Steger et al. (2009), both POM and SFM are central theoretical variables in "the family of constructs known as meaning in life," including predictors of mental and physical health (p. 353). POM has received the most attention and appears to have the strongest relations in prompting and maintaining physical and mental health (e.g., Ryff & Singer, 1998; Steger et al., 2009). This is likely resultant from the notion that SFM is related to less POM, and lower well-being overall (e.g., Steger et al., 2006; Steger, Kawabata, Shimai, & Otake, 2008). As Steger and Kashdan (2007) explain: "The absence of life meaning should, theoretically, drive people to seek it out. As part of a dynamic process, a deficit in meaning would stimulate people to search for it, resulting in them discovering a satisfying purpose and meaning in their lives" (p.

164-165). Additionally, they theorize that the strength of the SFM should subside, to a certain degree, as people find meaning, yet remain a significant motivation for most people (Steger & Kashdan, 2007).

A recent qualitative study by Eli (2015) examined how 16 women with AN, BN and other subvariants (EDNOS) of EDs, interpreted their experiences of binge eating. The study revealed how women described binge eating as "a practice through which the self experiences a sense of release, and existential emptiness is replaced by overwhelming fullness" (Eli, 2015, p.363). Similarly, the study found that eating disorder symptoms "constitute a metaphoric, embodied expression and negotiation of existential states" (Eli, 2015, p. 367). Although the term is not clearly defined in the study, the notion of 'existential emptiness,' is arguably an indication of the lack of POM (and pervasiveness of existential givens) in the anorexic. Understood in this context, the anorexic's SFM could presumably assist in nurturing and/or filling this emptiness in a more adaptive manner, including those who do not purge.

2.1.4 Meaning as Comprehension, Purpose, and Mattering

MIL, as defined by Park and George (2016), refers to "the extent to which one's life is experienced as making sense, as being directed and motivated by valued goals, and as mattering in the world" (p. 206). A closer examination of this definition reveals a tripartite view and conceptualization, in which MIL consists of three subconstructs; namely, (1) 'comprehension,' which refers to the extent to which individuals perceive a sense of coherence and understanding about their lives; (2) 'purpose,' which refers to the degree to which individuals experience life as being directed and motivated by valued life goals, and; (3) 'mattering,' which signifies the extent to which individuals feel that their existence is of significance, importance, and value in the world (Martela & Steger, 2016; Park & George, 2016; Steger, 2012).

This tripartite view, according to George and Park (2016), seeks to "add clarity to the literature as it outlines three more specific and targeted subconstructs without lumping them together into a singular more diffuse concept" (p. 205). In other words, the MIL construct tends to be "ambiguous and amorphous with unclear conceptual boundaries" (Park & George, 2016, p. 205). However, comprehension, purpose, and mattering should not be understood of as three distinct concepts, but instead as three closely related constructs that, together, engender MIL. As such, the authors maintain that they will naturally interact and influence one another; having a very low degree of one component will likely impact the others, and vice versa (George & Park 2016). For example, they explain that life seems incoherent, fragmented, and unclear for individuals experiencing low comprehension, whereas the future seems bleak and aimless for individuals experiencing low purpose. Similarly, they contend that individuals with a low sense of mattering feel that their existence conveys little relevance, and their nonexistence would make little difference in the world.

Park and George (2016) also make an important distinction between MIL and 'meaning frameworks,' whereby the latter refers to "the complex web of propositions that we hold about how things are in the world and how things will be" (p. 206). In other words, they are "mental representations of expected relationships among people, places, objects, and ideas" (Heine et al., 2006, p. 90). Meaning frameworks, therefore, tell us "What is and what ought to be" and "what goals should be pursued" (Koltko-Rivera, 2004, p. 4). Thus, meaning frameworks are the relationships we perceive and expect in the world (Baumeister, 1991). People's meaning frameworks are unique to the way they perceive the world, and meaning frameworks are influenced by culture and experience (Baumeister, 1991; Koltko-Rivera, 2004).

Additionally, Park and George (2016) suggest that meaning frameworks contribute to a sense of MIL; specifically, "the implicit and explicit propositions we hold about the world may contribute to our sense that life makes sense, is directed and motivated by valued goals, and matters" (p. 2017). Similarly, they explain that MIL is different than meaning-making; namely, the term 'meaning-making' is used to convey a similar notion in the adjustment literature, in which the emphasis is on how stressful life events disrupt individuals meaning frameworks, how individuals try to make sense of the event by applying their meaning frameworks to the event, and how in this process, new meaning frameworks may be created or old one's modified (Park & George, 2016). The following section examines these meaning-making processes in greater depth.

2.2 Meaning-Making Processes

In recent years, there has been an increasing interest in understanding the role of meaning-making or the processes in which individuals engage to mitigate distress and recover from stressful events or experiences (Park, 2010a). The meaning-making model (MMM) proposed by Park (2010a, 2013) provides a framework that integrates both theory and empirical findings on various topics, including meaning in life, spirituality, worldviews, and coping with difficult experiences such as trauma, grief and bereavement, as well as physical illness (Park & Gutierrez, 2010). Moreover, the MMM encompasses previous theories to expound the ways in which meaning impacts the coping process and, through coping, impacts psychological and physical health (Park, 2010b). The model identifies two levels of meaning: global and situational (Park, 2013); please see section 2.2.1.

Both global and situational meaning are implicated in coping with stressful experiences, and the degree to which appraised meaning is incongruent with global beliefs and goals

generates distress (Park, 2010b). The MMM is discrepancy-based, that is, it proposes that "when people perceive major discrepancies between their appraised meaning of a particular situation and their global meaning (i.e., what they believe and desire) it creates distress, which in turn gives rise to efforts to reduce the discrepancy and resultant distress" (Park, 2013, p. 40). While discrepancies can be mitigated in different ways by various coping strategies (e.g., problem-focused coping and emotion focused coping strategies), it is not always possible or amenable to directly repair or problem-solve in low control situations (e.g., trauma, loss, and/or serious illness); therefore, meaning-making is often the most adaptive method of coping (Park, Folkman, & Bostrom, 2001).

The MMM maintains that "recovering from a stressful event involves reducing the discrepancy between its appraised meaning and global beliefs and goals" (Park, 2010a, p. 259). Therefore, meaning-making refers to "the processes in which people engage to reduce this discrepancy" (Park, 2010a, p. 259). Discrepancies can be reduced in various ways, and subsequently, people engage in many types of coping (Park, 2010b). Several categorical schemes have been identified to describe meaning-making (described below), which are beneficial for appreciating the nature and scope of meaning-making (Park et al., 2001; Park, 2010b, 2013).

2.2.1 Global vs. Situational Meaning

Global meaning consists of the framework through which people perceive and understand themselves, as well their environment (Park & Gutierrez, 2013). More specifically, global meaning systems encompass beliefs, goals, and subjective feelings of purpose or meaning in life (Park & Folkman, 1997). Situational meaning, on the other hand, refers to the specific appraisal that individuals assign to events or incidences in their lives (Park & Gutierrez, 2013). When a potentially stressful situation arises, people make appraisals about the situation, including its

fairness and controllability and the extent to which it violates their goals (Lazarus & Folkman, 1984). In addition to appraising the characteristics of the event, people also make appraisals regarding the extent to which that event violates their global beliefs, goals, or purpose (Park & Folkman, 1997; Park & Gutierrez, 2013).

2.2.2 Automatic vs. Deliberate

Meaning-making has been conceptualized as both automatic or deliberate; that is, an individual can engage in meaning-making unconsciously or they can deliberately engage in the process to make meaning out of their situation (Park, 2010a). An example of automatic meaning-making processes is intrusive thoughts or the avoidance of reminders of the event; that is, it is considered "a recursive process thought to reduce discrepancy and help integrate the appraised meaning of the stressor with global meaning" (Park, 2010a, p. 259). Though this experience can be deemed as an unpleasant one, it can assist the person in making sense of their stressful event, and thus, find meaning in their suffering (Park, 2010a; Frankl, 2006). Other processes may also transpire beyond deliberate or intentional efforts. Central life goals, for example, may change through processes beyond intentionality, such as when formerly ignored thoughts that challenge the appeal of blocked goals become more available (Park, 2010a)67oupleed with "cognitive content that renders an initially aversive situation more acceptable" (Brandtstädter, 2002, p. 383).

Deliberate meaning making refers to a wide range of efforts to deal with a situation through meaning-related strategies or meaning-focused coping (i.e., differentiated from other coping efforts by its motive of decreasing the global-appraised meaning discrepancy that is generating distress (Park & Folkman, 1997). These coping activities and efforts can be directed toward changing either appraised or global meaning (Folkman & Moskowitz, 2007), revising

goals and seeking solutions to problems, or activating spiritual beliefs and experiences to help individuals survive their difficult experience (Folkman, 1997; Park, 2010a).

2.2.3 Assimilation vs. Accommodation

When a person encounters a stressful situation, and their global meaning does not correspond with their appraised meaning of the situation then something must shift (Park & Folkman, 1997). In other words, if discrepancies or inconsistencies between global and appraised meaning are to be addressed, Park (2010a) explains that one or the other (or both) must change. More expressly, this change can happen in one's global meaning (e.g., a shift in a person's meaning frameworks or understanding of the world), their appraised meaning of the situation (e.g., a shift in how they interpret the stressful event), or both. Meaning-making that involves changing situational appraised meaning to be more congruent with existing global meaning is referred to as 'assimilation,' whereas changing global beliefs or goals refers to 'accommodation' (Park, 2010a).

It has been suggested that assimilation is more common process than accommodation because it does not require individuals to change their overall global beliefs: instead "global beliefs change only when individuals are confronted with events too immensely discrepant with global meaning to allow assimilation" (Park, 2010a, p. 260). However, Park (2010a) maintains that accommodation might be more common and perhaps more beneficial, especially when individuals are confronted with life-altering and/or irreversible stressors (Park, 2010a). In such situations, she explains, "accommodation allows reorientation to other, more promising goals and thus may promote better adjustment" (Park, 2010a, p. 260)

2.2.4 Searching for Comprehensibility vs. Searching for Significance

There is a distinction between searching for comprehensibility and significance in events. The former refers to attempts to make the event make sense or "fit" within a framework of accepted rules and standards, while the latter refers to attempts to find significance or value of an event (Park, 2010a, p. 260). An individual who has experienced a difficult loss, for instance, may search for comprehensibility by reminding themselves that death is a painful reality of life. Alternatively, they could search for significance by contemplating what impact the loss or death will have on their life, and how it will change or shape who they are as a person (Park, 2010a). These meaning-making processes could arguably have important implications for the anorexic, as she often struggles to comprehend the syndrome and accompanying symptoms (Knapp, 2003), along with the potential significance it might have in her life.

2.2.5 Meanings Made

The meanings made refer to the products or outcomes of meaning-making processes: namely, "meanings made are end results or changes derived from attempts to reduce discrepancies or violations between appraised and global meaning" (Park, 2010a, p. 260). The meaning-making processes previously mentioned can lead to discovered or enhanced meaning in many different forms that include: (1) acceptance or coming to terms with the event; (2) reattributions and causal understanding, or coming to a conclusion about the cause of the event; (3) perceptions or insights of growth and positive life changes; (4) changed identity and/or integration of the stressful experience into identity; (5) changed global (or overall) beliefs and/or goals, and; (6) restored or changed sense of meaning in life (Park, 2010a).

3. Meaning in Life and Anorexia Nervosa

3.1 Existential Themes in Anorexia Nervosa

In many ways, AN is not only a functional syndrome (e.g., coping with life stressors, modulating emotions, and fostering a sense of control), but it is also an existentially meaningful one (Eli, 2015; Schnackenberg, 2016). The anorexic does not see her "sharply-defined ribcage, nor her jutting hipbones […] nor the stark outline of her skeleton," but rather, she sees only "fat" and grapples with the intolerability of it all (Way, 2013, p. 24). To the ordinary onlooker, it may seem incomprehensible and nonsensical that she would wilfully starve herself; however, to the anorexic, "food and weight obsessions envelop [her], engulfing the totality of her existence" (Way, 2013, p. 24). In other words, the anorexic's existence becomes structured around food and weight, and thus it plays an important role in structuring her identity (Espindola & Blay, 2009). The existential nature of AN requires a closer examination, in order to understand the accompanying existential themes and givens that are entrenched in the syndrome. Some of these existential themes include, but are not limited to, embodiment, anxiety, identity, and loneliness and social isolation which are discussed below.

3.1.1 Embodiment

Embodiment represents specific assumptions concerning body and mind (as well as body and culture), which owes its philosophical foundations to the French phenomenologist Merleau-Ponty (1962). There is a lengthy philosophical tradition that conceptualizes the mind and body as distinct and separate parts (e.g., René Descartes's mind-body duality or dualism, referred to as Cartesian dualism) (McBride & Kwee, 2018). In contrast to Cartesian ontology, however, Merleau-Ponty (1962) proposed that "mind and body were equivalent, intertwined, and inseparable" (as cited in Piran, 2016, p. 44). Additionally, Merleau-Ponty (1962) developed the

term 'body-subject,' suggesting that the body is not only "sensational," but also "sentinel in perceiving, interpreting, and experiencing the world meaningfully, and therefore as a center of subjectivity" (as cited in Piran, 2016, p. 44). Grounded in these assumptions, therefore, the construct of 'embodiment' refers to the experience of the body as engaged in the world; it is an individual's experience of living as a body (Piran & Teall, 2012).

McBride and Kwee (2018) contend that the Cartesian dualism has prevailed in the treatment of EDs with its unmistakable emphasis on correcting cognition and behaviour. More specifically, the anorexic is deemed to have maladaptive thoughts and negative perceptions toward food, body and weight, and thus, she is encouraged to change thoughts, correct her perceptions, and ultimately, "comply with the externally imposed rules of how to recover" (McBride & Kwee, 2018, p. 1). However, in keeping with a phenomenological and embodied perspective, it cannot be said that the anorexic's perception is 'distorted,' but rather that:

> [T]here is a difference between the perspective of the anorectic and of those who are in contact with her […] if the anorectic's perception of her body is of a fat body, then that is her perception; it is not changed or disqualified by the differing perceptions of those who surround her. It is her lived perception, the way she feels living in her body, and this is not changed by others trying to convince her that their differing perceptions are correct […] (Sanz & Burkitt, 2001, p. 44).

Understood in this context, a phenomenological and embodied framework would inquire into the anorexic's perception of reality: that is, asking "what are the elements that make up her lived, embodied perception of reality?" (Sanz & Burkitt, 2001, p. 44).

In his work, phenomenologist Max van Manen (2016) makes a significant epistemological case for the necessity of embodiment when considering human experience,

arguing that our body is a source of knowing. Through our body, we can know the world, what it is to feel, to be a self, which ultimately contributes to and is the source of our aliveness (McBride & Kwee, 2018). Not limited to cognitive kinds of knowing, he states that "we experience our knowing in how and what to do through our actions, through the situations in which we find ourselves, through our relations with others and the world around us" (van Manen, 2016, p. 270). It is through our embodied being, our corporeality, that we can relate to others (know others) and experience the world (know the world) (McBride & Kwee, 2018; van Manen, 2016). In her ED memoir, *Appetites: Why Women Want* (2003), Caroline Knapp conveys how AN is indeed a way to relate to others and experience the world or perhaps a mechanism for (dis)embodiment: "A woman's individual preoccupation with weight often serves as a mask for other, more intricate sources of discomfort, the state of one's waistline being easier to contemplate than the state of one's soul" (p. 17). From an existential standpoint, embodiment is an important construct for understanding the anorexic, particularly as it relates to her being-in-the-world. More expressly, AN is seemingly an existential statement that becomes an integral part of the anorexic's identity and Dasein.

3.1.2 Identity

The literature reveals how the 'anorexic identity' – wherein the 'anorexic's' sense of self is seriously shaped and influenced by the syndrome – signifies an integral, albeit complex, feature of AN (Conti, 2018; Williams, King & Fox, 2016). Throughout the past few decades, identity has been a topic of interest in the field of eating disorders. For example, Casper (1983) has proposed that "the lack of a stable self-concept and secure self-regard predisposes adolescents to use thinness in a misguided strife for individuation" (p. 388). Similarly, Bruch (1977) has contended that AN can be regarded as "a desperate but futile struggle to establish a

sense of control and identity" (p. 229). Perhaps this view is most poignantly described by Crisp (1980), who referred to AN as "a distorted biological solution to an existential problem" (p. v). At the heart of these understandings is the notion that identity plays a significant role for individuals with AN.

More recently, research has demonstrated the difficulty of "giving up anorexia," in the sense that "letting go of an anorexic identity" not only leads to uncertainty and fear for these women, but also an identity crisis (Conti, 2018, p. 82). Given that the diagnosis/syndrome provides women with a sense of worth and identity (and often for many years), it is understandable that recovery – particularly the process of identity redefinition that accompanies it – would be perceived as frightening (Conti, 2018; Pettie & Triolo, 1999). In a recent qualitative study, Conti (2018) explored 21 women's experiences of AN over 10 years and the ways they negotiated their identities in relation to the question of recovery. Interestingly, the article begins with a quote from a participant (Avalon), who states that: "Recovery isn't so much about the disease process, or recovering from it, it's about recovering yourself; it's about reclaiming your place in the world" (Conti, 2018, p. 72). This notion of "reclaiming identity" by finding a sense of "place in the world" conveys the potential shift (and meaning) that develops from AN over time. As Conti (2018) eloquently concludes:

> Rather than forgetting, they wanted to remember. Rather than being gone, the experience shaped their self-understanding. Rather than returning to some premorbid state defined as recovery, these women honored their experience as a journey of self-transformation that provided them with opportunity for growth and rich connection to their values (p. 91).

In some ways, this reaffirms the need to shift beyond the medical approach that pathologizes these women to a phenomenological and existential approach that seeks to understand these women's unique experiences with AN, including the meanings made and derived from it.

In their case study, Pettie and Triolo (1999) explored the deeply personal process of recovery for individuals with psychiatric illnesses, proposing that the recovery process is characterized by two key developmental tasks: (1) the struggle for meaning, and; (2) the reconstruction of a positive identity. The recovery process, according to Pettie and Triolo (1999), refers to "a quest for identity that starts with an identity crisis" (p. 256). Accordingly, they explain that "in order for people to evolve within their recovery process, they must tackle the task of reconstructing their identities [which] includes finding the self that is still there" (p. 256). Although their research and case studies are applied to psychiatric illness(es) in general, this process arguably corresponds to Conti's (2018) point, as well as Avalon (participant in that research study), who propose that the "journey of self-transformation" (recovery) encompasses "reclaiming" identity from AN, which in turn, leads to growth and meaning (p. 91). Moreover, it points to the relationship that exists between the anorexic and the syndrome, including the significance of exploring this relationship to better understand it.

3.1.3 Anxiety

Research provides some evidence to support the "personal utility" and "value" of restrictive eating behaviours in women with AN (Fox, Larkin, & Leung, 2011, p. 2). For example, in their qualitative study, Fox, Larkin and Leung (2011) explored the personal meaning of eating difficulties in 8 women with a variety of eating disturbances (e.g., restriction, binging and purging). The study identified three overarching themes in participants' accounts of their experiences with eating disturbances: (1) the experience of the eating difficulties as functional;

(2) negative effects of having eating difficulties, and; (3) ambivalence towards the eating difficulties (Fox et al., 2011).

Additionally, Fox et al. (2011) contended that the participants' accounts of EDs engendered a sense of uniqueness, suggesting that they may play a functional role in defending against existential anxiety (e.g., defined as loneliness, meaningless, fear of death):

> This is particularly striking in participants' accounts of their rigid belief in their invulnerability, despite being in some cases morbidly underweight. The belief that one is somehow different or unique allows a person to avoid accepting the distressing realization of death and the responsibility for one's own actions that result from this (p. 8).

Yalom (1980) also suggests that engagement with the belief that one is distinct or somehow different to others can be an indication of death denial (Fox et al, 2011). Similarly, Farber et al. (2007) argue that women with AN present "a disturbing lack of anxiety about their own life-threatening behaviour yet are preoccupied with death and anxiety about annihilation" (p. 207). Fox and Leung (2009) also maintain that anorexic behaviours may serve as a maladaptive coping mechanism for mitigating existential anxiety (p. 29).

The Danish philosopher Soren Kierkegaard's treatise on the concept of "anxiety" describes it as an all-encompassing existential challenge of human beings (Kierkegaard, 1980). More expressly, he maintained that when an individual strives to understand the potential of a new and unknown reality, existential anxiety will manifest and be prominent; namely, "one has no real knowledge concerning one's potentials because these capabilities are yet to be realized" (Simonÿ, Pedersen, Dreyer, & Birkelund, 2015, p. 2587). As Simonÿ et al. (2015) explain:

> Because anxiety is indicative of the opportunities available to the individual that are present as part of the consciousness, it is a portent of the insistence on making a choice. A choice rests on the assumption that we find our true opportunities in a given reality in accordance with our own inner certainty (p. 2587).

Understood in this light, the experience of existential anxiety might become heightened during recovery for the anorexic, particularly as she strives to experience and understand a new reality outside of the syndrome.

3.1.4 Loneliness and Social Isolation

Research provides some evidence how the women's high degree of dissatisfaction with treatment of AN and their perception that the treatment system is overly focused on, and driven by, food and weight. For example, in their qualitative study, the primary focus of Rance, Moller and Clark's (2017) by using semi-structured interviews, elicited the views of 12 women who were recovered, or in recovery, for anorexia nervosa and had received treatment. In addition, for ethical reasons, participants had to self-identify as recovered or 'on the road to recovery.' Since relapse is typically defined relative to recovery and remission, they also consider how recovery and remission are defined. However, the study simply stated: "Recovery, if it occurs, tends to be a protracted process with high levels of relapse and the likelihood of traversing from one eating disorder (ED) to another (e.g., from restricting AN to purging AN or bulimia nervosa (BN))" (Rance et al., 2017, p. 582). The results derived from a thematic analysis revealed the women's high degree of dissatisfaction with treatment and their perception that the treatment system is overly focused on, and driven by, food and weight (Rance et al., 2017). In contrast, "what the women really wanted was to be seen and treated as a 'whole person' and to have a 'real' relationship with their therapist" (Rance et al., 2017, p. 582). Echoing the narratives and

sentiments of many participants, one participant aptly stated, “eating disorders are not about food, they’re about life … [but] a lot of people want them to be about food” (Rance et al., 2017, p. 588). In many ways, the authors reflected how not only this participant, but the other participants from their study “perceived the treatment system as overly focused on food and weight:” Furthermore, their belief in the unhelpfulness of treatment which focused primarily on food and weight applied to all treatment settings (Rance et al., 2017, p. 588). The aforementioned participant continued to accentuate how she spent two years with a local ED service: “to get to the point where I realised that focusing on food and maintaining restoring weight doesn’t work for me, because all it does is push me further into depression … which I don’t handle very well … it makes me suicidal. (Rance et al., 2017, p. 588-87). Moreover, she had managed to get treatment from her community mental health team, explaining how “after much fighting and being a ‘mouthy cow’,” she had managed to get treatment focused not solely on her eating but also on her depression. (Rance et al., 2017, p. 588). The study and participant’s assertion that a lot of people – although it does not specify who these people are referring to, the authors suggest it refers to individual practitioners, treatment providers and institutions – want EDs to be about food and (implicitly) weight was supported by a number of women who spoke about not having received therapy during their inpatient stay. Furthermore, it points an existing gap, as it conveys the sense of loneliness and lack of community women with AN experience as they seek treatment for remission and recovery.

Social isolation is a universal human experience, impacting whole communities at times and reminding each individual of our need for connection. Isolation weaves through life on an intrapersonal, interpersonal, and existential level; all people experience this phenomenon, to varying degrees, at points in their development (Brown et al., 2021). Research has shown that

persistent social isolation is a predictor for cardiovascular problems, mental health disorders and increased mortality rates (Brown et al., 2021; González-Sanguino et al., 2020). Therefore, it is important for healthcare professionals to understand the various forms in which social isolation can manifest.

Humanistic-existential theorists have long addressed isolation as one of the existential givens (death, isolation, freedom, and meaninglessness) (Brown et al., 2021). Yalom (1980) outlined three types of isolation: existential, intrapersonal, and interpersonal isolation. Existential isolation encapsulates the pervasive innate sense of disconnection between one's self and the world (van Bruggen et al., 2017). According to Henri Nouwen, community has many connotations; namely, it can make us think of a "safe togetherness," as well as "a quality of heart that "grows from spiritual knowledge that we are alive not solely for ourselves but one another" (Nouwen, 1996/2009, p. 23). Accordingly, this is indicative of the importance of developing a sense of community with other people who grapple with AN or EDs, as it can connect them and assist in their healing; a community of people invested in their experience of the remission and recovery process.

3.2 Gaps in the Literature

Research on ED etiology and treatment has proliferated throughout the past few decades yet MIL for women with AN has received limited attention to date. Moreover, there is no study that the author is aware of concerning the association between search for, and presence of, meaning in life and the recovery process for women with AN. While recent evidence has emerged concerning the functional and existential significance of AN (e.g., Fox & Leung, 2009; Marco et al., 2017), these studies are mainly quantitative in nature, and thus they do not explore the experiences or understandings of the anorexic. Likewise, the implications of existential

givens on the anorexic and her lived experience with the syndrome have not been examined. To date, studies have incorporated what can be deduced as existential givens (e.g., anguish, loneliness and isolation), but they do not explicitly state them as such (Pettersen et al., 2012). Therefore, it presents an existing gap in the literature that requires further examination. Likewise, the spiritual dimensions of AN and the anorexic have been proposed (e.g., Richards et al.., 2007), yet without rigorous exploration.

3.2.1 Study Objectives

The study seeks to bridge the existing literature and research in the area of meaning in life for women in remission and recovery from AN. Additionally, it seeks to examine the existential significance of remission and recovery for women with AN. The objectives of the study, therefore, are fourfold and seek to explore how women in remission and recovery from AN experience: (1) the presence of meaning; (2) the search for meaning; (3) meaning in life, and; (4) the existential givens and significance of recovery and remission. It will thereby be guided by the following four research questions:

1. How do women in recovery and remission from AN experience the presence of meaning?
2. How do women in recovery and remission from AN experience the search for meaning?
3. How do women in recovery and remission from AN experience meaning in life?
4. What are the existential givens and significance of recovery and remission for women with AN?

4 Methodology

4.1 Interpretative Phenomenological Analysis

As previously stated, the study sought to understand how women in recovery and remission from AN experience the presence of, and search for, meaning in life. Based on the

research objectives and questions specified above, an Interpretative Phenomenological Analysis (IPA; Smith, Flowers, Larkin, 2009) research design was employed. IPA is a qualitative research method concerned with understanding how people make sense of their life experiences (Smith et al., 2009) by viewing individuals as actively engaged in interpreting the events, objects, and people in their lives. Therefore, IPA aims to provide rich and nuanced insight into the experiences of research participants (Smith et al., 2009). IPA draws upon the fundamental principles of phenomenology, hermeneutics, and idiography (Smith et al., 2009).

4.1.1 Phenomenology. Phenomenological research is central to IPA research and is concerned with attending to the way things appear to individuals in experience (Creswell, 2013). In other words, IPA aims at identifying the fundamental components of phenomena or experiences, which make them unique or distinct from others (Tuffour, 2017). Phenomenological studies will, therefore, focus on how people perceive and talk about events, rather than describing phenomena according to a fixed categorical system, conceptual and scientific criteria (Smith et al., 2009). An important part of this involves the researcher 'bracketing' their preconceptions and allowing phenomena to speak for themselves (Creswell, 2013). For this reason, the present author will engage in a discussion with her research supervisor and bracket her preconceived notions and experiences of the phenomenon in question before engaging in data collection (see 4.4 for additional information, as well as 4.7).

4.1.2 Hermeneutics. Another central theoretical underpinning of IPA is hermeneutics, which is broadly defined as the art and science of interpretation or meaning (Henriksson, Friesen, & Saevi, 2012; Tuffour, 2017). In this context, meaning is considered fluid and continuously open to new insight, revision, interpretation, and reinterpretation (Henriksson et al., 2012). IPA research is also said to be involved in a 'double hermeneutic,' in which the researcher is engaged

in making sense of the participants' sense making (Smith et al., 2009). For this reason, the researcher assumes a central role in analysis and interpretation of the participants' experiences (Smith et al., 2009; Tuffour, 2017). Furthermore, the researcher intuitively sought to probe the surface meanings by reading in 'between the lines' for deeper interpretation (Finlay, 2011).

4.1.3 Idiographic. IPA is also considered fundamentally idiographic because it is committed to the detailed analysis of a phenomenon in question (Smith et al., 2009). For this reason, it takes great care of each case, providing detailed and nuanced analysis, appreciating each case on its own before moving to the general cross-case analysis for convergence and divergence between cases (Smith et al., 2009). Researchers are required to carefully follow this idiographic approach throughout the analytic process for a thorough detailed examination of the convergence and divergence between the participants' experiences (Smith & Osborn, 2008).

IPA is well-suited for the study, as it seeks to elicit detailed accounts and descriptions of women's experience of the presence of, and search for meaning in life. Furthermore, it is inherently phenomenological in nature, as it sought to explore participants' experience of AN and recovery, as well as the phenomenon in question. It is also rooted in an ideographical approach, as it seeks to illuminate women's relationship to the lifeworld (Smith et al., 2009). Finally, it is hermeneutical in nature as the research was engaged in interpreting the meaning of participants' experience, including a double hermeneutic with the researcher making sense of the participants' sense making (Smith et al., 2009).

4.2 Participants

The study focused on young women who received a diagnosis of AN and medically identified as being in remission and recovery, ranging between 18 and 35 years of age and independent of one's relational status. Age range was restricted to increase the homogeneity of

the sample, as previous research has suggested some differences between younger and older people with AN (e.g. Fox & Leung, 2009). Specifically, evidence suggests that existential considerations become more pertinent in life as individuals get older (e.g., Fox & Leung, 2009; Fry, 2000), so the study focused on women in adulthood with AN to elicit an increased understanding of this population.

The inclusion criteria for the study also required that women have received an official diagnosis of AN. The rationale for this measure was to elicit detailed accounts of women's experiences of receiving this diagnostic label from the medical and psychiatric community. Given that women with AN have described feeling pathologized because of the syndrome (Rich, 2006), the study sought to explore their experiences further in this regard and the meanings attached to it. The study also required women to be medically identified as being in remission and/or recovery from AN because it sought to explore their understanding of what constitutes this process, as well as their experiences of it. Moreover, it required exploration whether they identified with this external medical prognosis.

According to Smith and Osborn (2008), there is no correct answer to the specific question about what constitutes an appropriate sample size. A defining feature of IPA is its commitment to providing a detailed interpretative account of the cases involved in the study, so this often requires a small sample: "thus in simple terms one is sacrificing breadth for depth" (Smith & Osborn, 2008, p. 56). A qualitative sample size may be determined based on study objectives, available resources and allotted time (Patton, 1990; Smith & Osborn, 2008). Therefore, the study involved 5-6 participants (see section 4.4), which enabled a large enough sample to provide adequate data, richness and depth of participants accounts of anorexia and recovery, as well as the presence and search for meaning. Similarly, it allowed the present author to keep within the

practical time limitations of a doctoral research program. It also ensured an adequate sample should some attrition occur.

4.3 Recruitment

Participants were recruited through advertising: online research listings through the National Eating Disorder Information Centre (NEDIC), social media eating disorder support groups (e.g., Project brEAThe), as well as local community agencies such as Hopewell (e.g., a not-for-profit registered charitable organization and Eastern Ontario's only eating disorder support centre). The present author used posters to recruit participants (see Appendix D) and plans to make a written announcement about the study in hospitals (e.g., the Regional Centre for the Treatment of Eating Disorders at the Ottawa General Hospital, which receives both inpatient and outpatients). Additionally, the present author relied on snowballing sampling techniques to identify potential participants. Snowballing is a sampling strategy where study participants identify and recruit other subjects from among their own acquaintances and contacts (Creswell, 2013).

4.4 Data Collection and Measures

Given that the study sought to elicit detailed descriptions, thoughts, and feelings from women with AN, semi-structured interviews (see Appendix B for semi-structure interview schedule and three-interviews series; Seidman, 2006) was the primary method of data collection. Women with AN have expressed feeling alienated and isolated, so semi-structure interviews allowed the present author to create a rapport with participants, while also providing space for them to openly think, speak, and be heard (Smith et al., 2009). Semi-structure interviews, therefore, provided a context for women to speak outside the prevailing medical discourse (Lock, Epston, & Maisel, 2004) that "constructs the experience of AN as an illness and the antithesis of

this as recovery" (Conti, 2018, p. 75). Semi-structured interviews also allowed for probing, uncovering experiences, details, and depth (Creswell, 2013). Participants were also asked to complete a brief demographic information questionnaire (see Appendix A) prior to being interviewed. The interviews will be audiotaped and transcribed (Creswell, 2013).

4.4.1 Three-interview series. The study also implemented the three-interview series (Seidman, 2006), which is a model of in-depth, phenomenological interviewing that entails conducting a series of three separate interviews with each participant. According to Seidman (2006), "people's behavior becomes meaningful and understandable when placed in the context of their lives and the lives of those around them" (p. 16-17). Therefore, the three-interview series involves the following objectives and tasks: (1) the first interview (focused life history) establishes the context of the participants' experience; (2) the second interview (details of the experience) allows participants to reconstruct the details of their experience within the context in which it transpires, and; (3) the third interview (reflection on the meaning) assists the participants in reflecting on the meaning their experience holds for them (Schuman, 1982; Seidman, 2006).

4.4.2 Interview One (Focused Life History). In the first interview, the researcher sought to put the participant's experience in context by asking him or her to share, as much as possible, about him or herself considering the topic up to the present time (Seidman, 2006). For example, this often involves asking participants to reconstruct their early experiences in their families, in school, with friends, in their neighborhood, and at work. In the context of this study, this required participants to explore their history and onset of AN, as well as recovery and remission, in detail. That is, the present author inquired about participants' experience in their families, in school, and with their friends to provide context of what was happening at the time for them.

4.4.3 Interview Two (Details of the Experience). In the second interview, the task is to concentrate on the tangible details of the participants' present lived experience in the topic area of the study. The participant is, therefore, asked to reconstruct these details. More importantly, the participants are not asked for opinions, but instead about the details of their experience, upon which their opinions may be constructed (Seidman, 2006). As Seidman (2006), explains, the "task is to strive, however incompletely, to reconstruct the myriad details of our participants' experiences in the area we are studying" (p. 18). The participants in the study, for example, were asked to reconstruct a day amid their experience of AN from the moment they woke up to the time they fell asleep. Furthermore, they were asked for stories about their experience at home as a way of eliciting details.

4.4.4 Interview Three (Reflection on the Meaning). The third interview involved the present author asking participants to reflect on the meaning of their experience with attention given to the intellectual and emotional connections between the participants' work and life (Seidman, 2006). "Making sense or making meaning" as Seidman (2006) contends, "requires that the participants to look at how the factors in their lives interacted to bring them to their present situation" (p. 18). It also entails participants to examine their present experience in detail and within the context in which it occurs. Moreover, the combination of exploring the past to elucidate the events that led participants to where they are now, and describing the tangible details of their present experience, establishes the context for reflecting upon what they are presently doing in their lives (Seidman, 2006).

4.4.5 Length and Spacing of Interviews. To meet the objective of each of the three interviews, Seidman (2006) recommends adhering to a 90-minute format. Similarly, he explains that anything shorter than 90-minutes for each interview is too short, whereas anything beyond

90-minnutes (e.g., 2 hours) is too long. The 90-minute timeframe "gives unity to each interview; the interview has at least a chronological beginning, middle, and end" (Seidman, 2006, p. 20). Lastly, Seidman (2006) maintains that the three-interview structure works best when the researcher can space each interview from 3 days to a week apart. For the purpose of the study, the interviews were spaced 3 days apart to allow participants time to reflect on their experience and the previous interview without losing a connection between the two (Seidman, 2006). Similarly, it allowed the present researcher and participant to establish increased rapport.

The three-interview structure for data collection method was particularly fitting for the study because without adequate contextualization there is little possibility of exploring the meaning and significance of an experience (Patton, 1989). Moreover, a "one-shot meeting" with a participant whom the researcher has never met risks treading on "thin contextual ice" (Seidman, 2006, p. 17). As previously mentioned, AN is a complex syndrome with multiple etiological factors (see section 1.3) and a lengthy duration, so it is necessary to elicit rich and detailed contextual data from the participants to effectively explore the phenomenon in greater depth.

4.5 Data Interpretation

IPA generally provides a set of flexible guidelines that can be modified by individual researchers, according to their research objectives (Smith et al., 2009). In the context of the study, the initial stage involved a close reading (or listening to audio tapes) of the transcript several times to assist the present author in immersing herself in the data (Smith et al., 2009). At this initial stage, the present author made notes about her observations and reflections about the interview experience, including additional thoughts and comments of potential significance. The next stage involved transforming those notes into emergent themes, which was followed by

observing connections between emerging themes, grouping them together according to conceptual similarities and providing each cluster with a descriptive label (Smith et al., 2009). Finally, the careful analysis described above lead to writing a narrative account of the study (Smith et al., 2009).

4.6 Validation Process and Determining Reliability

In an attempt to further support the validity and quality of the results, the present author employed principles outlined by Lucy Yardley's (2000) criteria for validity, as recommended by other qualitative researchers (e.g., Heffron & Gil-Rodriguez, 2011; Smith, Flowers, & Larkin, 2009). Yardley's (2000) work presents a broad array of quality criteria that can be applied in a variety of qualitative studies, including in IPA (Smith, Flowers, & Larkin, 2009). Yardley (2000) details four principles for assessing the merits of qualitative work: (1) 'sensitivity to context,' in which the present author included a substantial number of verbatim extracts from the participants' material, thereby giving participants a voice in the current study; (2) 'commitment and rigour,' in which the present author attended closely to what the participant were saying that involved a careful balance between closeness and separateness, remaining consistent in probing and ascertaining important cues from the participant to dig deeper; (3) 'transparency and coherence,' in which the present author clearly described the stages of the research process, enhancing transparency by describing how the interview schedule was constructed and the interview conducted, as well as the steps involved in analysis, and finally; (4) 'impact and importance,' in which the present author sought and endeavoured to provide the reader with a piece of research that was interesting, important, and useful.

Smith and colleagues (2009), as well as Yardley's (2000) criterion were implemented to ensure the research in the current study is credible in terms of both technique and interpretation.

Moreover, to ensure that the findings are an accurate representation of a women's lived experiences in remission and recovery from AN, as well as the presence of, and search for, meaning and purpose in life. Further, several primary procedures were used. First, data triangulation allowed for the converging of different sources of information (e.g., 3 semi-structured interviews per participant spaced 3 days apart). According to Seidman (2013), arranging three separate interactions between the researcher and each participant augments the study's validity. As described earlier, each respective interview served a unique purpose, and as such, they yielded a specific and unique type of information. Secondly, member checking was used by getting the feedback from the participants on the accuracy of the identified superordinates and emergent themes.

The reliability of the coding process of the subset themes was established using the following steps: (1) Intercoding was done by the main researcher (i.e., present author) and one colleague, (2) Intercoding was done on 10% of the transcripts. The intercoder was chosen as a text evaluator (external audit) based on her experience as a researcher, psychotherapist, and her knowledge of qualitative research analysis. She was involved with Saint Paul University in a research capacity while completing her Master of Arts in Counselling, and Spirituality. The first intercoder reliability index was 90%. After the text evaluation, the intercoder reliability reached 100%, which is higher than the minimum of 70% recommended by (Lombard, Snyder-Dutch & Bracken, 2002). Researcher bias was also reduced using bracketing and disclosure of the present author's orientation, values, expectations, and assumptions (Sousa, 2014), described in the next subsection.

4.7 Reflexivity and Personal Disclosure

As the analytic process of IPA is inherently interpretative, reflexivity is needed on behalf of the researcher (Smith et al., 2009). As the primary analyst, the present author constantly reviewed her expectations and interpretation of the data, monitoring their impact and noting how the analytic findings altered them. The present author acknowledges her role as a female registered psychotherapist (RP), recovered from an eating disorder service and how her own experiences of treatment have the potential to influence the interpretation and analysis of data (e.g., assuming that weight restoration is beneficial, but not the only answer for treatment and recovery). An example of reflexivity, when this assumption was apparent, the transcript was re-analysed so exceptions could be explored.

Transparency with respect to personal values and beliefs is important for researchers following an IPA framework (Smith et al., 2009). Within the domains of spirituality and mental health, the importance of this transparency is essential because it can be particularly difficult to remain objective when the issues of interest are linked to the researcher's core values and beliefs (Pargament & Exline, 2022). Therefore, this section will describe personal views and experiences of the present author. I am a white 33-year-old female, who grew up in a middle-class, rural home in Ontario, Canada. I was raised in the Catholic faith and have decided to continue holding Catholic values and beliefs as an adult. My interest in EDs, meaning-making and spirituality, as well as the remission and recovery process is resultant from my own history of BN.

Prior to my Master's in Counselling and Spirituality at Saint Paul University, my undergraduate degree in theology established my strong commitment to pursue theological studies in a way that would enhance my ability to help others in need of spiritual and

psychological counselling. My training in religious studies facilitated the exploration of divinity and faith, and similarly enriched my understanding of how spiritual and religious beliefs can be used within the context of healing. My genuine interest in studying spirituality and religion naturally progressed into the field of counselling and psychotherapy and the Master of Arts in Counselling and Spirituality, whereby I received clinical training and competencies in the subsequent areas: (1) conceptualization and assessments skills; (2) skills of self-awareness and self-reflection; (3) development and maintenance of the therapeutic alliance; (4) spiritual, social, cultural and religious dimensions into the therapeutic process. Through a series of inpatient and outpatient treatment, as well as opportunities to hear the personal accounts of other women, who have suffered from an ED such as BN, I developed an initial understanding of the complexity inherent in relapse, remission, and recovery responses and journeys toward resolution.

4.8 Research Permission and Ethical Considerations

Participant consent will be obtained prior to data collection, according to the regulations of the university's Research Ethics Board. A consent form prepared by the present author and approved by the Saint Paul University's Ethics Committee will be used for this purpose (see Appendix C). Participants will be asked to complete a brief demographic information questionnaire (see Appendix A) prior to being interviewed. The interviews will be held in person at participant work locations or in rooms at Saint Paul University Counselling and Psychotherapy Centre, depending on participant preference, at a prearranged time most convenient for them.

Interviews will be audiotaped and transcribed. The anonymity of participants will also be protected by numerically coding each returned questionnaire and keeping the responses confidential. The final report and findings section does not include any identifying information and participants are referred to using pseudonyms, which were chosen by the participants

themselves. All study data, including the completed questionnaires, interview tapes, and transcripts, will be kept in locked in a file cabinet in the researcher's office. Given the sensitive nature of the AN, the researcher will provide participants with a list of available resources if they require additional support.

5. Findings

This section presents the findings, which are the superordinate themes and subsequent subsets that correspond to "clearly related other themes" abstracted via subsumption that developed from the Interpretative Phenomenological Analysis (Smith et al., 2009, p.97; see Appendix E, as well as Appendix F). The present author intentionally uses the word findings, as this is in the present tense. In contrast, the word results in research suggests the final outcome or consequence of a sequence of actions. The underlying quality of the IPA researcher are "open-mindfulness; flexibility patience; empathy, and the willingness to enter into, and respond to, the participant's world" (Smith et al., 2009, p. 55). Therefore, this section states the findings of the IPA researcher's investigation, which is particularly necessary since the study included data generated from the present author's own research with the participants. Furthermore, it conveys the present author's willingness to enter into, and respond to the participant's world in a curious, present, and active manner.

The presentation of the findings is an integration of description and interpretation, which is proposed by the IPA methodology and divided into two parts. Part 1 introduces the reader to each of the five participants. The focus of this section is to delve into the phenomenological core of their experience as it relates to each of the seven superordinate themes:

1) Diagnosis of Anorexia

2) Experience of Anorexia

3) Anorexia Treatment Process

4) Experience of Remission and Recovery Process

5) Metaphors for Anorexia, Remission and/or Recovery Process

6) Spirituality

7) Meaning-Making Process and Sense of Purpose

In Part 1, some of the subsets are named in parentheses as they are referenced.

5.1. Part 1: Individual Participant Experiences.

As a first step in presenting the findings of this research, the present author would like to introduce the reader to the research participants: (1) Liesel/POM01ML; (2) Lotus/POM02YM; (3) Rose/POM03LT; (4) Stephanie/POM04BR); (5) Geraldine/POM05BS, including how the present author explored the concerns and lifeworld's of each participant (Smith et al., 2009). There will be a general introduction and description for each participant's diagnosis of anorexia and experience of it. Subsequently, the present author will present each participant's experience of the seven superordinate themes that emerged from the interviews. In addition, the findings for each superordinate will focus on the phenomenological core of the participant's experience of that superordinate theme as opposed to focusing on covering all of the themes that emerged across all the participants (e.g., see Appendix F for the emergent themes).

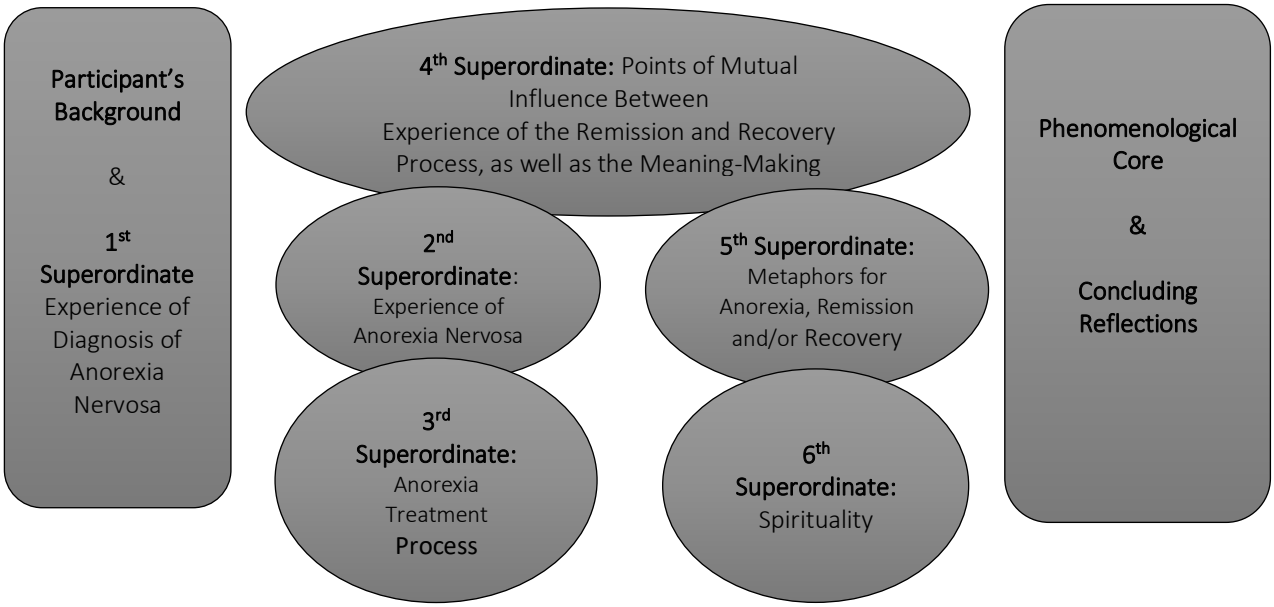
The first superordinate theme presented will be the participant's experience of the diagnosis of AN. The points of mutual influence between participant's experiences of AN are introduced in conjunction with their experience of the remission and recovery process, as well as their meaning-making process/sense of purpose; however, elements related to this superordinate theme will also be referenced throughout the rest of the account of the results for a given

participant. The following subsection will reflect the latter superordinate's, focusing on the participants' metaphors for anorexia, remission and/or recovery process, as well as spirituality.

Many of the participants' experiences and recommendations for the recovery process will be covered in section 5.2 of the findings, as well as in the discussion and in the conclusion. The phenomenological core of each participant's remission and recovery experience appeared to inform specific unique recommendations, a connection that should be acknowledged. Therefore, the discussion of their remission and recovery process, accompanied by their meaning-making and sense of purpose will be intertwined with a presentation of their recommendations. See Figure 1 for a visual representation of the layout.

Figure 1

Layout of the Presentation of Superordinate Themes in Part 1 of the Findings



Note. This format will be repeated for each participant.

Although the participants' diagnosis and experience of AN in and of itself does not address the research questions, it has been integrated at the beginning of each participant's

introduction for several reasons. Firstly, asking the participants about their experience of AN at the beginning of each interview set the tone for the interviews; namely, it was a manner to convey the message that the present author truly wanted to understand where the participants were coming from. The time spent exploring some of the nuances of their diagnosis and experience of AN indicated that the present author was willing to take the time to examine their experience and what was significant about it. Accordingly, this approach allowed the present author to genuinely become attuned and acquainted with the participants and may have permitted the participants to build some trust; as the present author was open and attentive in non-judgmentally receiving their experience of AN, the present author would do the same with their experience of remission and recovery. Remission and recovery, as well as relapse from an ED are topics, which are often accompanied by concerns about judgment or divided views. Therefore, as recommended by Griffith (2010), it was important to demonstrate respect for, and desire to understand, the participants' experience.

In summary, as an interviewer, the present author strived to approach each participant with open curiosity to build rapport, understanding, and context that would allow the present author to receive the rest of the participant's story and experience. As each participant is presented, the reader is invited to engage in a parallel process: to be open and curious in learning about the experiences of each participant, to meet them as a person with whom one can develop a rapport as they tell their story through me, the present author. Accordingly, readers can engage in a form of active listening, to focus first on understanding and encountering the participants rather than beginning to categorize their comments or determining whether to agree or disagree with what they are saying. Employing a mindset of active listening to the reading of these findings is a meaningful way to respect the courageous vulnerability of these participants.

The participants themselves resonated with the underlying principles of openness, curiosity, active listening and building rapport with the present author, as they raised the importance of understanding the complexity and lived experience of AN, as well as coping and identity (see Table 2). Accordingly, presenting each participant one at a time is the present author's effort to follow the participants' insights, as well as an invitation for the reader to engage in an encounter with the lived experiences presented here. The subsumption aspect of the analytic process is similar to abstraction, whereby "an emergent theme itself acquires a super-ordinate status as it helps bring together a series of related themes" referred to as subsets (Smith et al., 2009, p. 97). In this research and the subsequent findings, 'Experience of Anorexia Nervosa' became a superordinate theme and brings together a series of clearly related other subset themes (e.g., see Appendix E, and/or as conveyed in Figure 1; it is the 2nd superordinate theme [Experience of Anorexia Nervosa], accompanied by the subsets [AN as a coping mechanism […] AN as an identity]).

Table 2

Subsets: The complexity and lived experience of AN, as well as coping and identity

Participant	Quotations
Liesel	I would say for sure that once I started getting in my eating disorder like it was pretty all consuming in terms of like my focus. Like, and it went on for like at least a year before anyone really noticed I think that something was wrong. I'm just like…that is sick thinking…that really is the eating disorder taking over. I think the eating disorder in a way is like…it's a coping mechanism for this kind of out-of-control stuff that was happening with my health.
Lotus	So, I think I just internalized it, and turned it into, "I can control food that's the only thing I can control, and no one can take that away from me." I mean the fact that when you're in the hospital they basically…it's almost like…it felt like a jail to me […] Because they took all my coping skills and devices – whether unhealthy or not – away from me at the time […] There was a lot of questions in relation to the identity issue like, I didn't know who I was at that point. I mean, who was I without anorexia…who was I without being emaciated? I just didn't know who I was.

Rose	At first, I was in denial […] I was just like, "That's ridiculous, that's not me." And then when I…I was like, "Oh yeah, you're right." Um (*pauses*) […] Yeah…I think because it like (*grabs tissue*), I guess like, very childish. Like, weak. I was like, "Who has this at 28?" So, that's what it felt like (*tearful/stops*). I try like, now I kind of have like, coping mechanisms […] Yeah, because I think that that's a *significant* difference. Was that at the time it felt like, it was part of my identity.
Stephanie	Um, and I just felt, really, really low. Like emotionally speaking and very heavy and I wasn't at a place, um, in my life where I was really good at coping with heavy emotions. Yeah, I feel like before it used to be like, "I am my eating disorder, its's a part of me." And now I just see it as this…I don't know. It's like, it's a separate person that…that's there too, you know? (*pauses*).
Geraldine	I *loved* my eating disorder. Um, and I *miss* it. It is like a relationship. And it was *so* – in my mind when I had it – it was *so* supportive. It felt so supportive, it felt like my *only* (*pause/stops*). It felt like a person, you know. It was the only person that I could turn to. It was my coping mechanism for life. It was (*stops*).

Note. This subset theme will be further explored in section 5.2 of the findings

Liesel – POM01ML

Participant's Background and 1st Superordinate: Experience of Diagnosis of Anorexia Nervosa. Liesel is a married female in her early 30s, who was pregnant at the time of the interviews. She was born and raised in the province of Ontario in a religious and spiritual context. At approximately 20-years old, Liesel received a diagnosis for an autoimmune disease (i.e., ulcerative colitis) while she was a student at university. This participant chose the pseudonym Liesel, which is an abbreviation for her name. The name Liesel is primarily a female name of German origin, which is known from Liesel Von Trapp (e.g., who is a character from the musical "Sound of Music"). Liesel described the initial diagnosis of ulcerative colitis as a "relief" after receiving it (superordinate [1. Diagnosis of Anorexia Nervosa] under the subset 1.d. ambivalence about anorexia due to colitis, e.g., see Appendix E), and making the insight by her own admission that:

> Things still weren't that bad with my eating disorder when I first got my diagnosis, it was more like, just dealing with managing [colitis]. The only thing I can maybe think about is going away to university might have been a bit triggering […] things still weren't that bad with my eating disorder when I first got my diagnosis (e.g., with colitis).

She also refers back to her experience, accompanied by the complexity of receiving a clinical diagnosis of AN along with the ED symptoms. Although she used and put an emphasis on the past tense regarding AN, she disclosed: "I liked…I *liked* getting skinner…like, I *liked* losing weight, and I…I felt like I was, I guess, I thought I looked good at the time, or almost like…like I knew I looked kind of sick, but I was like, ok…I liked it…." In addition to "liking" symptoms of weight loss (superordinate [1. Diagnosis of Anorexia] under the subset 1.a.2. Maintenance Factors), Liesel seemingly minimized the initial diagnosis of AN, wherein she used humour and laughed about the potential severity of AN:

> So, I went to the [hospital] and…you know, you just go in first for your evaluation or whatever. I saw [the psychiatrist] who runs it, and um, so I got accepted. They said, "For sure," like, "You need to be accepted." I didn't have to go into inpatient, thankfully. But I wasn't like, dying or anything. Like, I was never…my…*my* rock bottom would not have been a lot of what other peoples were. I certainly wasn't in like organ failure or anything (*laughs*). I was still like living my life, like I mean, I was you know…kind of messed up, but I wasn't like, I wasn't someone who was on like, deaths doorstep or anything like that.

Schnackenberg (2016) refers to the inhibiting, and perhaps insensitive, nature that diagnostic labels can have on women with AN. In a corresponding manner, Zerbe (2001) also highlights this notion, stating that "behind every symptom of disordered eating lies a story that is

longing to be told" (p. 305). For this reason, the present author intentionally referred to clinical diagnosis from AN (i.e., no significant disturbance in eating or weight control behaviours or body image disturbance, etc.), while also giving particular attention to indicators of Liesel's personal experience of receiving a clinical diagnosis of AN and personal recovery.

2nd Superordinate: Experience of Anorexia Nervosa. Given the complexity of Liesel's initial diagnosis and experience with ulcerative colitis (e.g., finding the correct medication), Liesel explained that "[anorexia] was some sort of coping mechanism it became definitely as big as a problem as the colitis" (superordinate [Experience with Anorexia Nervosa] under the subset [2. Anorexia as a …] 2. a. Coping mechanism). More specifically, she explained, "I think the eating disorder in a way is like…it's a coping mechanism for this kind of out-of-control stuff that was happening with my health" In addition, Liesel disclosed, "I would say for sure that once I started getting in my eating disorder like it was pretty all consuming in terms of like my focus" (subset 2. a. Coping mechanism). After becoming malnourished from severe weight loss related to both anorexia and colitis, she explained that her parents insisted she move back home.

3rd Superordinate: Anorexia Treatment Process. Although she saw a therapist and her family physician, she received a referral and admittance to the Eating Disorder Clinic of a major hospital. Liesel asserted that she considered her family physician a "good doctor […] she wasn't very compassionate," asserting that "I don't think she really understood [anorexia] I don't think doctors have a lot of training" (superordinate [Anorexia Treatment Process] under subset 3. a. Beginning and nuanced with subset 3. b. Development of Eating Disorders and Difficulties with Current Treatment for Anorexia[1]).

[1] The present author intentionally integrated the appropriate and applicable subsets to assist the reading in understanding the participant's experience for the present and resultant superordinate [3. Anorexia Treatment

Liesel spoke of remission and recovery from anorexia nervosa as a process of fluidity and continuity wherein "something shifted for [her]." The manner in which she spoke of anorexia demonstrated its usage as a "coping mechanism," including how recovery was a gradual process:

> I don't know…the start of my *real* recovery. Like, I had a gradual like, recovery in terms of like, restoring weight and not restricting, not doing the restrictive behaviours, not doing the fitness type stuff, although still was really into yoga, but you know, it was a very gradual process [..]" [2]

With additional exploration, she shared that with recovery; "Honestly, my life was…*all* parts of my life were getting *a lot* better once I stopped having this obsession with [anorexia]." Liesel also asserted how her recovery was an internal process: "It was all internal, self motivated. Like my recovery…that's really how it was." For deeper reflection concerning the notion of "*real*" recovery, I asked Liesel for further clarification, and she shared until one has "some sort of realization," and it is "completely internally motivated […] Just because you have to want it for yourself" is genuine recovery. In her explanation, she alludes to the notion of building and having an internal sense of self in relation to recovery (superordinate [Experience of Remission and Recovery Process] under subset 4. b. 5. Attaining a sense of internal control and agency in ongoing recovery process).

As we shall see, the participants, including Liesel, used the language of recovery as a "shift," inferring the fluidity of the remission and recovery process from AN. More expressly,

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Process]. This will remain consistent throughout the remainder of the thesis with participants' superordinates and accompanying subsets to assist the reader in having the necessary and applicable information.

[2] The word '*real*' is italicized since the participant put emphasis on it during the interview. Words italicized and/or underlined are representative of both the emphasis and tonality. This will remain consistent throughout the remainder of the thesis with participants, who placed emphasis on certain words and tonality.

the findings of the participants convey how to be 'recovered' from AN is neither a finite nor limited experience; namely, a person is not perpetually well or ill, either healthy or unhealthy, etc. Therefore, it is more helpful to analyze in fluidity, transition, and journeys rather than the absolute of recovery from AN. Liesel voiced how the remission and recovery process is on a spectrum and part of a "paradigm" shift, and each experience will be distinct for participants and at different times (superordinate [4. Experience of Remission and Recovery Process] under subset 4. b. continuum):

> I get, like it does do something, it will shift something in you, at least the addiction part of it…the competitive part of it, like, all these aspects of the eating disorder that are like, mind…like you know, mind stuff […]. So, once you actually…change that, and you try to eliminate that, and you know, saturate yourself in actually positive messages and like, you know, kind of understanding where all this…this thinking about our bodies 'being wrong' in the first place comes from, then that's…it's like, it's like changing the paradigm completely.

In keeping with this language, Liesel's recovery process could be characterized as a shift in paradigm. As identified by American philosopher, Thomas Kuhn, the term paradigm shift refers to a significant transformation in the worldview, concepts, and practices of how something works or is accomplished (Eshel, 2017).

The shift from remission and recovery process, was a process of meaning-making and developing a sense of purpose, which led to Liesel feeling a sense of "freedom." Despite recovery being a process of fluidity and continuity, as well as a paradigm shift, the experience of AN was very time-consuming and "taking up a lot of [her] time":

> I think, yeah, like, recovery and meaning and all that it's more like, it was like, the door I had to go through to actually *live* my life, you know? […] I wasn't really…I don't feel like, I mean, obviously I was living and all that, but I don't feel like I was really *living* like…like, my *life* before I was in…got to recovery.

The resultant experience of the recovery process assisted Liesel in attaining a sense of internal control and agency (subset 4. b. 5. Attaining a sense of internal control and agency in ongoing recovery process), as she felt "very directionless" and "[she] didn't have a really good self-awareness at that time" in the midst of grappling with AN. During the recovery process, she developed increased self-awareness and sense of direction and purpose (superordinate [6. Meaning-making Process and Sense of Purpose] under subset 6. c. Developed from Remission and recovery):

> I've become aware and I'm like, "Ah that's silly." Like, realistically it's like, what kind of…how do I want to live? […] It's like, I don't want to have a life where I can't have a brownie whenever I want. I just don't want my life to be like that […] The *real* meaning that I got from recovery was just actually being free and just being like…just feeling like I could just *live* my *life* and not be restricted by this…thing that was taking over my life. It just feels like, what I like about (pauses) life in recovery is just like, every day I'm just living in *my life*

Liesel put an emphasis on living her life, implying an internal sense of personal internal agency and "*real* meaning" she experienced from "living [her] life" (4. b. 5. Attaining a sense of internal control and agency in ongoing recovery process).

4th Superordinate: Points of Mutual Influence between Experience of the Remission and Recovery Process, as well as the Meaning-Making Process/Sense of Purpose. The

present author used open-ended questioning to elicit deeper reflection from Liesel about her experience of receiving a clinical diagnosis of AN. Liesel explained that: "Once I started getting in my eating disorder like it was pretty all consuming in terms of like my focus […]" (superordinate [Experience with Anorexia Nervosa] under the subset 2. a. Cognitions). She expanded upon this response, disclosing that family and friends did not perceive anything was abnormal about her initial and ongoing weight loss given her diagnosis of ulcerative colitis: "I remember like them being kind of like, "Ok, you're losing weight, like, you're getting a bit thin," but aside from that there was never much of a concern I would say."

5th Superordinate: Metaphors for Anorexia, Remission and/or Recovery. During the interview processing, the present author inquired if words or metaphors came to mind for Liesel when she thinks about remission or recovery. Metaphors are intended to convey a different meaning than the literal meaning of the word or phrases. More specifically, a metaphor is a figure of speech including an implied comparison, in which Liesel acknowledged (subset 7.e. Mindfulness):

> Yeah, being outside of your self. Like, really, I don't know how else to word it, but yeah, like, um, (*stops*). Yeah, if you can remove yourself from your thinking as much as possible and that's not to say you're not thinking from your *own* perspective and you're not like, taking care of yourself […] Your willfulness about yourself. Like, *other things*, you know? That was important *for me*. And its not something like, I actively even think about or anything. Just…it just is (*stops*) becomes part of who you are. […] Like, being able to be present (*pauses*). Not really metaphors, but just like, getting out of yourself, and being so much in yourself kind of being present, being in the world and the situation. I think acceptance is a big piece of it. *For me* […] it's changing the paradigm completely.

Although Liesel was unable to identify a metaphor, she identifies the significance of acceptance and having an eternal locus of control for the remission and recovery process.

6th Superordinate: Spirituality. The emphasis on authentic/genuine meaning conveys how Liesel's increased self-awareness as a person or agent, who was capable of having influence over her own motives, behaviours, and possibilities (subset 4. b. 6. Self-awareness, as well as 4. f. self-awareness). Liesel echoed and referred to the significance of acceptance in the present moment (superordinate [Spirituality] under subset 7.e. Mindfulness):

> Well, I think, honestly, before recovery and maybe always I've had this, this like…this feeling of like, you need to have concrete…purpose and direction in everything. And I honestly think the big thing of recovery has taught me is just accepting things as they are […] I feel like, just being present in my life is…for me, is enough of a purpose.

Although Liesel had difficulty describing spirituality, the notion of acceptance, self-awareness, and transparency have been beneficial parts of her experience of recovery and healing from AN: "It's been much more just getting in touch with myself in certain ways and just like…getting real with myself. Just acceptance." While she was concerned that she did not define spirituality clearly, she does recognize its presence in her life (superordinate [Spirituality]):

> I'm trying to think if there is anything more about spirituality, but…because I'm not closed off to it, you know. I'm not like, uh (*pauses*). I'm not like, I…it's…I don't think of myself as a person who's not spiritual because it doesn't really feel true […] I do think though that there are like, as I said, some universal principles that do apply. So, yeah. I mean, I don't know, I wish I could have defined or given you a better explanation of spirituality…

The construct of spirituality has been studied in a variety of methods including meaning in life (Bloch et al., 2017), purpose, and spiritual coping (Charzynska, 2015).

> It's more just like…starting to be more present in life. Just like, being present in what you're doing, and I mean, it's not perfect, you're not like this perfect Zen person, but it's just like, yeah, just this lack of mental distraction that I used to have.

Liesel's emphasis on acceptance parallels mindful acceptance (Kelley et al., 2017; subset 7.e. Mindfulness), whereby mindfulness practice can enhance self-awareness and spiritual well-being (Kristeller & Jordan, 2018).

Phenomenological Core of Liesel. The phenomenological core of Liesel's experience of the remission and recovery from AN is captured in the following words: acceptance, authenticity, and paradigm shift. As previously noted, the core of Liesel's experience involved self-motivation, "trying to hold [herself] accountable," acceptance, as well as redirecting her sense of purpose. Liesel expressed having cognitive distortions such as catastrophizing ("all-or-nothing") thinking that accompanied her experience of anorexia, including how that shifted in recovery:

> It's *very* disproportionate like, your thinking and everything, it is all-or-nothing thinking. So, *everything* is black and white. *Everything* is life or death. *Everything* is like, the worst thing or the best thing. Um, so, totally. It's totally like, that whole perspective that you get in, in recovery, you know? Like, it's just like, yeah. "This isn't actually that big of a deal."

In this sense, the notion of acceptance and shifting her paradigm were significant aspects of her recovery.

Concluding Reflections from Liesel. Although this was the "first time that [she] had ever really thought about [the remission, recovery, and meaning-making process from AN]" Liesel provided many insightful comments regarding details about her healing process, accompanied by aspects that assist in this process. In various ways, Liesel's experience of AN had given her awareness, in which she was able to view matters through a more "critical lens." As previously stated, she felt there were some practical aspects about her family physician and the treatment program in the hospital; however, she also expressed some inadequacies:

> That was just like, self-directed, self-motivated. No one told me to do that, and that was just kind of stuff I got interested in and sort of just…helped me, but it definitely wasn't part of any formal like, therapy, or program I was ever in. It was just something that…clicked, it just clicked for me. It made sense. Um, and I think, I *always* think, well for most people, if they probably really educated themselves about that it would help a lot

Accordingly, she identified the significant components of acceptance, self-awareness, inner agency, accompanied by redirecting her sense of purpose (superordinate [Meaning-making Process and Sense of Purpose] under subset 6. c. Developed from remission and recovery). In addition, she reflected how this was the first time she had shared and reflected on her experience of remission and recovery from AN:

> Um (*pauses*). I don't…I don't think I could really add anything because I don't even know like, even in just articulating it…it's the first time I've even really thought about it, so I don't really have anything like, planned that I wanted to say […] I don't think that program is super amazing […] I couldn't strongly recommend it. I would recommend the inpatient if someone's like dying […] I don't think I really got better from being in that

> program […] my experience was just…it was just basically focused on food still […] I don't even think I really saw anyone other than dietitians.

In the context of Liesel's concluding remarks and reflection, it conveys how AN and EDs continue to have remaining stigmas associated with it. There remains a lack of adequate treatment for people with eating disorders, both within hospitals and for the longer duration in community-based care (Brambilla et al., 2014; Coelho et al., 2021).

Lotus – POM02YM

Participant's Background and 1st Superordinate: Experience of Diagnosis of Anorexia Nervosa. Lotus is a single woman in her mid 20s, who has an Arabic ethnic and cultural background. She was born and raised in the province of Ontario within a spiritual context, but not part of an organized religion. This participant chose the pseudonym Lotus, which she explained is a flower and a "huge symbol of recovery" as it "blossoms in darkness underground and spreads out." She shared that if she were to have a daughter, she would give her that name. Although, by her own admission, she was careful about approaching this research project, as she opened up, she came across as open, reflective, insightful, and authentic. More specifically, Lotus disclosed how she experienced emotional and psychological abuse during her upbringing at home, as well as in school: "I think for like, as long as I can remember, I felt a lot of anxiety. So, there's quite a lot of anxiety…and I think part of it was feeling like I didn't have control around the things that were happening to me or around me" (subset 1.c. events at the time of diagnosis of Anorexia).

Given the key principles of phenomenological psychology are peoples' subjective experiences and the meanings they ascribe to their lived world and how they relate to it (Langdridge, 2007), the present author softened her tone during interviews and reminded Lotus

the interview process (i.e., a phenomenological approach) permits her voice to be heard in a safe and nonjudgmental manner by the present author, including how her participation was voluntary that there were no consequences for withdrawing from the study at any time.

Lotus received an official diagnosis of AN while she was an inpatient at a hospital as an adolescent during her mid-teenaged years. She described the initial diagnosis of AN as difficult to comprehend, accompanied by denial after receiving it, disclosing the insight that:

> And when I was diagnosed, I mean, I think I thought at that time…I didn't really understand what an eating disorder even meant like, anorexia. And so, when they told me you know, you have this diagnosis I was like, "No, I don't." […] It just didn't make sense […] I hated it.

Prior to the formal diagnosis of AN, Lotus explained that she "struggled on her own," in which she remained "secretive" about the onset of her symptoms (subset 1.b. diagnosis and initial experience of anorexia). Lotus described her familial situation as "chaos" during that time, unveiling the perception that:

> Initially, my parents thought I had another disease like cancer or something and then when they found out my (*pauses*)…I remember the day we were all sitting around the table with the doctors and when the doctors told my parents about it…I remember my Mom and my Dad crying and I couldn't really connect […] I didn't want them there, so every time they would come to visit me at the hospital I would make it as quick I as I could, so that they would leave….I just…ugh…it was so…ugh (*sighs*)…now that I think about it….it's kind of like…my secret was exposed? And it felt awful.

The present author reflected on Lotus' difficulty accepting the initial diagnosis, as she mentioned a component of secrecy with her official diagnosis: "I didn't want that taken away from me. It

felt like once people found out about it…it was like…not a secret and people had the chance to take it away from now…. like everything else in my life. That's how I felt at the time" (subset 1.d. Impact of diagnosis, as well as subset 2. a. Coping mechanism).

2nd Superordinate: Experience of Anorexia Nervosa. Lotus also described her upbringing as "pretty lonely" (subset 1.b. diagnosis and initial experience of anorexia). Additionally, she described, "hating" her initial diagnosis of AN. She also spoke in the past tense, in which she described how she felt at the time of her initial diagnosis of AN: "I hated it. I mean, I didn't want that taken away from me. It felt like once people found out about it…it was like…not a secret and people had the chance to take it away from now…. like everything else in my life. That's how I felt at the time."

Given Lotus' use of the past tense, the present author asked what it is like for her to reflect on the experience of her former diagnosis of AN now in the present. Lotus reflected: "It's irrational. I just see it as…I cannot…I do understand why I was doing that, but at the same time, I …it's hard for me to imagine that I would do it again. Yeah" (subset 2. d. Experience and Effects of Anorexic-Self). The present author used additional open-ended questions with curiosity, asking Lotus about what she perceived was being taken away from her., whereby she explained: "I mean the fact that when you're in the hospital they basically…it's almost like…it felt like a jail to me" (subset 3. a. Development of Eating Disorders and Difficulties with Current Treatment for Anorexia).

3rd Superordinate: Anorexia Treatment Process. The notion of feeling imprisoned in the hospital and resultant treatment had the present author use additional open-ended questions and reflection with Lotus. In particular, the present author asked what Lotus felt was being taken away from her for additional clarification:

> Because they took all my coping skills and devices – whether unhealthy or not – away from me at the time. And I just could not fathom the idea of that. I just…hated it. I didn't want to be there […] The control that I had over food….and my weight. I mean, I didn't want to be force fed. I didn't want any of that. I just wanted to be back in my own world…alone in it.

Lotus further expanded on the notion of how she felt a sense of control, derived from how AN was utilized as a coping mechanism (subset 2.a. Coping mechanism). For this reason, the present author reflected back the notion of how Lotus felt she was taken out of her own world upon receiving the diagnosis, in which Lotus shared how AN had become an entity at the time: "It was like…my best friend, but it wasn't really my best friend now that I think about it. That's how it felt" (subset 2.b. Entity).

The present author asked questionings in the present tense for additional clarification and exploration of Lotus' lived experience with AN, as well as remission and recovery. In particular, the present author asked how Lotus would describe her initial experience with remission until the present time:

> I never thought I would be where I am now to be honest. I thought I would be a rotating patient…in and out, in and out, like I was before. For the first, I would say, 6 months, that I went into remission/recovery, I had a lot of doubts…obviously it was ups and downs as well…it's not linear.

Lotus echoes how the remission and recovery process is neither linear nor stagnant. Recovery from AN is not a specific or unambiguous process, but rather she highlights how it is a journey of "ups and downs," achievements and setbacks, stagnation, and progress (Bohrer et al., 2020; LaMarre & Rice, 2021). Lotus' expansion of her experience proceeded to illuminate possibilities

for navigating recoveries from AN and EDs in their full intricacy and multiplicity (superordinate [Experience of Remission and Recovery Process] and subset 4. A. Ongoing Remission, as well as subset 4. B. Self and Recovery-Self (transforming)). Furthermore, Lotus touched on how there is a need for more complexity and flexibility in understandings of the timelines, processes, endpoints, and versions of remission and recovery from AN:

> Anorexia was kind of like a love-hate relationship. Remission is more (*pauses*) confusion to me. I don't know how to describe it because you're in this state when you're not active in the eating disorder anymore, but then you still have those memories and thoughts that come up once and while, so it's distance, but I don't know, it's not…it's not love or hate for me at this point […] I don't know…if with time it just gets better and it just becomes neutral, but right now it's not love or hate […] It's a lot more peaceful I have to say (*laughs*) […] I guess with remission, I just found myself being able to be a compassionate person that I am.

Intertwined in her response and reflection, Lotus conveys how AN recovery is a dynamic, and neither a non-linear nor rigid process (subset 4. A. Ongoing Remission, as well as subset 4. B. Self and Recovery-Self (transforming)).

Lotus also revealed how remission from AN assisted in her capacity to be a more compassionate person, "who [she] is" (4. B. Self and Recovery-Self (transforming)). The present author reflected how Lotus identified her difficulty with connection in the midst of AN; subsequently, she asked how she would describe connection in relation to remission for herself:

> One thing that I definitely do realize – that I've noticed over the past two years – is that I have become so much more compassionate and understanding. Not just other people, but myself. Like, I know what I need at certain points. I think for a lot of people who struggle

> with eating disorders, when you're in the depth of it, with that…it's not purposeful, you don't do it on purpose, but you kind of just isolate yourself and not…you seem to be too self-concerned about yourself and not others around you.

Lotus naturally incorporated the notion of purpose in her response (superordinate [6. Meaning Making Process and Sense of Purpose] and subset 6. C. Impact of Sense of meaning and purpose with Anorexia), so the present author inquired if she had noticed any changes in what gives her a sense of purpose since she was first diagnosed with AN and now in the present moment, whereby Lotus replied:

> Um, I just feel like I have things to do. I still have things to do now, while before I just felt like this life (*inaudible*)…it was just all about controlling what I ate and what I didn't eat. And…I guess now, it's just, I feel like I have something to do on Earth. Sometimes I don't know what it is. Deep inside I know something…something I need to do…there is something I need to do now […] Yeah, I felt like there was so much emptiness way back then. Now that I think about it, it's just… and it's funny though because like, my eating consumed every part of me, and I still felt so empty.

Inner emptiness comes from a lack of connection with our authentic selves (Smith, 2021), so Lotus seemingly depended on AN with the intent of feeling occupied and fulfilled. Nevertheless, she also reflected on the satirical nature of her reliance on AN (i.e., feeling depleted and without gratification or satiety with AN), including how remission assisted her shifting her attention and focus inward (subset 6. D. Impact of Sense of meaning and purpose, nuanced with subset 6. E. Remission and Meaning-making process):

> I was just constantly feeling lonely and empty. And that's the difference now is that I can actually be around people and feel like I'm whole, like I have people surrounding me.

> Even when I'm on my own now. I live alone, so to me, I actually love it. […] I like it now because I'm friends with myself now.

4th Superordinate: Points of Mutual Influence between Experience of the Remission and Recovery Process, as well as the Meaning-Making Process/Sense of Purpose. Lotus explained that she had a strained familial situation, particularly towards her mother: "I wasn't really close with my family to begin with and now that they know something about me…especially my mom…I felt like I had a weak point." In addition, she revealed that "I mean, my Mom (*pauses*) um…was pretty abusive…physically and emotionally…psychologically kind of thing […] My Mom just… didn't like me…she still doesn't, but you know…" According to the looking-glass self-hypothesis (LGSH), people's self-representations (SR) develop from interactions with significant others, reflecting associations between what significant others think of them (i.e., actual appraisals), people's perceptions of significant others' appraisals of them (i.e., reflected appraisals), and SR (Silva & Calheiros, 2021). Unbeknownst to Lotus at the time of her experience and early diagnosis of AN as a youth, she disclosed experiencing neglectful and abusive caregiving from her mother (subset 1.c. Events at the time of diagnosis of Anorexia, nuanced with subset 2. d Experience and Effects of Anorexic-Self), which is susceptible to cause children to develop negative representations for themselves (Harter, 2015). The present author used open-ended questioning and gentle reflection during the interview to further comprehend Lotus' upbringing before and after she had AN:

> As you grow older it…kind of gets just like, "I don't need you as much anymore," but when I was a child I obviously...I needed her, but she didn't give me any love or affection […] I remember my elder siblings being close together and my younger siblings being

close together and I was always alone. So, when it comes to the eating disorder, anorexia specifically, it kind of filled that emptiness inside of me for a long time

Self-representations (SR; or self-schemas) are conceptualized as "cognitive generalizations about the self, derived from past experience, that organize and guide the processing of the self-related information contained in an individual's social experience" (Markus, 1977, p.1). Accordingly, Lotus described the "emptiness" she felt that AN sought to fulfill for her sense of self due to the difficult relationship she experienced with her mother (subset 1.c. Events at the time of diagnosis of Anorexia, nuanced with subset 2. d Experience and Effects of Anorexic-Self).

5th Superordinate: Metaphors for Anorexia, Remission and/or Recovery. Lotus voiced the intricacy of AN, including how it is a symptom of an underlying issue such as "trauma" in her case (subset 3. a. Development of Eating Disorders and Difficulties with Current Treatment for Anorexia). Furthermore, her response manifested a metaphor: "It's like putting air in a flat tire, but the hole's still there" (superordinate [5. Metaphors for Anorexia, Remission and/or Recovery Process] under subset 5. Metaphor of Remission and Insights attained from Active Remission-Self).

Throughout her interviews and the findings process, the present author observed how Lotus often stated: "My eating disorder […] I am, etc." She was characterizing AN and the ED as a part of her identity by stating "My […] and I am […] - *cogito, ergo sum* - (Latin: "I think, therefore I am) statement devised by the French philosopher René Descartes (Krau, 2019). As mentioned in the literature review, existentialism is a form of philosophical inquiry that explores the problem of human existence and focuses on the experience of thinking, feeling, and acting. Moreover, existentialist thinkers frequently explore issues related to the meaning, purpose, and value of human existence (Krau, 2019). Given that Lotus identified that AN was "it was my

identity," the present author genuinely questioned how Lotus would describe herself when she was experiencing AN, looking back. Lotus shifted the language tense from past into present without initiation from the present author, conveying separation from AN now that she is in the recovery process:

> I guess I was just someone who had anorexia, and was underweight, and was in and out of hospitals…that's what the identity was, and like the community I met through my journey the eating disorder community and stuff like that. So, at the time, I started kind of distancing myself from that identity. I had to let go of a lot of those things to kind of figure out who I am without the eating disorder

Lotus is now able to articulate a separation between herself and experience with an ED, especially AN. Subsequently, she is creating her own identity, which is indicative of her healing process: "I'm a strong person. I hope I am. I think I am (*laughs*) […] I see myself more worthy (*pauses*) of remission. I see myself more worthy of…respect from others…from myself too."

6th Superordinate: Spirituality. In the preceding excerpt, Lotus alludes to the notion of connection in her response, as she describes feeling a sense of wholeness and connection. Therefore, the present author asked if and how Lotus connects to spirituality. The practice of connections reinforces holistic thinking and our awareness of how the spiritual, emotional, and mental aspects of our being imbue and nourish each other. In Gaventa's (2018) definition of spirituality, it evolved to include three primary dimensions: "(1) Core values, meaning, and identity, including what is sacred to someone; (2) Connections and relationships, to self, others, the sacred, time, and place (3). A sense of purpose, call, vocation, or obligation, being able to contribute" (p. 52). Lotus describes what gives her a sense of purpose, as well as connection:

> Nature. Yeah, it's as simple as that. When I'm outside just looking at life…to me…that's…that…. I don't know…I love that because for the longest time when I was in the depth of my eating disorder, I didn't really look at the world…like it was….it didn't have colour to me because all I could think about was food, food, food…food and I just didn't pay attention to anything around me.

Lotus referred to how the remission and recovery processed enabled her to connect with the world around her, particularly nature: "Spirituality to me means connecting to deeper things […] I associate spirituality with nature" (superordinate [7. Spirituality] under subset 7. a. Connection and Hope):

> When I was really sick that wasn't…I wasn't…I guess I lost my spirituality for a long time. By the time I got better, I just started to realize that the place that I feel most comfortable in, and happiest in, is nature, most often alone. That's what I like to do. I often just…part of my self-care to be honest, I just walk to the park and just sit on the swing […] That makes me feel grounded like I have a purpose. The world still exists I guess, no matter how sad I feel. Things are still moving; the trees are still swaying.

Lotus' response highlights the significance of nature in both her sense of purpose and spirituality, as those subsets are nuanced and interwoven in her reply. To understand Lotus experience further, the present author reflected how she shared that AN had given Lotus something, which for her was "control," so she inquired how remission, if at all, plays into that. Lotus replied without hesitation: "It gives me hope" (subset 7. a. Connection and Hope). She proceeded to reflect and accentuate:

> The best way to actually fulfill remission is by, as I said before, challenging yourself. And not just with food. A lot of people think that eating disorders are about food, and

> weight, and calories. Its not though. Its sooo much more than that (*emphasis*) […] I mean, I don' like…at the beginning of my eating disorder it had nothing to do with my body or my weight. I was so young to the point where I didn't…I didn't notice those kinds of things. It was, there was a lot of fear…a lot of it was anxiety…a lot of it was I guess, feeling lack of control…for the events around me. Um (*pauses*) it was a coping mechanism that was not good […] Food is just a symptom of an underlying issues […] Yeah…it's an underlying issue that the food…the weight loss all that stuff for people with anorexia specifically, it's just a symptom, an underlying issue. Its almost like, and I've experienced that myself every time I went to treatment…it was almost like filling…filling a flat wheel with air, without looking at the cause of why the flat…where there was flat wheel in the beginning…there was a hole in it.

Phenomenological Core of Lotus. Similar to the previous participant, the phenomenological core of Lotus' experience of the remission and recovery from AN is captured in the following words: strength, hope, and letting go. Lotus articulated aspects she learned from her experience and struggles with AN: "I feel like this is one of the things that I've always wanted to do." The present author asked for additional clarification about the notion of what compelled her to attend the interview, in which Lotus responded:

> I just, I remember my Dad one time told me that I should never let my struggles go to waste [pause] maybe my struggles and the years that I've struggled with anorexia…will help other people in a way. So, I just… his words got to me, and I think, I think a lot of us should really not let our struggles go to waste.

She has an ability to deeply reflect upon her own experience of AN, as well as remission and recovery. Lotus' response also has the notion of empathy interwoven into it, as she expressed a

desire to have the capacity to comprehend and feel what another person is experience from within her frame of reference namely, the capacity to place herself in another's position with an ED. Lotus also highlighted the notion of letting go of AN, including the identity and sense of purpose she perceived it gave to her. Lotus highlighted the notion of letting go AN: "So, at the time, I started kind of distancing myself from that identity. I had to let go of a lot of those things to kind of figure out who I am without the eating disorder" (4. f. Grieving process involved in remission and recovery from anorexia).

Concluding Reflections from Lotus. Although this was her first interview about AN, remission, and recovery, Lotus provided many insightful comments regarding details about her experience with AN, as well as her healing process. She also provided depth into her experience with AN, as well as her remission and recovery process. Moreover, she also highlighted her sense of meaning and purpose from this in closing remarks, as she disclosed in concluding remarks for her last interview: "the Universe itself has put me on this earth for a reason, and so, I owe the Universe, I owe the people around me something." She proceeded to expand on her response and experience of the interviews, including manners that remission and recovery have impacted herself of purpose in life:

> More hope. I don't constantly feel like I need to die. I don't always feel like I need to disappear and just not exist in this world. My purpose I guess (*pauses*) the eating disorder…anorexia and remission itself could be my purpose. It could be my purpose to kind of help others and just…if my story could help someone then that's all I want. Just one person…if it could help just one person then I'm happy, that I didn't let my struggles go to waste […] I'm actually grateful for my experience […] I chose the mental health profession because I get it, and I've been through it […] In a way, to help others.

In the context of Lotus' concluding remarks and reflection, it conveys how remission and recovery from AN and EDs can be facilitated by a sense of meaning and purpose. Additionally, it conveys themes of existential concerns that are seemingly lacking in present treatment for AN and EDs (Fox & Leung, 2009), as they are focused merely on food and BMI (Fox & Leung, 2009).

Rose – POM03LT

Participant's Background and 1st Superordinate: Experience of Diagnosis of Anorexia Nervosa. Rose is a single woman in her early 30s, who has a European cultural background. She was born and raised in the province of Ontario within a religious context of Catholicism, including "a mixture" of spirituality integrated into her faith-based practices. This participant chose the pseudonym Rose, which she explained is her grandmother's name, while she also selected a last name for her other grandmother's maiden name. Rose shared that she selected those names as pseudonyms, as they "symbolize humour, confidence, and strength in [her]."

The present author observed how Rose spoke quietly during the initial interview. Similarly, Rose provided responses in a tentative manner, accompanied by upward inflection suggesting ambiguity and hesitation at various points. She also frequently laughed and used humour, particularly during what could be perceived as emotional content during the interview. However, during the second and third interviews Rose presented as less tentative in her responses than her initial previous interview, so she required less prompting than the initial interview. Similar to the process the present author used with Lotus (e.g., participant 2), the present author softened her tone during interviews and reminded Rose the interview process (i.e., a phenomenological approach) permits her voice to be heard in a safe and attentive manner by

the present author. Furthermore, the present author remained present with Rose by responding with empathetic reflection and paraphrasing of her responses to the interview questions.

In Martin Heidegger's philosophical writings, the concept of *Dasein* reflecting the notion of a ''living being'' through their activity of ''being there'' and being in the world is introduced (Cerbone, 2009). More expressly, *Dasein's* fundamental aspect is their enquiry into being, particularly their ability to question and focus on personal existence (Heidegger, 1927/2011). This is arguably a beneficial quality of interpretive phenomenology, as it allowed the present author an opportunity to be present, permitting Rose an opportunity to illuminate the ''ordinary, taken for granted living as something more layered, more nuanced, more unexpected and as potentially transformative when something is revealed of the extra-ordinary'' (Friesen et al., 2012, p. 33).

Rose received an official diagnosis of AN while she was working with a psychologist during her late twenties (superordinate [1. Diagnosis of Anorexia] subset 1. b. dx of AN). She described the initial diagnosis of AN as difficult to comprehend, as well as "very upsetting," accompanied by experiencing "denial" after receiving it, disclosing the insight that:

> I'd been seeing my psychologist for about 3 months, she brought it up. And, I was like, "No, that's crazy, I'm not…" Because I wasn't counting calories, I just wasn't eating. So, I talked to my psychologist about…because she always said (*chuckle*), she actually specialized, she specializes in eating disorders […] Yeah, so it was *much* later… twenty-eight.

Prior to the formal diagnosis of AN, Lotus explained that she "was kind of lying to [herself]," in which she was in a relationship that was unhealthy and "not great" and she was "very depressed" (e.g., his family called him "overweight" and frequently compared him to Rose). She ended up

terminating the relationship with him and seeing her psychologist shortly thereafter (superordinate [1. Diagnosis of Anorexia] under subset 1. c. First encounter with ED\AN):

> Well, I just thought she [the psychologist] didn't know anything. I was just like, "That's ridiculous, that's not me." And then when I…I was like, "Oh yeah, you're right." Um (*pauses*). It was like, it was probably, it was very upsetting. I was very upset… Yeah…I think because it like (*grabs tissue*), I guess like, very childish. Like, weak. I was like, "Who has this at 28?" So, that's what it felt like (*tearful/stops*) […] At first, I was in denial, and we talked more about a week or two-weeks later, and then I was like "Oh wait, yeah."

Rose acknowledged how "upsetting" the initial diagnosis was for her at the time, including "it [anorexia] was the only thing I had control over for sure, at the time […] like, my identity and my self, being a failure" (superordinate [2. Experience with Anorexia] under subset 2. b. feeling uncomfortable in her own skin, nuanced with subset 2. d. AN was part of her personal identity).

2nd Superordinate: Experience of Anorexia Nervosa. The present author reflected how Rose emphasized the late onset of AN and the severity of her experience with it, including how it developed quite quickly. Rose agreed and further reflected: "Yeah. Mmhmm (*pauses*). But then, I guess my recovery was also quite quick too. Because it was all, it all happened (*pauses*) really within I'd say like, a year to 14 months" (superordinate [4. Experience of remission and recovery process]). Given Rose's statement "I guess" in response to her recovery process, the present author observed how she seemed slightly uncertain and reluctant about her response.

> I felt like, "Ok, I'm going to relapse." Like, I did have a relapse. What is it? Relapse, collapse, or something? Um, but yeah, I did relapse, I remember thinking like, "Ugh oh." And it's *very* scary. I found it very frightening when I relapsed. I was like, "Ok, I'm just

> going to fall back into it." And then I was like, "Oh no, that's literally all-or-nothing thinking…" I was like, "classic" (*mumbles/smiles*). Um yeah, and so I remember thinking back and I was like, "Ok no, this is just like a bump in the road."

In her response, Rose questioned the language of relapse, asking if it "collapse or something?" Although relapse and "collapse" are semantically related, her specific use and questioning of the word collapse is a unique expression for ED relapse. In contrast to relapse, a "lapse" in AN recovery is an isolated occurrence, in which the individual engages in a disordered behaviour (Carter et al., 2012). Consequently, one of the challenges inherent in treating AN is that individuals with the diagnosis are often characterized by significant ambivalence about recovery (Bewell and Carter, 2008; Carter et al., 2012). Rose's comment nuances what she stated earlier, where recovery did not arise or manifest that quickly. Accordingly, it conveys how recovery is neither distinct nor unambiguous, including how relapse occurs: "I thought I was more impervious than I was? And I think…and that's how some people relapse. Not a finite state and it doesn't mean like, a perfect recovery. It's the same perfectionism that's like; my recovery had to be perfect" (superordinate [4. Experience of Remission and Recovery Process] under subset 6. c. recovery, dimension: growth). Rose's reflection of how both the development of AN and recovery emerged "quickly," intuitively shifted the interview into questions about her initial experience with recovery up until the present time (superordinate [4. Experience of remission and recovery process] under subset 4. a. recognition of remission and recovery process; nuanced with subset 4. f. 2. recovery had the greatest impact on her life when she was able to donate organ):

> I donated um, part of my liver […] So, I was like, an anonymous organ donor […] I hadn't seen my registered dietician after I was in remission, but then I went to see her to

> determine like, a meal plan because it takes a while like a month or so for your body to adjust.

EDs are regularly associated with other major psychiatric disorders and medical conditions; the presence of an eating disorder may complicate emotional and physical resilience after transplant, for example, through impaired self-care, or other modulating factors (Jaiswal et al., 2015). Rose proceeded to explain that: "I feel like, working towards recovery was…it was a lot of work, but yeah, recovery you just feel really…yeah, just comfortable, and yeah, it's the complete opposite. Like, you just…your mind is elsewhere" (4. f. 2. recovery had the greatest impact on her life when she was able to donate organ).

3rd Superordinate: Anorexia Treatment Process. After discussing her experience of being diagnosed with AN, Rose discussed features of her experience of treatment for AN. As research conveys, treatment for AN often succeeds in temporarily restoring weight, but individuals with AN are at an exceedingly high risk for early relapse (e.g., Khalsa et al., 2017; Walsh et al., 2021). The current lack of consistent responses to treatment highlights the need for an improved ability to support the AN diagnosis, experiences, and syndrome trajectories. In terms of her AN treatment process, Rose indicated that she was neither hospitalized nor received formal admission to a treatment setting (i.e., hospitalization as an inpatient and/or outpatient). Rather, she received treatment from a psychologist, who specialized in EDs and registered dietician, as well as group therapy:

> I talked to my psychologist about…because she always said (*chuckle*), she actually specialized, she specializes in eating disorders. And my friend had referred me not knowing that because I, I saw her for depression. Um, because I quit my job and I moved back, so I was really depressed and didn't know what I wanted to do with my life […] I

> don't remember if I told anyone…initially. I was very big about it, um, and it was nice because I knew my experiences were private [..] the psychologist said, you don't…like, you have to really…either be like, inpatient or like, make it happen at home, but yeah.

The present author, as well as the reader can see that Rose used past tense in describing her psychologist (e.g., "she specialized, she specializes"). In doing so, she is reflecting on the present moment and ambiguous about her recovery process. As stated in the previous findings of her 2nd superordinate, Rose accentuated a transient increasing risk of relapse, comprising how "[she] did have a relapse. Relapse, collapse."

Given that Rose did not receive formalized treatment in a medical setting (i.e., hospital) for AN, the writer continued to explore her experience of the diagnosis with AN, as well as treatment with AN. During the interview, Rose stated that she eventually disclosed her diagnosis to her mother:

> I told my Mom and she was just… "What should I do?" So, then I saw a registered dietician. She was great. She was retired from CHEO, so she was really good, she was lovely. And um (*pauses*), so she gave me like, a guide of what to eat So, like, just basically looking at things to eat for um, breakfast, lunch and dinner, and like, the two snacks. And, my Mom just like, made that happen.

As mentioned in the study's abstract, the majority of research within the field of treatment and recovery from AN are derived from the perspective of quantitative outcome studies, which focus on the probability of recovery and relapse over time (e.g., Dawson et al., 2004; Walsh et al., 2021). However, there are a few researchers, who have explored recovery from AN using qualitative methods in an attempt to understand the individual's experience (i.e., Federici & Kaplan, 2008; Tozzi et al., 2003). These qualitative studies have identified themes associated

with recovery from AN, such as supportive relationships, family, self-discovery, self-acceptance, motivation to change, and being understood (i.e. Federici & Kaplan, 2008; Lamoureux & Bottorff, 2005).

During the interview, Rose also reflected on what she perceived as beneficial and impactful for her AN treatment process. In particular, she expressed a sense of "hope" through supportive relationships (e.g., please see excerpt below), as well as family (i.e., her mother). As articulated in the next excerpt from Rose, she accentuates the valuable nature of Mitwelt:

> My psychologist suggest I do group therapy and that is what I found really helpful. Initially, I was like, "No, that's so awkward, I won't have anything in common with these people." So, I did the one for people over 30, so there was three of us and we each had sort of like, a different issue I guess, so that was really nice because everything was different […] Yeah, it just really gave me, it gave me a lot of perspective. And um, perspective and hope…and just, and it was, it was though (*stops*) because I think it was Monday nights, and it was each Monday, I remember I was doing a bit better, a bit better and I could see my progress, which was very helpful for me.

A sense of community and peer support groups have the potential to offer validation, wisdom of lived experience, hope for and modelling of recovery, as well as a non-judgemental approach of group members suffering with similar ED diagnoses and syndromes such as AN (Budarapu, Garg, & Austin, 2022). Although the authors do not define 'wisdom of lived experience,' the use of this term suggests they attribute a lot of importance and validity of one's lived experience. Interwoven in Rose's response is an aspect of Dasein (being-in-the-world) that is constituted by her relationships and interactions with other people in group therapy, particularly the subsequent

sense of community and "progress [and] hope" for remission and/or recovery and treatment process for AN.

4th Superordinate: Points of Mutual Influence between Experience of the Remission and Recovery Process, as well as the Meaning-Making Process/Sense of Purpose. Rose expressed finding AN as childlike and naïve at first, so the present author inquired about her familial situation at the time: "My family, we never had a scale, we never counted calories, like…I was always really thin, so it never came up. My parents are like, adorable (*laughs*)." While Rose initially laughed in explaining her familial situation at the time of the interview, the present author stayed present and provided Rose an opportunity to reflect further about her familial and interpersonal relationships at the time of the diagnosis, in which she shared:

> I talked to some of my friends and family, it was like (*stops*) because I was weighing (*stops*), I weighed like, 98 pounds. I had lost like a third of my body weight, um, really quickly and….um […] My Mom is like, an amazing cook, so we just had like, well-balanced meals, but we're all…my brothers and I are all really thin, so we just, I *never* thought about what I ate because it didn't matter. And it wasn't until, and I think like, probably in my like, late teens early-twenties I was like, "Ugh, I should work out" and like, felt a bit pudgy.

The average age of onset of AN is 16 – 17; however, the number of cases of children affected and cases of early onset continues to rise (Favaro et al., 2009) Some authors have noted that late-onset AN is related to various separation experiences that occur in middle and old age (Kimura et al., 2007). Therefore, the present author reflected how Rose recognizes that AN is not restricted to age, asking how she makes sense of it now:

> Now, it's just like, looking back, and thinking like, "Oh, wow." It got, it was more like, not knowing myself, and like, being in the situation that obviously made me deeply unhappy, but not acknowledging it, right? And trying to make other people happy and like, I talked to my psychologist about this really recently, about how it's like, there's certain I guess, certain characteristics or whatever and I have a lot of those…like perfectionism.

5th Superordinate: Metaphors for Anorexia, Remission and/or Recovery. In contrast to her experience with recovery, Rose explained how with AN (superordinate [6. Meaning-making Process and Sense of Purpose] with subset 6. a. AN self has no meaning or purpose, whereas the recovery self has meaning and purpose):

> You can't see anything. Like for me, it was just like, every day was *awful* and there was *no* purpose. I had *no* sense of purpose. I had *no* sense of meaning. It was like, it was like, I read somewhere, and this how it feels like, all the colours are gone, you know? You see like, life becomes gray. Not even black and white. Just gray.

The present author reflected on the bleak nature of AN for Rose, wherein she provided metaphors: "When I think of recovery, I think of like, the lights being turned on again, or… (*long pause*) There's like, a dark passenger with you. That's what it felt for me having anorexia" (superordinate [5. Metaphors for Anorexia, Remission and/or Recovery Process] under subset 5. a. lights being turned on again., as well as subset 5. b. Anorexia is a dark passenger):

> I came out of that as well, like it all kind of like, came together. Um, and it just helped like, knowing, like just kind of figuring it out what I wanted for life, and kind of like, the meaning, like…what gives me…what is it I want to achieve in life. What is meaningful to me, and it may not be meaningful to other people […] Rationally, I know all the things

> I've learned from the experience and the *really, really* positive things that have happened and come out of it.

Rose's response alludes to how there is a long philosophical tradition conceptualizing the mind and body as distinct and separate parts; specifically, central to this notion is that the self has been within or synonymous to the mind (McBride & Kwee, 2018). This dichotomy has prevailed the treatment of EDs with its evident focus and emphasis on correcting cognition and/or behaviour: "The construct of embodiment offers the perspective of the self as an integrated whole" (McBride & Kwee, 2018, p. 1). Rather than the self being distinct from the body, the body is the self, and consequently struggle with the body is also an existential struggle with the pain of being a self (McBride & Kwee, 2018; superordinate [3. Learning from Anorexia] with subset 3. a. positive aspects learned from AN):

> If I think of anorexia as a thinking pattern, or a depression as a thinking pattern, um, I can derive meaning from it rather than feeling it has to do with like, my identity and my self, being a failure and like (*stops/pauses*).

6th Superordinate: Spirituality. Similar to Rose's experience with AN, recovery and remission, "changing over time" she reflected on the evolving nature of her experience with religion and spirituality (superordinate [7.] under subset 7. b. role during recovery process):

> I guess, it's changed over time. So, when I was younger, like, I grew up Catholic, we went to Church every week. Um, and I really enjoyed it. Like, I alter served for 5 years and I had very positive experiences. But I was very, um, I remember, I was very scared of, again, probably again the perfectionism and obsessing. I was going to go to hell for various reasons (*laughs*). I had no concept of what sin actually was […] Um, and that's what it was to me, was like, all…was guilt. Like, classic Catholic guilt (*mumbles*). Um,

> and then it all kind of changed and I was pretty religious in the beginning. Very religious in my own way. Like, a friend of mine, I still do…we do Bible study together. We still do […] I think, for me, spirituality is…as I reflect on it more, it's…like, what is my…guide, like, spiritual path.

In ED literature pertaining to the relationship between AN and religion and/or spirituality is that of religion as a beneficial treatment adjunct and benefactor of recovery (Marsden et al., 2007; Rider et al., 2014). Indeed, several studies have revealed that religion can contribute positively to the treatment and recovery process (e.g., Richards et al., 2007; Rider et al., 2014). Within the field of psychology, it is widely acknowledged that the nature of religion's impact on mental health hinges upon individuals' styles of religious usage (Pargament, 1997). In this context, the present author inquired to Rose about what was the role of spirituality or religion, if any, in her recovery process: "Definitely. So, like, I would find a Bible passage that really…meant something to me and my remission. Like, for each week. And then I would sort of make that my reflection for the week and how I carry that out" (7. b. role during recovery process). She proceeded to further expand in more detail about her experience of religion and spirituality:

> Well, I think for me, um, it's like, the meditating…and thinking like, "All the things that I'm going through, that everyone's been going through for thousands of years." Like, "This isn't new… this isn't…" like, reading the psalms and proverbs, particularly were helpful, especially proverbs. Um, and Job was a bit much and Ecclesiastes and knowing like, "Ok, this is…this is" like, "the human condition. This isn't unique." Because I remember thinking when I was sick that – when I was anorexic that – (*pause*) it was…it felt like, I was the *only* person going through it? Like, it was like, *no one* could quite

> understand like, my specific struggle […] I feel like my experience really…*for me,* made me realize how fragile life is and how…life can go one way or another. And depending on the decisions you make it can…like, I feel very fortunate.

A number of positive religious coping strategies are correlated with positive religious coping such as altruistic religious appraisals, seeking spiritual support, and spiritual connection with others (Pargament & Exline, 2022; Rider et al., 2014). Rose's reflection seemingly highlighted the positive religious coping strategies, including the negative religious coping strategies. Correspondingly, she identified negative religious coping that include punitive religious appraisals, reappraisals of God's powers, spiritual discontent, self-directing religious coping (e.g., "classic Catholic guilt").

Rose also identifies the "human condition," alluding the themes that compose the essentials of human existence, including birth, growth, emotion, aspiration, conflict, and mortality (Diamond, 2021). Existential therapy is centered on the understanding that each person is the creator of his own life and has the freedom to choose how to respond to each moment of existence (Diamond, 2021). In the existential approach, the therapist seeks to understand how the patient experiences life from his unique perspective, which the present author was able to integrate with Rose in the IPA approach (4. f. remission and recovery shifted her perspective and sense of meaning and purpose in life, nuanced with subset b. role during recovery process):

> Like, I feel like life is just like, life is very complicated and its not easy and I feel when people try to make it…black and white…that's when things get…like, that's when people lose understanding and tolerance. And for me, that's what spirituality is, *for me.* And *that's*…I think I gained more and more of that through my various experiences.

Phenomenological Core of Rose. The experience of remission and recovery from AN for Rose is captured in the following words: ambiguity, acceptance, and insight. As previously mentioned, her experience and resultant fear of relapse conveyed her ambiguity with the recovery process of AN accompanied by her lack of meaning and *Dasein*:

> I think, like, when I think of when I was going through it, I had *no* purpose. Like, I felt *very, very* lost. And…and that…that was my when I was sick, it was like, "I don't know what I'm doing with my life, I have no purpose […] And so, now that I'm recovered…I have, like I have, I *do* feel that I have a purpose. It's not…this isn't my existence just…dealing with anorexia. Like, I returned to my life and the goals and everything (6. g. impact of AN on sense of purpose and meaning; nuanced with subset 6. e. Meaning-making: how it relates to life prior during and after AN).

Interwoven in her response and reflection, Rose conveys how recovery from AN is a dynamic and non-linear process, including a process imbued with a sense of meaning: "it allows you to see the world in "shades of gray […] as well as with more ambiguity and acceptance" (6. c. recovery, dimension: growth). She further articulates how recovery was "an evolution," accentuating:

> I guess that recovery…um, for me, was an evolution and the meaning like, how I find purpose and meaning in life – the core of it – it's the same, but how I carry that out or how I experience that has evolved as well. It's just an evolution. I can't say, um, yeah. It evolves and it gets deeper, that's how I feel like, my meaning in life. My purpose and all that, it just gets deeper as I progress through life […] everything feels intertwined like, the depression and the anxiety and everything. Um, but…I…when I look back on it (*pauses*) yeah, definitely newfound purpose.

Concluding Reflections from Rose: Throughout her process, Rose offered many intuitive comments regarding details about her experience with AN and meaning-making, as well as her recovery process and fears of relapse. She also provided depth into her experience with AN, as well as her remission and recovery process. In addition, she shared: "I think reflecting back on it makes me like, nervous in a sense? I felt before really far removed from anorexia and when I was thinking it…I was like, "Ugh" (*winces*). It's such an awful thing to contemplate." Understood in this context, she was open with the present author in sharing her experience in the study and consenting to participate.

Rose also highlighted her sense of meaning and purpose from this in closing remarks, as she disclosed in concluding remarks for her last interview: "I just feel like, there's *so many* more possibilities and more possibilities to explore. I have…I don't have the same limitations on myself […] I think, I feel like…if I think of recovering, it was thriving […] And, for my spirituality, it allowed…my like, prayer life to thrive my spirituality to thrive." She proceeded to articulate in her response and experience of the interviews, including manners that remission and recovery have affected her insight:

> "Your accomplishments always remain the same, so obviously, my perception of anorexia it's more shame-based […] So, I feel like, "Well, ok, that's something I've learned, so I have to be more compassionate towards myself" (4.j shame-based perception of AN; 4. i. recovery as an ongoing process).

In the context of Rose's concluding remarks and reflection, it conveys how remission and recovery from AN and EDs can be facilitated by a sense of meaning and purpose. Moreover, she conveys the continuum of remission and recovery from AN. Additionally, Rose's responses

reveal how existential themes and concerns are seemingly lacking in present treatment for AN and EDs (Fox & Leung, 2009).

Stephanie – POM04BR

Participant's Background and 1st Superordinate: Experience of Diagnosis of Anorexia Nervosa. Stephanie is a single woman in her mid 20s, who was born and raised in the province of Ontario within a religious and spiritual context. This participant chose the pseudonym Stephanie, in which she disclosed was "one of my ED therapists. She was someone who is calm, patient, and safe. I felt very comfortable with her." At approximately 14 years old, Stephanie identified experiencing the onset of AN: "I'd say that I developed anorexia and started having symptoms when I was 14. That's kind of an estimate in the sense that, um, the onset of my symptoms (*stops*)" (subset 2. Reasoning behind the Development and Maintenance of Anorexia). However, she confirmed that she received an official diagnosis at 17 years old and she described feeling "very confused" by the initial diagnosis and subgroup of AN: "Um and I was being taken care of by the eating disorder inpatient team […] your diagnosis is that you have anorexia with bulimic tendencies (*mumbles/softly chuckles*) (superordinate [1. Diagnosis of Anorexia]).

During the initial interview, Stephanie frequently used soft chuckling and laughter, which is indicative that she was attempting to minimize her experience with AN as "an issue." Humour is a complex phenomenon. While "humour" can be defined as anything that makes a person laugh or smile, there is no generally accepted theory of humour, or even an agreed-upon definition (Ostrower, 2015). Nevertheless, humour persistently contains some measure of self-observation or truth (Vaillant, 1994). Moreover, humour can be cruel or healing; namely, it can express love, hatred, and aggression (Ostrower, 2015) According to Freud, people predominantly

use humour in situations, in which negative emotions arise such as sadness or fear (Norton, 1989). The essence of humour is that the person spares themselves of the distressing and painful effects that the situation causes by ceasing the emotional possibility of sorrow through humour (Newirth, 2006; Ostrower, 2015). In this way, humour enables people to cope with harsh situations without being overwhelmed by emotions (Ostrower, 2015).

Stephanie's combination of humour, light chuckling, and hesitancy – conveyed in excerpts and quotations from her interviews below – is seemingly resultant from her using humour as a defense mechanism, disclosing that "[she] was sexually abused." Accordingly, Stephanie's hesitation (e.g., "Um" and pauses) and quiet laughter during moments of deep reflection are indicative of humour as a defense mechanism, as well as her vulnerability and openness with the present author. Stephanie mumbled in describing weight gain caused by medication, which suggests it could still be an area of sensitivity. Similar to the process the present author used with Lotus (e.g., participant 2) and Rose (e.g., participant 3), the present author softened her tone during interviews and reminded Stephanie the interview process enables her voice to be heard in a nonjudgmental and thoughtful manner by the present author. Consequently, the present author remained present with Stephanie by replying with empathetic reflection and paraphrasing her responses to the interview questions.

In describing the onset of AN, Stephanie disclosed that she received a diagnosis for epilepsy prior to her diagnosis of AN:

> So, prior to developing those symptoms, I…um, struggled a lot, um, socially. I, um, was bullied a lot and probably I'd say the 4 years leading up to my symptoms, and, um, I was also diagnosed with epilepsy, which is a chronic condition, and um, I had to adapt to a

> new lifestyle with medication that actually caused weight gain […] I started to (*pauses*), as well as having the symptoms of anorexia, I started also…um, purging.

In addition, Stephanie disclosed that she had been sexually abused: "Um, and I was also, from the age of around 8 up until the age of 17…I was sexually abused […] So, it's like, you really felt powerless […] Yes, very powerless" (subset 2. Reasoning behind the Development and Maintenance of Anorexia). She also revealed how the diagnosis and experience of AN was interconnected for her: "I'm able to…to prove to myself and prove to my eating disorder. Like, I speak about it as if it's like, a separate person, really (*laughing*)" (subset 2. b. Anorexia as an entity).

2nd Superordinate: Experience of Anorexia Nervosa. Stephanie also described how she was a dancer, specifically a ballerina: "I don't know if this was related, like I don't if any of that is related to my anorexia – um, but I, um, got into dance. And I became a competitive dancer." She further reflected on her experience of being a ballerina (Superordinate [2. Experience with Anorexia Nervosa] under subset 2. b. Anorexia as an entity, nested with 2.b. 1. Source of external sense of agency):

> I *really* loved it. Like, I thought it was a great outlet, emotionally, physically, and even a really great social outlet. But…I (*stops*) it's the stereotype that ballerina often, or so focused on their weight, that certainly was something that. Um, it's within the culture – I guess – is dance you know, the costumes you wear, and the amount of awareness that being a dancer brings to your body… Because you're being *so* aware of everything that's going on. And I think once my symptoms started….it actually had a negative impact on my…performance? […] that I wasn't eating enough to have the energy to be dancing 6 to 8 hours a night, and so, my performance was suffering? And I became very, ugh,

> frustrated with that? And, I thought that my performance was suffering because I was too fat, so it was kind of a vicious cycle of not really knowing at the time that…it had nothing to do with whether I was fat or not. It's because I wasn't giving myself the energy I needed or food…

Stephanie's response conveys how she perceived she had a sense of external agency by engaging in AN symptoms and behaviours; specifically, sense of agency refers to the feeling of control over actions and their consequences (Moore, 2016).

Stephanie's reflections also highlight the manner in which she frequently engaged in body comparison (superordinate [2. Experience with Anorexia Nervosa] nuanced with subset 2. c. Body shaming and comparison):

> I'd be thinking about the clothes that I was wearing. I would be comparing myself to like, everybody around me. Like, "Oh my God she…" you know, "is so much thinner than me, she's so much better than me." Like, "I wish I was more like her and like, nobody likes me because of how fat I am." Just like these *really* terrible messages about…you know my worth equals the size of my body […] I felt like, as I'm doing all of these behaviours it feels like, this is what I *need* to do. This is…I'm doing the right thing for what, you know, I *need,* and it felt very much like, like, in my mind it wasn't wrong. In my mind, "This was different than what other people might be doing, but it was normal." And, because I have such *bad,* severe body dysmorphia.

Given Stephanie's emphasis on "I *needed* to do it" the present author used open-ended questioning to ask what need she was seeking to fulfill, including how she made sense of that need. Stephanie responded: "I think it's kind of, like, control over my own body. Control…

(*Stops*). Like, feeling like I have a sense of my own life (superordinate [2. Experience with Anorexia Nervosa] under subset 2. a. Method of fostering a sense of control).

Osler (2021) seeks to provide a phenomenological account of anorexic bodily experience; namely, Osler notes that although AN is frequently recognized in terms of a distorted body image, this approach does not accurately reflect many participants' bodily experiences. In addition, "focusing primarily on body image gives rise to the impression that AN is a form of radical dieting gone awry as a result of misperceiving and/or misjudging one's body size or shape" (Maiese, 2021, p. 63). To account for the complex bodily experiences of individuals with AN, Osler (2021) differentiates between various aspects: (1) the body-as-object (e.g., a physical object that has a spatial and temporal location); (2) body-as-subject (i.e., the medium through which we have a world; (3) the visceral body (i.e., it is a physical body, but an organic object, one with needs, feelings, and affectivity).

Stephanie was seemingly contending with experiences of the body-as-object as alienated or distanced from the body-as-subject, accompanied by the visceral body:

> So, I think…from my experience at least with anorexia and having symptoms of anorexia, it…um, it doesn't matter how much weight you lose, it doesn't matter how few calories you eat, it doesn't matter how much exercise that you force yourself to have in a day, it's never good enough […] And so, with that, for me, came a lot…um, low feelings and depression and anxiety. And, a lot of self hate as well because it's just this…like, "Why can't I do this? I'm not even good at having, you know, this so-called eating disorder." And…so, that's kind of where that suffering came from was, you know, not only is my body depleted from (*pauses*) energy and nutrients, but there's also this other side of…you know, I'm not…I'm not good enough even at something that I've tried so

hard at (subsets 2. Anorexia as a coping mechanism and 2. a. Method of fostering a sense of control, as well as nuanced with subset 2. c. Body shaming and comparison).

3rd Superordinate: Anorexia Treatment Process. Additional accounts in the literature frequently find that recovery is not so static, defined or neatly ordered. For example, Garrett's phenomenological study (1998) suggests that recovery is not a final endpoint or achievement, but rather an elastic concept including the fluctuation of advances and setbacks. It is fluid, constantly moving, never finished or an entirely complete journey with an "infinite number of variations" and "its fine details are different for every person" (Garrett, 1998, p. 42). Stephanie accentuates this as she reflected on various instances in which remission and recovery was an enduring process that required replacing thoughts and behaviours, as well as processing emotions (4. b. 1. Vulnerability in Remission and Recovery 4. f. Remission and Recovery: An Enduring Process):

> I had to let go of my need for control, definitely. I had to let go of the ideologies that came and that really grew with the illness. Um, and I had to let go of this feeling of like, fear of vulnerability because when you're in recovery and remission you're very vulnerable because you are trusting professionals to guide you it's just like, every…fear of your life becomes very much consumed by…by the illness […] Um…for me, I determined [recovery] from where I stopped having symptoms. So, I may have still been having thoughts such as, um, for example, the urge to go and body check. But if I didn't act on it, then for me, that wasn't symptomatic. Those are thoughts and everybody has thoughts. For me, as long as I'm not acting on it, and as long as I'm able to understand…that that is an eating disorder thought, and I'm able to know like, that has *nothing* to do with me, per se?

During moments of emotional overwhelm, the support and testimony of others in both the community and the therapeutic setting become an important means of renewal and connection, thereby bolstering the individual's own resolve (Koenig, 2012). This seemingly was part is Stephanie's experience as she shares some aspects of connection that assisted in her remission and recovery (subset 4. d. Dynamics that assisted in Remission and Recovery):

> When somebody else is able to look at the same situation and be like, "It makes sense that this is difficult," like "Let's not…let's not try to invalidate that," and "let's just like, work on it," you know, "use self-compassion and everything." It makes it a lot easier, and it takes away the judgment. […] And I think like, being able to now trust others and trust myself and think about those things openly is also really huge. It's very helpful. Also be in that with me, and be like, "That's so amazing," like, "I'm so proud of you." Like, I think *that* was definitely needed and like, it really helped me and encouraged me to continue […] Going to therapy is also *very* helpful.

4th Superordinate: Points of Mutual Influence between Experience of the Remission and Recovery Process, as well as the Meaning-Making Process/Sense of Purpose. In contrast to AN, Stephanie described the process of remission and recovery as being "peaceful." Given that she previously stated that she spoke about AN "as if it's like, a separate person, really (*laughing*)" (subset 2. b. Anorexia as an entity), the present author inquired how in comparison to AN she described her relationship with remission and recovery. Moreover, the present author inquired if it was different from Stephanie's relationship with AN:

> Yeah, that's a good question. It's definitely different than my relationship with anorexia. Um, my relationship with recovery and remission is very much one of like, finally having peace. And it's comforting and I feel…like, my best friend, almost? Like, it's this sense

> of like, support, like, I don't know how else to explain it (*smiling*). I just feel *so* much stronger with remission and recovery, whereas with anorexia my feeling and my relationship towards it was very much of vulnerability and powerlessness. And…chaos. Like, it was very much the opposite of peacefulness. So, that's kind of how I would distinguish the two […] I'm retraining my brain to cope differently with the stresses in my life. And to, um, find other ways to kind of, um, appreciate myself better. That isn't harmful (superordinate [4. Experience with Remission and Recovery Process] under subset 4. b. Growth, nuanced with 4. a. Challenges).

Stephanie verified the perception that she had a relationship with AN, which she compared to her relationship with remission and recovery. She described the relationship with AN as "vulnerability and powerlessness," whereas remission and recovery are described as "really empowering" and "peaceful." In doing so, she highlights dichotomous thinking, which is one of the most common types of cognitive distortions observed in women with EDs (Bryne et al., 2008). Dichotomous thinking is a kind of cognitive rigidity whereby individuals tend to see reality in polarised categories of "either-or" rather than as a continuum of possibilities (e.g., If I'm not in recovery and thereby successful, I am an anorexic and a complete failure) (Bryne et al., 2008). As a previous participant accentuated (e.g., Lotus), the remission and recovery process are not linear or static.

5th Superordinate: Metaphors for Anorexia, Remission and/or Recovery. In describing and identifying metaphors of AN, Stephanie disclosed that she experienced AN as "like poison" (superordinate [5. Metaphors for Anorexia, Remission and/or Recovery]). She proceeded to explain that: "When I was very symptomatic with *no,* almost no insight into the illness that it felt like it was very much a friend […] I think in like, let's say, my darkest

moments with anorexia it definitely…disguised itself as a friend" (subset 5. a. Metaphor of Anorexia presented as a friend at first; but shifted to a poison upon entering recovery; nuanced with subset 2.b. Anorexia as an entity). In contrast to AN, the present author inquired how she would describe remission and/or recovery in a metaphor, a sentence, or a few words:

> (*Long pause*). If I had to describe it in a sentence (*laughs*), I guess I would say, it's *very* difficult, but it's one of the best of things that's ever happened to me. It's one of…like, the *very* difficult times that you go through at the beginning are *worth* every single moment that you'll experience afterwards […] I guess it's like, metaphoric, but if you're able to open a door in life, like, make sure you're reaching back to bring others with you through that door (subset 5. b. Metaphor of recovery is opening a door to life, imbued with empathy by reaching back to help others through that door; nuanced with superordinate [4. Experience with Remission and Recovery Process] and subset 4. a. Challenges, as well as subset 4. b. Growth).

As Stephanie alluded to in reflections, AN is a striking example of the complex nature of the human body (Skårderud, 2007). Moreover, her responses accentuate how the human body also functions as a symbolic tool, as a language to communicate with others and with ourselves about matters beyond corporeality itself (Skårderud, 2007). After discussing metaphors symbolic of AN and/or the remission and recovery process, Stephanie proceeded to discuss her experience of the remission and recovery process: "I have loved it *so* much (*smiling*). I'm not saying it wasn't difficult […] I saw like, "Oh my goodness" (*smiles/lightly laughs*). All of these beautiful aspects of life that I've been… missing out on because of the illness" (subset 4. a. Challenges, nuanced with subset 4.b. Growth). After reflecting on the remission and recovery process, she shifts from

describing “my anorexia” to “the illness,” thereby creating a distance and *Dasein* like Rose (participant 3).

The interview naturally shifted into questions and responses about Stephanie’s sense of meaning and purpose in life during her experience of AN, as well as during the remission and recovery process:

> Um, so I think like, when I was diagnosed and symptomatic…I felt the most…purposeful and meaningful things in life had to do like, with my…with the number on the scale with, you know, being successful and eating less than this certain amount of calories […] So, it was really difficult to find meaning and purpose in life outside of anorexia. Whereas *now* I think because I can…like, I see myself? I’m able to…find meaning and purpose completely aside from anorexia symptoms […] I think [recovery and remission] just nourishes who I am as a person and what I’m able to offer, and you know, and when I’m able to succeed because of my *perseverance* because of my *dedication* and my *passion* like it, things that are more about *me* as a person. My characteristics, my personality, my values, my…my morals (superordinate [6. Meaning-Making Process and Sense of Purpose] comprising subset 6. e. Former sense of meaning and purpose developed from AN, nuanced with subset 6. f. Influence from remission and recovery).

Stephanie alludes to the significance of her resilience, by stating the significance of giving back to others, including how her position as “a pediatric emergency nurse […] I try to strive to do impactful work. I find that those are things that make me feel like I have purpose and meaning in life in general” (subset 6. b. Motivation and/or Inspiration). She proceeded to expand on how there is also meaning in her personal life, which assisted in her remission and recovery process:

> The meaning that I've had in my personal life and that's *really* based in my relationships and connecting with others. That's where I really, like, I would say that's where the *heart* of the meaning in my life comes from (subset 6. a. The need for human connection).

Stephanie put emphasis on how working as a nurse, as well as connection with how others instilled a sense of meaning and purpose in her life. It is relevant to note that nurses, psychotherapists, and other health professionals become wounded healers after recognizing, transforming, and transcending the pain of trauma in their lives (Farber, 2017). Correspondingly, Carl Jung (1951) believed we have a collective unconscious, in which "there exists the archetype of the wounded healer, whose wounds are both a burden and a driving force in his need to heal the problems of others" (Farber, 2017, p. 24). Understood in this context, Stephanie's awareness of her own wounds (e.g., her past trauma, epilepsy, and ED) can equip her with empathy to assist others such as patients as a wounded healer (Farber, 2017).

In various ways, Stephanie alludes to how there is a kind of reciprocal influence in her connection with others: "Whereas now food consumption doesn't consume me. I eat what I need to have the energy that I need to give my all to my patients and their families to make sure that I have what I need to care for them" (6. a. The need for human connection). The fixation of food no longer consumes her mind and/or essence/core, but rather, it nourishes her sense of purpose and connection with others (subset 5. b. Metaphor of recovery is opening a door to life, imbued with empathy by reaching back to help others through that door). Irvin Yalom (2009) considers treatment as a dialectical process, in which the therapist, as a person, participates just as much as the patient: "I prefer to think of my patients and myself as fellow travelers, a term that abolishes distinctions between 'them' and 'us' (the healers)" (p. 8). The notion of a fellow traveller arguably encompasses other helping professionals such as nurses, including Stephanie.

6th Superordinate: Spirituality. The present author also inquired what the role of spirituality – if any – was in Stephanie's remission and recovery process: "Um (*long pause*). I think if anything, it was being able to connect with myself through that spirituality" (superordinate [7. Spirituality]). Given the long pause from her, it conveyed that she was deeply pondering and reflecting on the question and her subsequent response. For this reason, the present author stayed present with her, and gently inquired how she might define spirituality:

> I define spirituality is just like, it's just positivity, it's positive energy, it's positive messages […] I really do believe that it's different for every person, and I think it really depends on like, what your relationship is with God or to spirituality. And, I guess, I would say for myself, like, spirituality is…just like, believing in something that's bigger you […] So, I grew up religious. Um, I grew up going to a like – as a Christian – going to church and I think that my relationship with the Church never really formed […] I respect everybody's like, own values and visions and the way that they connect with spirituality […] I very much saw the Church as an institution and I felt like, connection-wise; I don't get that when I go to Church (subset 7. a. Spirituality and Faith; nuanced with subset 7. b. Meaning and Significance of Spirituality in remission and recovery).

Spirituality can be seen as an experiential process that concerns the relationship with the inner self, with others and with that which is beyond the self—the transcendent or sacred (Grant, 2017). At this level, it ceases to be a theoretical concept but rather is grounded in the lived experience and becomes an anchoring discipline (Lelwica, 2010; Perrin, 2007; Koenig, 2012). This is conveyed in how Stephanie integrates spirituality and her Christian faith into her recovery process, as she proceeded to explain:

> I could connect with God in that way. And being able to be like, "Ok, so why was this helpful?" This was helpful because it allowed me to reflect on things. It allowed me to feel unconditional *love* and unconditional *compassion.* "Ok, so how can I take those things and turn it towards myself?" And you know, I can be the provider of that instead of feeling like, it's coming externally? "Ok, so, I'm going to ensure that I'm reflective, I'm going to give *myself* this unconditional love and compassion […] So, I think like, at large, spirituality, for me, means connecting…connecting with something outside of yourself. Connecting with something that's kind of like, it kind of feels bigger than you. I get that feeling that it happens for a reason (7.d. Spirituality represents connection with something outside of oneself, providing a sense of comfort and trust, nuanced with subset 7.e. Spirituality signifies coherence, continuity, synchronicity, and permanence).

A challenging reality in the recovery process lies in the knowledge that the person in active recovery does not wait for feelings of strength, enthusiasm, and bravery to emerge in order to continue forward (Lelwica, 2010). On the contrary, it is by intentionally "journeying in self-acceptance with a warrior spirit that progress is made" (Grant, 2018, p. 6). While Grant does not define what constitutes a warrior spirit, it alludes to the fluidity – "it is fluid, constantly moving" – or engaging in an active recovery process (Matusek, 2007, p. 5). The term 'spiritual warrior' originates from Tibetan Buddhism, intended for one who combats the universal enemy perceived by the religion: ignorance (Avidyā), which is the ultimate source of suffering according to Buddhist philosophy (Moacanin, 2003). Different from other paths, which focus on individual salvation (e.g., in religion and theology, salvation largely refers to the deliverance of the soul from sin and its consequences). Accordingly, the spiritual warrior's complete and correct practice is that which compassionately helps other beings with wisdom (Moacanin,

2003). In many ways, Stephanie conveys a warrior spirit, as she helps others as well as herself in the process of recovering and healing from AN, trauma, and epilepsy.

Phenomenological Core of Stephanie. The experience of remission and recovery from AN for Stephanie is captured in the following words: trust, empathy, perseverance, connection, and compassion. She described how with the diagnosis of AN, she experienced a sense of detachment, whereas she experienced trust in self and others in recovery: "I think with anorexia like, often, when you're symptomatic it feels like a huge fault and flaw […]. And so, I do think that vulnerability plays a pretty significant role in your recovery and remission because letting go and trusting others."

Interwoven in her responses and reflections, Stephanie highlighted how she had to honour her remission and recovery process, pace, and experience "I needed a lot of compassion and a lot of (*pauses*) self-compassion, which is… it was something that I had to learn." Compassion Focused Therapy (CFT) was specifically intended for people with high shame and self-criticism (Gilbert, 2010), who frequently experience high levels of external threat (i.e., fear of criticism and rejection) and internal threat (i.e., self-criticism and feelings associated with being a failure, flawed and/or inferior). She also captured with emphasis how she was able "to succeed because of [her] *perseverance* because of [her] *dedication* and [her] *passion.* Additionally, Stephanie reiterated how:

> Anorexia it focuses on the purpose of weight loss…appearance, whereas remission and recovery it…it…the words that come to mind, is connection […] And like, to get *rid* of it, to be able to *be* in recovery and remission, requires relationships and those connections.

Concluding Reflections from Stephanie. Although this was her first interview experience about AN, remission, and recovery, Stephanie provided many intuitive comments regarding details about her experience with AN, as well as her healing process. She also provided depth into her experience with AN, as well as her remission and recovery process. As previously mentioned, intertwined in her responses convey the significance of empathy for Stephanie as a nurse and wounded healer:

> The things that matter to me are really like kindness, compassion, respect, treating others the way that you want to be treated and like, really something that is huge for me is kind of that…I guess it's like, metaphoric, but if you're able to open a door in life, like, make sure you're reaching back to bring others with you through that door. So, that's something else that is really important to me is you know, we're all kind of like, in this together, and life is pretty difficult, so if you're able to make it through some difficult circumstances like, make sure you're finding ways to support others to…to keep going with you […] And just saying you know, I had to figure it out, so you have to figure it out too." I think, like, there's a real sense of community and compassion and kindness, in you know, looking back and saying, "Hey, I figured out how to get here, let me show you, let me help you." Like, "We're in this together," you know what I mean?

Stephanie also conveys resilience from her experience with AN, accompanied by the resultant meaning and purpose she received from remission and recovery: "I just feel *so* much stronger with remission and recovery […] That the things that I do to find purpose are, you know, are good enough." To clarify the concept, "resilience is an internal strength that triggers internal and external resources that help get out from an adversity, in this case the eating disorder" (Las

Hayas et al., 2016, p. 579). According to Reivich, Seligman, and McBride (2011) the core competencies that contribute to resilience include:

1. Self-awareness (i.e., being able to identify counterproductive thoughts, emotions, and behaviors)
2. Self-regulation (i.e., being able to moderate impulses, thoughts, emotions, and behaviors to achieve goals as well as being willing and able to express emotions)
3. Optimism—being able to notice the goodness in oneself and in others, identifying what is controllable, and remaining grounded in reality
4. Mental agility—thinking flexibly and accurately, maintaining perspective, and willingness to try new strategies
5. Character strength—being able to identify one's strengths and relying on these to overcome challenges and meet goals; and
6. Connection—building strong relationships/willingness to ask for and offer help (p. 27)

In the context of Stephanie's remarks and reflections, it expresses how remission and recovery from AN and EDs can be facilitated by a sense of meaning and purpose. Moreover, she conveys the fluidity and continuum of remission and recovery from AN. Additionally, Stephanie's responses reveal how existential themes and concerns are seemingly lacking in present treatment for AN and EDs (Fox & Leung, 2009). As demonstrated from Stephanie's findings and quotations, she has resilience after enduring a history of sexual trauma and epilepsy, as well as long-standing experience with AN. Although she initially used humour at the beginning of the interview process, with time and openness of IPA, she conveyed resilience. More specifically, Stephanie's responses and reflections are interwoven with self-awareness, optimism, mental agility, character strength, and connection (Reivich et al., 2011).

Geraldine – POM05BS

Participant's Background and 1st Superordinate: Experience of Diagnosis of Anorexia Nervosa. Geraldine is a woman in her early 30s, who has a European cultural

background. She was born and raised in the province of Ontario within a religious context of Catholicism. Although she is no longer part of an organized religion such as Catholicism, she associates spirituality "to a relationship with God, the Transcendent, or an Entity greater than [herself]." This participant chose the pseudonym Geraldine, which she communicated is her paternal grandmother. More expressly, she shared the motivation and "hope" in taking this pseudonym for the study: "to honour her positive impact on my life." She further disclosed aspects of her grandmother's influence on her life, including what choosing the name signified for her:

> She grew up in Newfoundland with 9 siblings. Her father was gone most of the year fishing and her mother passed away quite young, so she became a very strong and independent woman quickly. As soon as she was old enough, she and her sister moved to Ontario and became nurses […] My Grandma, whom I lovingly called G-ma, was instrumental in my treatment. She taught me about strength, in all its various forms, and self love. I'm so thankful for her love and support - all whilst she was undergoing chemotherapy. Wow!

Geraldine described being unable to identify with the initial diagnosis of AN, as she was at university during the time: "Um, I truly, I didn't think there was anything wrong" (superordinate [1. Diagnosis of Anorexia] and subset 1.a.1. Initially, she did not think anything was wrong with her). Accordingly, she alludes to experiencing "denial" about her initial diagnosis of AN. She stated: "*Mmhmm. Huge* denial. Huge and I would say that's something big with a lot of, a lot of people who experience eating disorders not thinking that you're actually sick?" (1.a.2. In denial, even though she felt extremely unhappy and depressed). She also

described having other mental health issues (e.g., concurrent disorder) like depression at the time of her diagnosis of AN:

> Like, I was horribly unhappy and there was times where I was so depressed I wouldn't get out of bed. I felt like it was…the price you pay to be…perfect […] I had this drive that nobody else had and if it meant that there were some days that I couldn't get out of bed or there was some days where, you know, I cried the whole day or whatever then so be it. Like, I… "I have *so much* restraint and so much self-control" or at least so I thought […] Um, I think (*pauses*) *years of*, um (*pauses*) sort of starving myself and on this quest for perfection […] My idea was to be the smart one. […] Um, I had…I'd done to this support group and then my eating disorder just sort of really spiralled, and then they referred me to, um, which was on campus, was the university, um, hospital and I was diagnosed (superordinate [1. Diagnosis of Anorexia Nervosa] accompanied by the subset: 1.a.2. In denial, even though she felt extremely unhappy and depressed, as well).

2nd Superordinate: Experience of Anorexia Nervosa. As previously mentioned in the literature review (e.g., see 1.2 Clinical Features of Anorexia Nervosa), AN is considered to have a specific relationship to perfectionism "with self-evaluation being dependent—despite the occurrence of adverse consequences—on the pursuit and attainment of personally demanding standards in the domain of control overeating, shape and weight" (Vandereycken, 2006, p. 356). Furthermore, the denial might be part of a pattern of abnormal perfectionism, which is making the person's self-evaluation over dependent on the pursuit and achievement of self-imposed, ever more demanding standards of food restraint and or weight loss (Goldner, Cockell, & Srikameswaran, 2002; Shafran, Cooper, & Fairburn, 2002).

Geraldine alludes to her pursuit and attempts of attaining personally demanding standards of perfectionism through AN: "Um, but I just remember this like, I mean I still have this *obsession* with like, school and, and being perfect. I mean I did a double master's like, "That's stupid, that's crazy. Who does that? Nobody" (*laughs*) (subset 1.a.3. Years of starving herself on this quest for perfectionism). Although she implements humour through laughter like participant 4 (e.g., Stephanie), Geraldine put an emphasis on having an "obsession" with "being perfect."

According to research and studies, the notion of denial is referring to more than just health matters or self-perception. Rather, many theories of anorexia nervosa have in common the assumption that the disorder constitutes an attempt to re-establish a form of self-regulation of unpleasant emotional states and other aspects of the self (Goldner, Cockell, & Srikameswaran, 2002; Goodsitt, 1983; Shafran, Cooper, & Fairburn, 2002; Vandereycken, 2006):

> This is actually my superpower everybody. I'm really, really good at this" and… "If I *don't* have *this*, I wouldn't get A+s on this or I wouldn't get A's and if I'm *really* good at it then like, my grades are even higher." At least that's what I *thought*. Right? So, like, how wrapped up I was in it, how dedicated I was to my eating disorder, I thought reflected in my grades? (Subset 1.a.3. Years of starving herself on this quest for perfectionism).

She proceeded to put an emphasis on her perceived notion of perfectionism, as well as attempting to re-establish a form of self-regulation: "I felt like, I had to find my own identify because I couldn't possibly be feminine because I wasn't perfect. Because I wasn't beautiful. Um, I was *really* concerned with, with my body and what I wore […] I was very good at…trying to be functional and managing everybody's expectations, but also having this really hidden, this *secret" (*1.a.3. Years of starving herself on this quest for perfectionism).

3rd Superordinate: Anorexia Treatment Process. As previously mentioned, Geraldine disclosed that she received treatment as an inpatient at a hospital on an eating disorder unit, and she felt "I also couldn't let these people *down* because they were trying to *help* me, and I didn't want to disappoint *them*." She put an emphasis on how she perceived she was unable to disappoint the treatment team. In various ways, she alluded to her propensity to be a people-pleaser, who is someone who finds it difficult to say no to others, often at the expense of their own needs (Yudofsky, 2014). Moreover, individuals with AN are closely "attuned to the wishes and wants of others and have such refined empathic facility, many have problems with "overpleasing" others" (Yudofsky, 2014, p. 1). Nevertheless, individuals arrive at "overpleasing" others by many routes, including those who have low self-esteem and histories of trauma and/or impaired attachments (Yudofsky, 2014). Geraldine continued to reiterate:

> Because they were trying to *help* me, and I didn't want to disappoint *them,* and I, it was…I…it's hard to explain, it's more of a feeling like, like…I…I felt *absolutely* hopeless because I was…I wasn't…following my rule of life that I've been, you know, been following the whole time…is that anorexia and me are best friends, and I *need* this in order to be successful in life.

Similar to the process the present author used with previous participants such as Lotus (e.g., participant 2), Rose (e.g., participant 3), and Stephanie (e.g., participant 4), the present author softened her voice during interviews and reminded Geraldine that the interview process permits her voice to be heard in an attentive and respectful manner by the present author. Accordingly, the present author remained present with Geraldine by replying with empathetic reflection and paraphrasing her responses to the interview questions. In this light, Geraldine proceeded to indicate the perceived interpersonal nature of AN she experienced:

> It's hard to stop to talk about my eating disorder without sort of…nostalgia? I guess? Because we were *best friends*. Like, when I needed it, I call him "Ed." But when I needed him, *he* was there. Always, without, without fail. Like, if I needed to be consoled my Ed was there. When I…when I needed encouragement, *he* was there (superordinate [Experience with Anorexia] subset 2. b Interpersonal relationship with anorexia and "Ed").

In phenomenological literature, it is often suggested that "I both am a body (subject) and have a body (object)" (Leder, 2021, p. 60). However, one would neither say I "am" nor "have" another person; both verbs would be inappropriate, almost unintelligible. Therefore, "it would seem more accurate to say I "am-with" the other, whether our relationship be friendly or hostile in tone" (Leder, 2021, p. 60). The author, Leder (2021), included the hyphen to mark the depth of both connection and separation the anorexic experiences. As the interviewing process progressed, Geraldine reflected: "So, I've stopped going to the unit a year ago. And so, it's been a year exactly almost on my own. So, I feel like, that is *my*, my first year of recovery" (superordinate [4. Experience of Remission and Recovery Process]). The present author reflected how it was a process for Geraldine, in which she mentioned separation and some distance between herself and "Ed," but also an opportunity to make a conscious decision: "Mmhmm. Yeah. I think (*pauses*). I think there was sort of this revelation that I was allowed…to make…I had the freedom of choice" (4. b How Remission and Recovery has changed her sense of Self and Identity).

4th Superordinate: Points of Mutual Influence between Experience of the Remission and Recovery Process, as well as the Meaning-Making Process/Sense of Purpose.

The interview questions and Geraldine's responses proceeded to shift from her experience of AN towards the remission and recovery process. The present author reflected and paraphrased components of Geraldine's interview responses, in which she accentuated AN was comparable to a "prominent relationship and friend" that she perceived she had with "Ed" (e.g., AN) in her life at the time with the experience of AN:

> It was….it was my everything. It was my everything. And then, I mean, so in recovery as well, or like, trying to…get to even the idea of recovery, having to *give up* this…*relationship* was like an astronomical ask […] Like, not only is it your *best friend*, he becomes your partner. It, it is *you*. They're asking you to lose a part of yourself. And I…*never* believed it was possible. Ever, ever, ever. […] But, um, like, *very* (*stops*). So much better than before of course and my life is so much better than, than it was when I like, realized that it's toxic and it's sickening and it's not right, but…it's still kind of really *sad* because we were so close (*sighs/laughs quietly*) (subset 2. b Interpersonal relationship with anorexia and "Ed").

The present author echoed how remission and recovery required grieving; namely, the notion of letting go, as Geraldine said, "it was a part of [her] 'Ed," as she characterized AN. Given that she confirmed that she perceived it was the loss of a relationship, she reflected: "Mmhmm. I very much still mourn it…" (Superordinate [4. Experience of Remission and Recovery Process] subset 4. a. Grieving the loss of anorexia during remission and recovery).

Complicated grief is characterized by a wide range of symptoms, including identity confusion or a sense that a part of oneself has died with the departed (Reid et al., 2020). EDs and grief have a multifaceted, as well as complex relationship. More specifically, an ED may be a learned dysfunctional means of coping with emotion by "stuffing down feelings," and "the

narrative of the eating disorder can sometimes mask other stressful and upsetting events" (Reid et al., 2020, p 980). The present author reflected and queried how Geraldine made sense of her mourning, if at all, inquiring what she perceived she was mourning:

> Um (*long pause*). I…for some reason, I…I…loved…I… (*stops*). I don't know why I don't remember really any of the horrible parts of my eating disorder. I'm pretty sure your body probably does that because, you know, because it's trying to survive. But um, I…*loved* the feeling of control that I thought I had over my life. I…I *loved* the person I was *trying* to become. I *loved* the drive that I had. The…the ability to – at least in my mind – be as close to perfect as possible. And to continue to strive to…to that standard? Um, so, functioning now in life, *for me*, when feelings of perfectionism, um, for example, come up, I…I have a lot of problems because I, I *love* it […] I get really scared because I don't know if this is sort of like, a little opening…I get scared and excited at the same time because (*stops*). "Is Ed going come" (*stops*). "Is Ed going come back, am I letting him back in?" "Am I…am I going to go back into this process?" Because I mean, we've all relapsed.

People in recovery may also find themselves grieving their ED, which adds another layer of difficulty onto the recovery process (Reid et al., 2020). As voiced in her response, Geraldine expressed grieving and feeling bereft of "Ed," as well as conflicting emotions (e.g., fear, excitement, grief, and anticipation) during the remission and recovery process. In reference to relapse, Geraldine expressed, "Like, you're either going to do it or you're not doing it. And I ***hate*** that. Like…it…it shouldn't have to be black and white." As she reflected on the remission and recovery process, she shifts from describing "my anorexia" to "you're" (e.g., the other

potentially experience an ED) thereby creating a distance and *Dasein* like Rose (participant 3) and Stephanie (participant 4).

Geraldine proceeded to expand on how the remission and recovery process is neither a linear nor a finite process in her experience and understanding: "I think a lot of people even though they, they *say*, "Oh well, it's not linear, it's ok." The disappointment and the…the sadness and the *guilt*, for sure the *guilt* of you not being able to get your life together" (subset 4. d. Continuum and Fluidity of Recovery). Like other participants, Geraldine reflects on the continuum and fluidity of the recovery process. In addition, she alludes to the subsequent emotions that are derived from relapse such as sadness and guilt. Although guilt can be a sign of a healthy/positive mindset when presented or expressed appropriately (e.g., feeling guilty for hurting someone during a disagreement or argument), difficulties and challenges arise when guilt is misplaced, or irrelevant to our actions (Blythin et al., 2020). By way of example, feeling guilty for eating or feeling guilty for indulging in self-care. Both of these are common occurrences in eating disorder recovery. Oftentimes, people with eating disorders (and those without) feel guilty for attending to their needs (Blythin et al., 2020).

It is now relevant to define the role of shame versus guilt in AN. To begin, it is important to recognize that feelings of guilt and shame are among our most private, intimate experiences (Rortveit et al., 2010; Tangney & Dearing 2003). In particular, guilt and shame influence one to evaluate and render judgement and may have a myriad of negative interpersonal and individual implications in a person's life. Shame is a multifaceted experience comprising various aspects and components that vary from person to person, indicating the complexity of feelings, cognitions, and actions (Gilbert 2007). Shame is rooted in the 'threat to the self,' while guilt is associated with caregiving, desire to avoid doing harm to others, and concern about others'

welfare (Rortveit et al., 2010). Lewis (1971) proposed a fundamental difference between shame and guilt that centers on the role of the self. According to Lewis (1971), shame arises from the self 's negative evaluation of the entire self; that is, after painful self scrutiny the self perceives itself to be inadequate in some respect (e.g., worthless, incompetent, powerless, or bad). Guilt, on the other hand, is said to arise from the self 's negative evaluation of its behaviour. In some situations, guilt and shame can coincide (Duffy & Henkel, 2016).

Research has implicated shame as a significant factor in the etiology of EDs such as AN and BN. Shame is defined as a negative evaluation of the self, involving components of anger, anxiety, and disgust (Gilbert, 2003; Goss & Allan, 2009). Feelings of shame are intense and unpleasant, making them difficult tolerate. Individuals with AN present high tendencies towards harm avoidance and often use disordered eating as a means of regulating negative affect (Burney & Irwin, 2000; Duffy & Henkel, 2016; Goss & Allan, 2009). As a result, shame has been implicated as an antecedent factor to ED behaviours. Goss and Allan (2009) suggest symptoms such as restricting caloric intake and/or purging may be employed in an attempt to alleviate underlying feelings of shame. However, this relief is typically short-lived. Therefore, having engaged in AN and ED behaviour induces more feelings of shame, followed by a renewed need to escape the feeling, becoming a self-perpetuating cycle which maintains AN (Goss & Allan, 2009; Skårderud, 2007).

Research has focused primarily on the role of shame in AN, but it is necessary to address guilt as well. According to Duffy and Henkel (2016), guilt is considered an adaptive emotion. Someone with AN, however, may feel guilt for their eating pathology, while also feeling unable to change their behaviour, especially if they have tried to do so and relapsed (Duffy & Henkel, 2016). When a guilt-inducing action cannot be resolved, the inability to change may be perceived

as a flaw within the self, more reminiscent of shame than guilt. In this situation, simple guilt may become shame-fused guilt: guilt with all the negative impacts of shame (Tangney & Dearing, 2003). An Australian study discovered that the level of shame associated with eating behaviour was the strongest predictor of the severity of the ED (i.e., AN and/or BN) and suggested that a woman with ED tended to "condemn her disturbed eating behaviour (guilt) and to condemn her own inadequacy in this regard (shame)" (Burney & Irwin 2000, p. 58). Therefore, "eating-associated shame emerges as a substantially more important consideration than is eating-associated guilt" (Burney & Irwin 2000, p. 58).

Geraldine puts substantial emphasis on the guilt and shame she experienced with AN, including how her sense of meaning and purpose in recovery has allowed it to dissipate "the guilt, shame [and] anxiety":

> I think that like, the guilt, shame, anxiety I think those are residuals of my past life because I ***never*** would have been allowed to do that before. The ***guilt*** I would ***feel*** for ***doing*** something ***that***…was ***not*** within the rules of whatever anorexia had or my parents had or what have you. The guilt was ***overwhelming***, but ***now***…. I…I can ***do*** things and I still get so much guilt and shame and embarrassment and all of those like, anxiety, that like, those are very, very, very common for me. So sometimes, that makes it much more difficult to be able to do things, but I ***still can***. I have to remind myself, "Oh, you know what like I want to…" you know, "if I want to go for a walk tonight later at night, I'm ***allowed*** to do that. I don't have to feel guilty. I'm allowed to create ***my*** rules and ***my*** boundaries. ***My*** purpose […] And I think that like, the guilt, shame, anxiety I think those are residuals of my past life because I ***never*** would have been allowed to do that before. […] ***So***, it's just really, its…recovery is, is worth it. Recovery gives meaning or allows

> meaning and purpose. Um, because it, anorexia eating disorders, maybe mental illness, I don't know how far you can expand that, but there is *no*…. *there is no* meaning.

Geraldine continued to reflect and disclose aspects of her experience with relapse during the remission process:

> I've tried to recover lot's of times. Um, and I think sometimes are more (*pauses*) every…for many of the times there was always a component missing, I would say […] It's just, it's, it's *no* life. It's no life to live." So not only is there, um, this separation that you have to make between you and Ed… I had to get to a point where I was like, "Ok, that's it, I'm done." I…I guess people call it rock bottom. Like, I had to actually…*want* every single part of me to get better […] I…I was at a really low weight probably like, 80 or 90 pounds, something like that and I was in…a *very* abusive relationship um, and…I don't know where it came from, I don't know (*pauses/stops*). I honestly, I feel like it just happened (subset 4. b. 3. Active Remission-Self).

In the response above, Geraldine paused, which was indicative that she was thinking about what she was going to say to the present author in her answer. Additionally, there seemed to be some hesitation, as she processed the question and her answer. Geraldine's pauses are indicative of her hesitation, reflective of feelings of ambiguity, doubt and/or nervousness. She stated that her recovery "just happened," which is suggestive that it was an instantaneous/active decision for Geraldine to shift into the recovery process. However, Geraldine proceeds to mention challenges of initiating the remission and recovery process below, conveying that it is a continuum. It is important to note that "just" is one of those words that is intended to minimize what one is stating. An acceptable or more positive use of the word is when it is an adjective to describe a recent action or occurrence (Joiner & Westphal, 1978). Nevertheless, the overuse of a word like

"just" has negative aspects when it is used to diminish the importance or difficulty of an activity, making it seem disingenuous (Joiner & Westphal, 1978; Muradian, 2021).

Similar to other participants, Geraldine endured trauma (e.g., a physically abusive relationship) and so AN likely provided her with a sense of control until she felt that she lost it and her identity:

> And so, like, "I want to do something with my life, I'm ready to create," I guess, "my own identity." And maybe I was scared of that for a long time? I think maybe that had a lot to do with it because there were all these identities that everybody else was throwing out, it's like, "Hey, be this, be this!" And it's like, "Let me make up my own mind." […] I just…I used (*pauses*) the resources and I stuck to my guns, and, and…it's still working? So, I've stopped going to the unit a year ago. And so, it's been a year exactly almost on my own. So, I feel like, that is *my*, my first year of recovery (subset 4. b How Remission and Recovery has changed her sense of Self and Identity, as well as nuanced with subset 4. b. 5. Determined Recovery-Self).

Geraldine accentuated "*my, my* recovery," conveying that she took ownership of it and Dasein, as well as igniting a feeling of internal agency (4. b. 5. Determined Recovery-Self). She articulated the challenges of emerging into the process of remission and recovery, including how "I remember […] I had been…thinking about suicide for like, many, many months […] as my, as like, a way…to disappear?" (Subset 5. 1. a. Contemplated suicide). Accordingly, the present author used empathetic reflection, wherein Geraldine highlighted the depths of her suffering and pain at the time.

The interview shifted and moved into how Geraldine would describe her relationship with remission and recovery, including how it was different from her relationship with AN:

> Oh, very much so. Um, well, actually the similarities would be that I…I do think about it often. Like, I, I do think about, "Ok, it's ok…you're…you're in *recovery*, you're *practicing* recovery." And, um, I try to make sure that all of the negative thoughts that definitely still surface, that I'm actively countering them with positives. Like, "No, that's not true, that's…that thought is not rational, that's not real […]. The freedom of being able to spend your time without all of those negative perseverating thoughts. And all of the…the structure with treatment is…incredible, and it's *worth* recovery. A hundred percent […]. The moment that I chose recovery was really big. I had, um, I had *just*, I'd decided to get out of a very abusive relationship both sort of mentally and physically, and, um, and I remember looking in the mirror […] and so, in that moment I was like, "Well, that's it. I'm…if…if I'm strong enough to breakup with somebody that I was so dependent on, but that was abusing me, how is that even different than my eating disorder?"

The present author used paraphrasing and provided Geraldine the opportunity to further expand on her experience of remission and recovery: "Yeah, I need to change the narrative because right now how this is going, it's not going to go much longer. Like, "This has an end." It's a life that I mourn, but I don't want […] there are moments still in recovery that I grieve. I'm sad that it's…it was such a huge part of my life. I devoted *so* much energy to it. For *so* long" (subset 4. a. Grieving the loss of anorexia during remission and recovery).

5th Superordinate: Metaphors for Anorexia, Remission and/or Recovery. After exploring features, she expressed pertaining to her experience with the remission and recovery process, the present author inquired if there were any words, a sentence, or metaphors that came to mind when Geraldine thought of remission and or recovery: "*Hmmm.* It…it is a sense of

freedom, which is really nice" (superordinate [5. Metaphors for Anorexia, Remission and/or Recovery Process] nuanced with subset 5. e. 3. Liberation of Recovery). While she highlighted the sense of freedom and liberation that she experiences from recovery, she also revealed another metaphor for AN and remission:

> I think the best would be… you know, being in prison that…I would extend it to all mental illness. Um, but definitely with an eating disorder….and it feels <u>*so*</u> far away because your on-death row. [Anorexia] It's a *death sentence*. And you're sort of waiting for parole. It really is, *it is* a death sentence. *It is* a prison. You are locked in there and…and a lot of people for a very long time I wasn't even (*pauses*). Um, *aware* that I had an eating disorder. […] Recovery feels or parole or (*breath*) that freedom. It's <u>*worth it*</u>. Yeah, but I think maybe that would probably describe it best (subset 5. e. 2. Imprisonment of Anorexia, nuanced with subsets 5. e. 3. Liberation of Recovery).

Interwoven in her metaphors of AN (i.e., as jail and prison) was also the symbol of Geraldine being "[her] own warden now. *Yeah! I am!"* […] I was able to sort of to *choose* to *not* have that Ed (*stops*) anorexia around." She also corrected herself by establishing a separation between "Ed" and "anorexia" and/or "my eating disorder," by using different language tenses and pronouns. She also highlights the "freedom of choice," which is indicative of Frankl and an internal locus of control:

> <u>*Yes*! *Choice!*</u> There was never choice in my life before. I felt like, I mean, I *think* I thought there was. Um, and, as like, for control. But <u>*now*</u> that I *know* what it's like sort of on the other end of the stick (*light chuckle*) it's kind of really amazing. Like I can go out right now and I <u>*can choose*</u>, you know?

As previously mentioned, the words italicized and underlined are representative of the emphasis that Geraldine used in her responses during the interview, particularly towards the power of her "choice." Frankl (2006) acknowledged the importance of our power to choose. More specifically, he understood how free we are to choose our own attitudes about our lives. This quote is a phenomenal example of this point. "Everything can be taken from a man but one thing: the last of the human freedoms – to choose one's attitude in any given set of circumstances, to choose one's own way" (Frankl, 2006, p. 86).

Following the exploration and discussion of Geraldine's remission and recovery process, accompanied by subsequent metaphors, the present author inquired if she had noticed any changes in what gives her a sense of purpose since she was first diagnosed with anorexia and now: "I don't *feel* the need to…I don't feel the need to be perfect anymore. My purpose isn't to impress other people" (superordinate [6. Meaning-Making Process and Sense of Purpose] with subset 6. b. Meaning and Purpose since being diagnosed with Anorexia). Geraldine continued to reflect on the sense of purpose she has received from remission and recovery:

> It's ***definitely***…being recovered has allowed me to have a sense of purpose […] I now feel like I'm *allowed* to. I'm *allowed* to exist. I'm allowed to… want things for myself. And I'm *allowed* to *do it* […] I really do believe that…. a purpose is to, um, of mine I guess, is to as best as I am able to *share* and *help* other people in similar situations. Um, and, and so, I, I feel as though…there's that sort of overwhelming or overlying greater purpose is there. And I don't know. I, I don't feel like anything is dictated or whatever, but I, I feel as though everybody is connected. We're sort of all in this human condition together. And I would call that spirituality. And…um, and it is my responsibility, I feel it's everybody's responsibility to *help* other people, if they *can* […] I'm learning to be a

> much more gentle person. To be more kind. To be more positive (subset 6. c. Impact of Remission and Recovery on Sense of Purpose).

German psychiatrist and philosopher, Karl Jaspers, had a key proponent of existentialism focused in his philosophy on existence describing it as the experience of freedom and possibility which constitutes the being of an individual who is aware of "the encompassing" by suffering, conflict, and guilt (Talarczyk, 2011). Moreover, the Jaspers' concept includes discovering one's own "existence" "by experiencing such values as: courage, dignity, faithfulness, solidarity, responsibility, autonomy" (Talarczyk, 2011, p. 74). As previously mentioned by Frankl (2006), although we are all subject to circumstances in our lives, we are free to choose; namely, to choose the way we think about those circumstances, as well as to choose also how we will respond to them. Geraldine chose to use her experience with AN, remission, and recovery, to help others for a sense of meaning and purpose.

Geraldine mentioned spirituality in her response, so the present author asked how she would define spirituality (superordinate [7. Spirituality] with subset 7. c. Spiritual Beliefs and Values):

> I feel like there's something bigger than me going on. Um, and I don't know whether or not it's controlling my life or whatever, but I feel like…there *is* a bigger purpose. I don't think I went through all of these things in my *life*….to…*not* share them […] I really do believe that…. a purpose is to, um, of mine I guess, is to as best as I am able to *share* and *help* other people in similar situations. Um, and, and so, I, I feel as though…there's that sort of overwhelming or overlining greater purpose is there. I, I feel as though everybody is connected. We're sort of all in this human condition together. And I would call that spirituality. And…um, and it is *my* responsibility, I feel it's everybody's responsibility to

> *help* other people, if they *can* […] *So*, emotions for me, you know, with because of my spirituality because of my *connectedness to* people are, are amplified.

6th Superordinate: Spirituality. The present author reflected how when Geraldine described spirituality, she highlighted interconnectedness of the "human condition." Part of that process involved as she shared, allowing herself to connect (e.g., "as a smile, sharing, through participating or that connection"). In addition, Geraldine described having a tumultuous association with religion: "Like, "I don't know if religion is *for me*?" I don't….and I'm, I like being able to not know. And…I was almost immediately excommunicated … from life" (subset 7. b. Questioning religion and faith). She revealed some additional painful experiences of religion after questioning her faith, and some resultant "horrible" remarks made by her mother:

> I have one daughter and a son. I don't have two daughters." "I…it's going to be so terrible because when we all die…You're going to be burning in hell and we're going to be in heaven and we're going to be so sad that you're not there with us." Like *horrible* statements that I *never* thought would come out of my mother's mouth. And um, just, it…it honestly….it was like, my life had changed in an instant and, um, I…I didn't know how to handle it. *At all*. Um, I *really* leaned into my eating disorder, really, because I was… "Well, *this* isn't working anymore. I need to go more. I need to do more. I'm not being enough, so if I do eat, I'm going to purge […] And it wasn't until, um, my parents were, I don't know how they were contacted, but when I did attempt suicide and was admitted, *somehow* my parents were contacted. And my mom flew in and…she, I remember her coming to my bedside and just being like, "Finally, something bad has happened." And she put like a cross over my neck and said, um, "You're going to be coming back," like, "You're going to come live with

> us and you're going to become Catholic again," or whatever like that (subset 7. a. Experience of Religion, nuanced with subset 7. b. Questioning religion and faith).

Geraldine expressed feeling "Very much punished. *Very* much. I think I'm still sort of dealing with all of it." She described the punitive aspects of questioning the existence of God in a Catholic high school: "We ended up asking like, the existence of God […] I, I *don't* know? Like, I never thought that I could *question* that before" (subset 7. b. Questioning religion and faith).

As conveyed in research, a prominent theme in the psychology literature concerning the relationship between AN and religion is that of religion as a cultivator and preserver of AN (Rider et al., 2014). For example, one of the earliest works to emerge reflective of this theme was a theoretical exploration of the transmission of the discipline of self-starvation down through the ages of Christian history (Lelwica, 1999; Raider et al, 2014). She proceeded to disclose inherent challenges she experienced from her mother after questioning her faith, including the impact it had on recovery, as well as her life:

> After the moment, you know, where my mom was there and she was all about her religion and…it was *hard* because it wasn't like, "Oh my goodness my daughter….is having this hard time in life, I love her, and I'm here for her." It was, "Oh my goodness…my daughter can be perfect again *this* way," or it…it just wasn't about me. I didn't feel that any of it was about me. I don't think I was actually seen. And, I didn't have any, I really honestly, I ended up a month later in the hospital I…I…attempted suicide again. And, um, and my parents didn't come out, thankfully (subset 5. 1. b. Attempted suicide).

The present author proceeded to soften her voice, while also implementing empathetic reflection and paraphrasing. Geraldine continued to express: "I'm not trying to knock religion at all and for

some people it's really wonderful and that's wonderful." But I *understood* sort of all of a sudden that I, I was sort of blindly following all of these rules and not questioning them because it, they were my, it was my *belief* system." Accordingly, Geraldine was allowing herself to question her belief system, providing herself with a sense of agency, autonomy, and freedom of choice (Frankl, 2006).

Phenomenological Core of Geraldine. The phenomenological core of Geraldine's experience of the remission and recovery from AN is captured in the following words: resilience, courage, empathy, freedom, and choice. Resilience is defined as "the process of adapting well in the face of adversity, trauma, tragedy threats or even significant sources of stress" (Kane et al., 2019, p. 391). Moreover, it reflects the ability to maintain a stable equilibrium, within the concept of resilience also includes rebound from adversity (Bozikas & Parlapani, 2016; Kane et al., 2019). Geraldine conveyed resilience, as she stated: "If I'm strong enough to breakup with somebody that I was so dependent on, but that was abusing me, how is that even different than my eating disorder." Likewise, she contemplated and attempted suicide, but she found a sense of purpose and meaning since recovering from AN:

> You just have to give…it some breath, so you can actually realize those connections and maybe put two and two together. And that makes me a better, stronger person. It allows me to understand myself better, and then that in turn gives me more purpose and meaning.

Interwoven in Geraldine's reflections and responses about her experience with the onset and diagnosis of AN, as well as the remission and recovery process conveys both courage, resilience, and vulnerability: "Vulnerability sounds like truth and feels like courage. Truth and courage aren't always comfortable, but they're never weakness" (Brown, 2012, p. 37). While she

described the recovery process as "hard"," she also described "*recovery* is like, a big old open field. And the opportunity…to live is there, which is *so nice*."

Intertwined in Geraldine's responses are also empathy, freedom, and choice. Eating disorders (EDs) are often perceived as self-inflicted and a matter of choice rather than medical conditions (e.g., Crisp, 2005). Subsequently, persons with EDs are held markedly more responsible for their illness than, for example, people with depression or anxiety (e.g., Thörel et al., 2021; Thörel & Thörel, 2022). The inference of responsibility for a mental illness or disorder represents a cognitive aspect of stigmatization (Link & Phelan, 2001). Therefore, Geraldine's recognition of her "freedom of choice" and "hope" for her recovery, conveys her inner strength and courage (Slade & Longden, 2015), as well as her empathy for others with AN:

> I, *hope* desperately that there is a reason why I went through everything I went through. And I hope that, and some days I still go through it because it's hard to feel as though it just happened because it happened, you know what I mean? Like, it's hard for me to be ok with. It just happening to people, and it is killing people because that's *terrible*. It just hurts. It breaks my heart.

Concluding Reflections from Geraldine. Geraldine offered many sensitive assertions, reflections, and statements concerning aspects regarding her experience with AN, as well as her restorative and healing process. She also provided depth, openness, and awareness into her experience with AN, as well as her remission and recovery process. Intertwined in her responses convey the significance of empathy, resilience, and connection for Geraldine:

> I'm just thankful I get to see different parts of myself that I've been developing without going back and seeing…. what is that like? What did I create? What have I been creating? It's *really* wonderful to have…that ability to, to sort of look at yourself…self

> under a microscope in a good way. I mean that *truly*. Like it's really it like, I almost feel like it should be a portion of treatment. I think treatment should continue during recovery. I don't, it, it would be *really* wonderful to have… I wonder how much this could benefit other people. You know? Like this has *truly* benefited me. There are things that I discovered about myself, um, just from talking with you. And, um, and having you sort of summarize the things that I'm saying. It's, it's kind of really *incredible*. I'm *really* thankful.

In addition to expressing gratitude, Geraldine also reflected on the depth and insight she obtained from the interview and reflection process:

> Well, and sort of this process with you has been *really wonderful* because *so many things have come up.* Um, because maybe I'm re-evaluating or just like, I guess. I'm going to call it talk-therapy. Like, can *bring up* to the surface things that maybe were, you know, just bubbling underneath for *so long*. And sometimes let things stew, connections can be made. And you just have to give…it some breath, so you can actually realize those connections and maybe put two and two together. And that makes me a better, stronger person. It allows me to understand myself better, and then that in turn gives me more purpose and meaning […] Because now I understand myself a little bit more. So, I think, like you've definitely *inspired* me to, um, like, *take time*, you know? Every once in a while, whether it be like every other month, or every 6-months or whatever to just…. sort of go back through everything and, and, and think, "Ok, well where was I? Where am I now? Where do I want to go?" Sort of just those three simple questions. And I think that…it, it'll help me sort of reflect.

The present author reflected on the integration and application, even though it's a 3-step interview process, as Geraldine touched on, the concept behind it is to give the "breath," to have that "breath" as she said. The space in-between it to think and reflect and for her and the present author to come back and connect:

> *Mmhmm!* And to delve a little bit deeper each time […] I feel like there's something bigger than me going on. Um, and I don't know whether or not it's controlling my life or whatever, but I feel like…there *is* a bigger purpose. I don't think I went through all of these things in my *life*….to…*not* share them.

5.2. Part 2: Superordinate's Across Participants

As a second step in communicating the findings of this research, the present author will focus on presenting the superordinate themes that emerged across the experience of the five participants. The superordinate themes presented in Table 3, accompanied by subset themes in Appendix E.

Table 3

Superordinate Themes Across Participants
1. Diagnosis of Anorexia
2. Experience of Anorexia Nervosa
3. Anorexia Treatment Process
4. Experience of Remission and Recovery Process
5. Metaphors for Anorexia, Remission and/or Recovery Process
6. Spirituality
7. Meaning-Making Process and Sense of Purpose

Each superordinate will be presented alongside statements from the participants.

1st Superordinate: Diagnosis of Anorexia

As research and literature demonstrates, there is disagreement regarding the etiology and indeed the concept of anorexia nervosa. As a result, Kay and Leigh (1954) stated, "there is no neurosis specific to anorexia nervosa and no specific anorexia nervosa" (p. 428). However, Russell et al. (2019) consider AN to be a well-defined syndrome, while Crisp (1977) has claimed that there are both specific and non-specific levels of psychopathology and abnormal behaviour within the condition. Women's practices of, and narratives about, self-starvation are both in dialogue with, and indexical of (e.g., a linguistic expression whose reference can shift from context to context), medical and critical accounts of the anorexia (Shohet, 2007; 2018).

It is now relevant to discuss the concept of polysemy. More specifically, polysemy is a linguistic phenomenon where a word has multiple related meanings or senses (Devitt, 2021). Polysemy is contrasted with homonymy, where a word form has distinct but unrelated meanings; for instance, 'bank' (financial institution vs. river edge). An expression is unequivocal if it has only one meaning; otherwise, it is ambiguous: "If an expression is ambiguous, and the multiple meanings are somehow related, then the expression is said to be polysemous. If the multiple meanings are not related, the expression is homonymous" (Wallace, 2019, p. 4333).

Instances of polysemy and homonymy fall under the phenomenon of ambiguity. An expression is ambiguous if it has multiple meanings, where the meanings are either related (in case of polysemy) or unrelated (in the case of homonymy). In the case of this study, the *diagnosis* of AN - is said to be polysemous when it is associated with two or several related senses (e.g., the researcher asked Geraldine how the metaphor of AN provides her with a sense of "comfort"; Lotus referred to AN as "a friend" and "a comfort"). The participants expressed having varied, but parallel understandings and experiences of their diagnosis of AN.

In terms of receiving a diagnosis of AN, the participants expressed feeling a lack of understanding and association with the initial diagnosis. For example, Geraldine (e.g., participant 5) stated: "I truly, like, putting the label of like, "Oh, you have anorexia, you have an eating disorder." Even, even just like, the general term of 'eating disorder' was… (*stops*). *So* many labels." She stopped in her response, which was indicative of her attempting to process her experience of being diagnosed with AN. With additional time to process, accompanied by paraphrasing from the present author, Geraldine reflected (superordinate: [Diagnosis of Anorexia 1] accompanied by the subset 2.b. Label of anorexia or eating disorder was misunderstood):

> I know that people know that eating disorders exist. Sure. And, and we're told about it, but I think it's still swept under the rug. Very much so […] Mmhmm. So, it's, it's nice now to not feel the *need* or the, um, the necessity to really even identify with the label anymore. It's not…my defining characteristic anymore. My defining characteristic isn't me trying to…*find* recovery. Recovery is so much more than weight restoration (*laughs*) […] I've sort of made this sort of flexible identity of who [Geraldine] is and what [Geraldine] wants and…there's, there's motives behind that and goals.

In a similar manner, Rose (e.g., participant 3) articulated: "I remember thinking (*pauses*). The eating disorder was like (*pauses*) like another part of me…like it, like it…it was like, *distinct*, it's like I had such negative voices…mmhmm" (subset 1. c. First encounter with ED\AN).

As existing research indicates, a significant number of individuals with an ED experience an eating disorder voice (EDV) (Pugh et al., 2018; Ling et al., 2021) or, in the context of AN, an "anorexic voice" (Tierney & Fox, 2010; Pugh & Waller, 2017). The EDV describes a hostile second- or third-person commentary related to eating, shape, and weight (Pugh & Waller, 2017), experienced as internally generated yet separate from the self (Fox et al., 2012): a "sub-self" containing "needs, feelings, perceptions, and behaviour that have been dissociated from the

patient's total self-experience" (Sands, 1991, p.37). Another participant, Lotus (e.g., participant 2) echoed: "Anorexia took the permission away […] I had no voice anymore. It was just all about that…it promised control" (subset 1.d. Impact of Diagnosis). In many ways, it nuances an "anorexic-self," in which the participants had a fragmented sense of self consumed and obscured by the diagnosis and experience of AN.

After receiving a diagnosis of AN, participants highlighted their lack of understanding, knowledge, and ability to grasp the implications of the syndrome. Moreover, participants accentuated existent gaps in the current diagnosis and treatment process of AN, including some of their motives for participating in the current study (i.e., participant 1 – Liesel):

> I'm totally an open book about this because I know that there's not enough stuff for eating disorders out there, like I'm super…I almost feel frustrated by the lack of stuff about eating disorders out there. Like resources, funding, you know, so that's why I'm like…I'll obviously participate in something about this because it's important […] And it's, again, it's not even frustration for myself because…I somehow got through it […] It's more for like, what I see like…in just everyday, and just what people like…how many people are unaware of how…toxic what…our culture is. I'm just like, "Oh my God…if like this huge proportion of men were dealing with this…this psychological issue we'd probably be dedicating more resources to it…there wouldn't be six beds in eastern Ontario for it […] Everyone was always like, monitoring me and seeing what I ate, and um, looking at me to see how skinny I was and stuff. And like, I felt annoyed by that, and just like, 'Leave me alone, and let me do what I want.' Um, so, a lot of the stuff I did was like, very secretive.

The participants proceeded to accentuate the lack of continuity of care, including the ambiguity of the diagnosis and explanation of it (i.e., participant 4 – Stephanie):

> Yeah, um, it was kind of strange in the sense that, um (*pauses*). Until finally, I think it was like a month or so in, they…they came in and said, 'You know,' like, 'after hearing

> your history and also observing the way that you eat…or don't eat, and, all the other symptoms,' um, we, like, 'our diagnosis is that you have anorexia with bulimic tendencies' (*mumbles/softly chuckles*). Um, and so then I just…I didn't really understand because I thought …for so long that it's normal […] But I was just kind of really confused with what she meant (*trails off*). Like, I was very confused, and I mean, especially because leading up to them saying that this is my diagnosis there were a lot of, um, shared mealtimes where I would have a nurse practitioner watching me eat, and…telling me how to eat telling me how not to eat. And, you know, to have someone regulating your eating without telling you why […]. So, um, it made me so anxious to change *any* eating behaviour that I had? Um, but it was just real confusing because I just didn't understand why they were doing these things. And then, they come with this diagnosis, but they didn't fully explain like, 'because of these things we have determined that this is your diagnosis.' It was just kind of like, in your face, 'This is…this is what (*stops*)…your diagnosis is,' and 'You're going to be forced to do these things.' And um, 'You have to gain weight.'

The lack of clarification from the medical field presents a gap, which requires further information and explanation for patients/clients diagnosed with AN. With additional time to reflect on her experience of the diagnosis of AN during the interview process with the present author Stephanie (e.g., participant 4) reflected the holes in the medical system:

> I mean, clearly, given the symptoms, and the way I was feeling about my weight, I'm not going to have the same concerns as they had. So, I think, um, although I understand their intentions, and it makes sense to me as an adult, I think back and I would have really benefited from a more (*pauses*) let's say holistic, um, approach to care? In which, yes there are these people who are taking care of the medical aspect, but they're also – whether it's the same people or different people – who are making sure that the way that I'm feeling…*(stops*).

In a similar manner, Lotus (e.g., participant 2) also reflected on the lack of understanding upon her initial diagnosis: "When I was diagnosed, I mean, I think I thought at that time…I didn't

really understand what an eating disorder even meant like, anorexia. And so, when they told me you know, you have this diagnosis I was like, 'No, I don't' It just didn't make sense" (subset 1.b. Diagnosis and Initial Experience of Anorexia).

As the participants voiced in their responses about their diagnosis of AN, it conveys how AN is an enigmatic syndrome with myriad complex features. For example, AN is often conceptualized as the persistent intake of a diet low in calories and low in dietary fat is a central and sustaining feature of the illness, combined with the focus on weight loss and emaciation (Maine et al., 2009). However, the participants disclosed how AN was also a method of coping and fostering a sense of agency due to trauma (i.e., participant 2 (Lotus) and participant 4 (Stephanie), as well as concomitant disorders (i.e., participant 1 (Liezel) with ulcerative colitis, refer to subsets 1.b. concomitant disorder (physiological), nuanced with 1.d. ambivalence about anorexia due to colitis; participant 4 (Stephanie) with epilepsy; and participant 5 (Geraldine) with depression).

Given that one of the challenging aspects in treating individuals with AN is individuals' ambivalence about making changes in their eating, coupled with a tendency to deny the potentially serious nature of their syndrome (Hope et al., 2013; Mitchell & Peterson, 2008); therefore, the present author suggests that the intake assessment for AN begin by determining, from the individual's perspective, what prompted the evaluation and assessment. Furthermore, trauma issues are often leading and compounded by negative diagnosis and resultant treatment experiences: "Many of our patients with long-standing, ostensibly treatment resistant eating disorders, speak of feeling quite traumatized by hospital admissions, then rejected by clinicians in ambulatory treatment services when they fail to recover or stay recovered" (Russel et al., 2019, p. 393). Participants told the present author they felt "stuck" (e.g., participant 5; Geraldine)

and "powerless" (e.g., participant 4; Stephanie) to change their AN behaviours, tendencies, and inclinations after their diagnosis and resultant hospitalizations and/or treatment. Moreover, participants felt misunderstood and flawed by family, friends, and clinicians; subsequently, participants did not initially understand their diagnosis. As a result, it likely manifested as a loss of identity and an attack on a fragile sense of self (e.g., leading to "Ed," as Geraldine described and/or subset 2. d Experience and Effects of Anorexic-Self for Lotus, which will described in additional detail in the next superordinate subsection).

As expressed by participants regarding their diagnosis of AN, it is beneficial to note that clinicians, family, and friends must never lose sight of the fact that there is much more to remission and recovery than weight gain. As Stephanie (e.g., participant 4) explained:

> I think now, in retrospect, um, the way that I make sense of it is that, um, I know that I was medically unstable, and I know my heartrate was very low, it was like in the low 40s. I know that my weight was very low. And so, I can understand why they were *so* concerned about the medical piece. Um, however, it wasn't explained to me, so I can understand and also (*pauses/stops*) […] think back and I would have really benefited from a more (*pauses*) let's say holistic, um, approach to care? In which, yes there are these people who are taking care of the medical aspect, but they're also – whether it's the same people or different people – who are making sure that the way that I'm feeling…*(stops*). And my more, you know, psychological/emotional state is also being attended to, as I'm being *forced* to go against what my body is telling me.

The participants articulate that moving beyond diagnosing pathology and prescribing medications, there are non-traditional conceptualizations and subsequent treatments/therapies can enable people with AN to take part in their spirit, replenish their joy, feed their mind, and accept their bodies. As alluded to by Geraldine (e.g., participant 5):

> Then also, like, sort of altogether in a whirlwind, I also was put on Prozac and…another Trazodone, I think? I think I just started saying 'yes' to everything and I don't know if it, if it was a week or if it was a month or two, but I…guess internally I had, I…that…it…I couldn't do it anymore […] *now* I'm participating in my life. Like, my life is mine. I am making decisions for me to do things, whereas before, Ed was making the decisions […] I think there was sort of this revelation that I was allowed…to make…I had the freedom of choice […] how ***wonderful*** to be able to ***experience*** sadness. ***That's***…. I have to remind myself of that sometimes. Because I get very ***overwhelmed*** with certain feelings and I have to remind myself I've never ***had*** because I, I've, I have not experienced that feeling. I ***know*** what that feeling is, but I've never allowed myself to experience it. How do you experience sadness when you have no connection to ***anything?*** How do you experience joy when you are ***not*** connected to anything? ***Joy*** was watching a number on a scale go down. Sadness was watching it go up. Anger was when people wouldn't let you do what you wanted to do. But you had no ***connection*** to anybody. Like, ***at all!*** ***So***, emotions for me, you know, with because of my spirituality because of my ***connectedness to*** people are, are amplified.

Participants highlighted their experience of the diagnosis of AN, including the resultant difficulty comprehending and accepting the pathology of an ED. As highlighted in the previous section (e.g., 5.1: Part 1: Individual Participant Experiences), there was notably a broad variation in some participant features (e.g., participant age, probability status and concomitant disorders) and intervention features (e.g., setting and format, hospitalization/programs, providers). With this in mind, the subsequent superordinate examines details of the participants' experience of AN such as a typical day, as well as the patterns, inclinations and tendencies associated with it.

2nd Superordinate: Experience of Anorexia Nervosa

In addition to the diagnosis, the present author asked questions that focused on concrete details of participants' lived experience with AN. For instance, in the second interview, questions asked sought to assist participants in reconstructing the details of their experience e.g., prompting

question: How would [they] describe a typical day with anorexia? In doing so, the participants reflect a myriad of aspects of a typical day with AN, which are conveyed in the findings of subsets from this superordinate (e.g., Appendix E) and further described in this section below.

As previously mentioned, AN is a life-threatening disorder reliant on behaviors, such as excessive food restriction and/or exercise; nevertheless, such behaviors may be secondary to an "objectified" attitude toward body image and self (Moccia et al., 2021). As current research demonstrates, the severe weight loss and starvation of AN may potentially lead to a multitude of adverse medical sequelae, including cardiovascular, metabolic, endocrine, and other disturbances that increase the susceptibility to increased risk of premature mortality (Treasure et al., 2015). However, participants in this study revealed and accentuated aspects of their experience with AN, which extended beyond merely behaviors (e.g., symptomatology such as excessive food restriction and/or exercise) and psychopathology (e.g., severe disturbances in body image, etc.). More specifically, the participants accentuated a struggle for identity along with an incomplete sense of selfhood, including how poor coherence of body representations was commonly experienced by them in the course of AN (e.g., [participant 1: Liesel – POM01ML] including subsets 2. Anorexia as a…; nested with 2. a. Coping mechanism; 2. b. An entity; [participant 5: Geraldine - POM05BS] accompanied by subsets 2. f. View of anorexia and subsequent experience of it; nested with subsets 2. f. 1. Evolvement, as well as 2. f. 2. Languishing).

In terms of a typical day with AN, the participants disclosed various behaviours they experienced in relation to their experience with an ED. For example, Liesel reported (superordinate: [2. Experience with Anorexia] accompanied by subsets 2. c. Typical day with Anorexia and 2. Characteristics of AN nested with 2. a. Cognitions, as well as 2. b. Affect):

> I mean, definitely, it's a constant preoccupation. So…from the moment you wake up, you're thinking. Well, first thing I would want to do is pee and then weigh myself. From what I can remember, there definitely would never have been a day that went by without me like, weighing myself [...] I mean…it seems like it was a constant obsession […] I just remember it was like, a lot of time spent in front of the mirror, you know, examining everything […] Yeah, it was like, it dominated my thoughts […] But it really is…like from the minute you wake up, it's like, 'Ok, got to go check to see if I lost any weight or gained any weight or just you know…God forbid gained any weight.' Very rigid. Definitely rituals. I mean, really it was all around, I just…I ate only specific things, and…did certain behaviours and, yeah…it was honestly like, it was just kind of like a gray dull time, you know. Like, nothing was that exciting because…it just dominated my thoughts, like I couldn't be happy because I was just fixated on all the things that were wrong and what I needed to do to fix them.

Given Liesel's emphasis on preoccupation and obsession, the present author inquired if she could further elaborate and explain. Without hesitation, Liesel shared: "Like body stuff. It's more like, it was more like, my perceived physical flaws […] my preoccupation with like, you know, being so stressed about being in a bathing suit or…. how I looked, you know, what I was wearing, just being so stressed out about that all the time." Another participant Lotus echoed the concept of "rituals" and "obsessions" associated with her experience of AN: "Um, rituals, I would say. Like, the moment I woke up it started…the obsessions and rituals. I would have to get up and weigh myself and just go through the day like that. It started like that and ended like that as well" (subset 2. c Eating disorder Behaviours and Daily Activities of Anorexia).

Preoccupations are defined as ideas, thoughts, images, or impulses that repeatedly enter one's mind; likewise, they may seem to occur against the person's will (Lew, 2013). Obsessions are recurrent and persistent thoughts (e.g., obsessing is a cognitive aspect), impulses, or images that cause distressing emotions such as anxiety or disgust (Levinson et al., 2019). On the

contrary, rituals and compulsions are behaviours or acts that one may feel driven to perform. At times, the person may try to resist doing them, but this may prove difficult (Lew, 2013). Additionally, AN cognitions and behaviours serve a function similar to obsessions and compulsions (e.g., as a temporary relief for anxiety, while predicting longer-term increases in anxiety and AN symptoms) (Levinson et al., 2018). The present author inquired if Lotus could expand on her admission of her daily rituals in relation to AN (subset 2. c Eating disorder Behaviours and Daily Activities of Anorexia):

> Um, exercising. Over exercising. For me, there wasn't like specific foods that I would allow myself to eat. It was just not eating. Just doing certain rituals to kind of get myself through the day […] I guess for me; it was more liquids. Like, I would drink diet coke or coffee. Things like that. Yeah, and then I guess at a certain point…by the time I picked up purging, I would add to my rituals and it was…I guess I would go a week or so without eating and just…I guess…like, staying on like, coffee or diet and then I would binge and then I would purge and it would continue as a cycle for like 2 days or 3 days and then…I would have to weigh myself after each purging and then make sure…its really weird to talk about…because like for me…coming from a healthier state it sounds like not normal (*laughs*).

Lotus' notion of using rituals to "get through the day" is symbolic of the complexity she experienced in coping at the time. The present author inquired what it was like for Lotus to reflect on a typical day with AN after she expressed finding it "weird" and laughed as a result, wherein Lotus stated: "It's irrational. I just see it as…I cannot…I do understand why I was doing that, but at the same time, I …it's hard for me to imagine that I would do it again. Yeah."

The exploration and disclosure of a standard day with AN, was seemingly difficult for other participants. For example, Rose shared aspects of her experience, followed by pausing and stopping, suggestive of how the reflection of her experience with AN elicited some emotional

aspects since being in recovery (subset 2. a. typical day with anorexia, nuanced with subset 2. b. feeling uncomfortable in her own skin):

> When I was suffering from it the *most,* I wasn't really aware of it. So, it's a bit different. So (*pauses*) I just wasn't really…eating. I was just working or working out, or doing other things and like, trying, not…I guess I was also consumed by like, my body image and how I felt about that… Yeah, it was very…very negative and it was really focused (*stops*). I was really focused inwardly, so I wasn't really (*pauses*) aware, didn't really care what was going on like, in the world. Because everything sort of…you just kind of turn inward, and I wasn't thinking about all the things I wanted to do and planning. It was almost more day by day. I just didn't feel able to engage with other people and I just felt kind of trapped…in my, in my own body […] it's just awful. It was an awful feeling. I think that's what I think of like, anorexia. It's just awful. You're just really down on yourself and you just don't feel comfortable, and you feel like…trapped and uncomfortable. You're just not comfortable in your own skin. I think that's the best way to describe it. Yeah, I was very self-conscious.

Rose put an emphasis on how unpleasant and dreadful her experience was with AN, as she repeated the words "uncomfortable" and "awful" in the above quote on a few occasions. As Rose alluded to in her response, AN severity can be identified as any disturbance of emotional balance as evidenced by a pattern of maladaptive behaviour (i.e., preoccupation with AN ritualistic behaviours and perfectionism) and deterioration of functioning (i.e., as a result of genetic, physical, chemical, biological, psychological, social and/or cultural factors) (Lew, 2013). In addition, this deterioration of functioning can be as a result of physical, psychological, or social factors (Lew, 2013). Interwoven in Rose's response is how she sought to manage her "inner" world of emotions through behaviours of AN instead of expressing them in healthy, manageable ways.

In a similar manner, Stephanie reflected on specific behaviours and inclinations that she engaged with on a regular basis in the midst of her experience with AN (subset 2. a.1. typical day with anorexia nuanced with subsets 2. c. Body shaming and comparison and 2.b.1. Source of external sense of agency):

> Um, it would entail waking up quite early to make sure that I got my, um, morning workout in. And I would never eat before my workout. I would be wake up and go straight to the gym, and I always aimed for a very specific number of calories that I had to burn on the treadmill, moving. And then, I would do my weights, and then…after that, I would allow myself to have, um, 5 types of very specific crackers with a teaspoon of peanut butter. It's all so, very, very specific. Like, it was very specifically portioned. I *always* knew how many calories I was intaking and…I would write down (*stops*). I was always obsessed and thinking about like, 'Do I look fat right now?' I'd be thinking about the clothes that I was wearing. I would be comparing myself to like, everybody around me. Like (*pauses*) having anorexia consumed my life. When I had…when I was symptomatic it was…there wasn't a single thing that I did that…wasn't in some way like, linked or influenced by my anorexia. And it just…like, it felt like dreadful every day. I think like, in the moment, I didn't think there was an impact. I felt like, as I'm doing all of these behaviours it feels like, this is what I *need* to do. This is…I'm doing the right thing for what, you know, I *need*, and it felt very much like, like, in my mind it wasn't wrong.

Paradoxically, Stephanie accentuated how AN "consumed [her] life" and she was "obsessed" with the syndrome and resultant symptoms, but she continued to experience a lack of satiety. As with the symptomatology of AN, she sought to starve herself to lose weight, but she continued to lack gratification and fulfillment unbeknownst to her at the time. Accordingly, Stephanie put an emphasis on how she perceived she "needed" to seemingly seek control by engaging in recurrent preoccupations and rituals related to her body weight and/or shape during her experience with AN.

The participant Geraldine also described her experience with AN, particularly a standard day with the syndrome. In addition to the associated behaviours and symptoms, she also disclosed negative cognitions and emotions associated with her experience of AN (subset 2. c. Typical Day with Anorexia, nuanced with subset 2. c. 2. Bad Days and Continuum of challenging experiences during a typical day with the Anorexic Self, nested with Emotions, Cognitions and Physical Sensations):

> Basically, the idea was, or at least for me, 'How long could I wait before…I *had* to eat something?' So, get up, get a shower, get dressed, um, get to school or get to work, um, maybe have a cup of tea, but (*stops*). There's *so* many…there were so many negative thoughts associated with every moment of the day. Um, and I *really, really, really* isolated because I felt that people could *see*…every little ounce that I ate. Every little bite. They could see it on my body. And it was humiliating and embarrassing. And it scared me. And I thought that I wasn't going to be accepted and that people were laughing at…like at me behind closed doors and not even behind closed doors. And, yeah, it was *really* horrible. The thoughts were terrible. The negative perseverating thoughts would be…unbearable sometimes […] So, I mean when I was *really* bad, I couldn't sleep. Like, I could not sleep. It's probably because my body was…so hungry […] I used to have this, um, *horrible* habit of, um, buying all of this, like, fresh produce and then making a *massive* meal and then packing it up into little containers and not eating it? I used to *love*…watching it *rot.*

She put an emphasis on the sense of isolation, humiliation, and embarrassment that she felt with the syndrome, as well as the satisfaction she experienced from "watching [food] rot." She seemingly experienced a great deal of preoccupation and sense of internal control. Moreover, Geraldine – and other participants – emphasized the compulsive nature of AN, which lead her to developing rigid eating habits, whereby she became particularly meticulous in her eating routine. Furthermore, Geraldine revealed how following a period of starvation, she became heavily

preoccupied by cooking and preparing food, despite having no prior interest in consuming it. On the contrary, she put an emphasis on how it gave her a sense of satisfaction (e.g., "*love*") and presumably control by watching the prepared food/meals rot, decay, and perish. She expressed wanting to "disappear" by sleeping to eradicate the cognitions of AN: "To me there was no other way to disappear than to really go to sleep. I hadn't quite figured out any other way to silence my thoughts." Paradoxically, she perceived having "good days" with AN (subset 2. c. 1. Good Days and Continuum of growth and experiences during a typical day with the Anorexic Self, nested with Emotions and Cognitions):

> Um, let's try to remember a typical day. Ok, um, I mean, there's always good days and bad days. I mean, I feel like maybe there was good moments too. Like, being able to wake up and get out of bed was always a plus. Because…for some reason, you'd feel this like, rejuvenating energy, you know? (*light chuckle*). You don't wake up and the first thing you think is, 'I'm a terrible person or I'm worthless.' You, you wake up and you don't have those thoughts and it's…it's like, such a weight is lifted. Um, it's like, you know, you don't know what happiness is until you've felt like, the opposite, until you've been upset or sad. It's like, you're *sad* and walking around sort of as this shadow and then all of a sudden you wake up one morning and you don't have these horrible…negative thoughts running around in your head. You can go about your day and maybe even not even feel bad about…you know, putting some cream in your coffee or some milk in your tea or using real…a cup of big sugar instead of a sweetener, you know. And, and not feeling bad about it? Like…and not having to justify it. So, you can just…I mean, those days were wonderful […] They were so few and far and in-between.

Although Geraldine disclosed some positive or "good days" with AN, she acknowledged the inconsistency, discrepancy, and confusion she experienced during that time. In particular, she expressed how "they were so few and far in-between"; therefore, positive and/or "good days" with AN were sporadic, irregular, and scare.

Participants highlighted their experience of AN, particularly the symptomatology and associated behaviours, emotions, and cognitions. As highlighted in the previous section (e.g., 5.1: Part 1: Individual Participant Experiences) and literature review, individuals with AN often have specific behavior (e.g., food restrictions and excessive exercise), and show perfectionism, preoccupations, and rituals associated with their body and food. However, as the participants conveyed in the findings, it is important to consider that a person with AN is unlikely to display every sign or symptom. With this in mind, the subsequent superordinate examines details of the participants' treatment process with AN, including existent gaps and how their experience and resultant findings can further our knowledge.

3rd Superordinate: Anorexia Treatment Process

As previously mentioned, AN is a syndrome that impacts both the physical and psychological well-being of individuals. In spite of the development of various treatment approaches, existent research conveys that dropout rates are high (e.g., Wallier et al., 2009) and treatment success rates are poor (e.g., Bulik et al., 2007; Keel & Brown, 2010). For example, it is recommended that inpatient care – when it is required – should include psychological treatment with a mutual focus on both eating behaviour and attitudes to weight and shape, as well as wider psychosocial issues with the expectation of weight gain (Rance et al., 2017). Moreover, following inpatient weight restoration, "people with anorexia nervosa should be offered outpatient psychological treatment that focuses both on eating behaviour and attitudes to weight and shape, and wider psychosocial issues with regular monitoring of both physical and psychological risk" (NICE - National Institute for Clinical Excellence, 2004, p. 65). More recent research by Richmond et al. (2020), emphasizes the need to incorporate psychological factors in defining recovery from AN such as self-acceptance of body image. They also indicate how

physical markers (e.g., weight restoration) are understandable given the inherent negative effects observed in malnutrition, including worsening of ED cognitions as well as other associated physical and psychological co-morbidities (e.g., reduced metabolic energy, obsessive compulsive disorder, anxiety, etc.). However, Richmond et al (2020) conclude that "clinicians should remain open to additional markers of recovery such as body acceptance and eating-related behaviors/emotions that may be of critical importance to patients" (, p. 1209). Therefore, they determined that, "communication regarding outcome goals is imperative from the outset of treatment." (p. 1217).

As clarified in the previous superordinate sections, during the interview process the participants discussed their diagnosis of AN, as well as their resultant experiences with the syndrome. In addition, they revealed qualities of their experience concerning treatment, which led to the present superordinate [3. Anorexia Treatment Process]. Additionally, participants clarified how the medical treatment overlooked their psychological issues such as trauma, negative coping strategies and concomitant disorders (e.g., trauma with participants Stephanie, Geraldine, Lotus; as well as concomitant disorders with participants Liesel, Rose, and Stephanie). On the contrary, participants highlighted how the treatment focus was on weight restoration and seemingly lacked the knowledge and expertise of EDs such as AN and/or BN. As Liesel articulated (superordinate [3. Anorexia Treatment Process] for subset 3. a. Beginning):

> I went to my family doctor for something, and she had just been like, 'You're pretty…you're severely underweight' and you know, she just…she wasn't the most…she wasn't the best about it. Like, I don't think doctors have a lot of training. Actually, now that I know what I know, I know doctors don't really get enough training in it […] It was more like her bedside manner. She's still my doctor, like she's a good doctor…it's just, I don't think she really understood it […] she wasn't very compassionate, she was just kind

> of like annoyed […]. She probably just didn't have training in that, but also…I know like, that, I was so like…just like not rational at that time (*laughs*). She did the right things, like looking back, you know. She did the right things. She gave me a referral, like she didn't do anything detrimental to me. She was concerned enough to refer me to the Hospital…the Eating Disorder Clinic there.

Given that Liesel expressed having some disappointment with her family physician, the present author asked for additional clarification and expansion about her experience in the hospital:

> So, I did the day program […] Like, I just went. It was kind of like…honestly, I don't think that program is super amazing. I don't have…I couldn't strongly recommend it. I would recommend the inpatient if someone's like dying, because like 'Be in a hospital so you don't die,' but like, I just want through the motions of it. I don't think I really got better from being in that program.

Liesel reflected that the treatment "it wasn't that great," so the present author inquired if there was something that she perceived was missing during her treatment (subset 3. b. Development of Eating Disorders and Difficulties with Current Treatment for Anorexia, nuanced with 3. d. Her dissatisfaction with the medical team):

> My experience, yeah, my experience was just…it was just basically focused on food still. Um, like I didn't even…I don't even think I really saw anyone other than dietitians. So, it was mainly…which it was fine, like, I see a dietician now, but like I…all I remember is going in for like these check-ins…it was almost just like a check-in twice a week with dieticians. And you had to bring like a food log of everything you ate, and I'm like, looking back, I'm like, I mean I see what they were trying to do, but honestly, anybody could write just lies and I'm sure I did. And also, like, um, you're still being obsessed with food (*laughs*) like if you're forced to write down everything that you're eating, you're still obsessed with food…like it's not much of a…

The present author reflected and paraphrased how Liesel's response underscored how she felt there was a strong focus on food, wherein she responded (subset 3. d. Her dissatisfaction with the medical team):

> Yeah, yeah, and that's what they did. Like, I don't think it's like, 'We have this idea of where you should be,' its more just like, 'We don't want you to die, so just show me that you're eating enough, and we'll be satisfied, and we'll graduate you from the program.' So, I think I had to go for like 5 or 6 weeks […] Everyone was always like, monitoring me and seeing what I ate, and um, looking at me to see how skinny I was and stuff. And like, I felt annoyed by that, and just like, 'Leave me alone, let me do what I want.' Um, so, a lot of the stuff I did was like, very secretive. It was like, truly a compulsion.

As mentioned in the previous superordinate [2. Experience of Anorexia Nervosa], Liesel described her experience the diagnosis as "a compulsion." Similarly, Lotus reiterated the "rituals and obsessions" of AN in the findings in the previous superordinate subsection.

With additional time during the interview, the present author remained present with Liesel and used paraphrasing and reflection. In doing so, Liesel identified strategies of her experience with treatment that assisted her in initiating and sustaining remission, as well as the recovery process (subset 3. c. Strategies and treatment that helped sustain Ongoing Remission-Self and Active Recovery-Self):

> 'Ok, I'm going to go to treatment; it is what it is….' There is acceptance to a certain point… But, at that time, like, I knew that it was a problem. I was never…I was never unaware, like I always knew what I was doing was weird […]. I think it's a big part of…any 12-step program, for example, a lot of it is…acceptance and that's like a big thing I've learned in my life is over and over again. A message I keep *always* getting is having to…integrate…is like, acceptance […]. And also, another thing for me to always remind myself is no one else is judging me. I'm judging me, but like, no one else has these expectations for me […] There's a lot of stuff around body positivity and body love and stuff, and I'm like, 'That's ok,' but I actually don't…for me, I don't really think

> that's a solution because I think for a lot of people that's just not going to happen. I think it's more like, about…neutrality […]. I do think I'm more aligned with like, a normal, or like, healthy person without disorder eating and thinking. The issues…the thing is, I don't think there are many people like that period. Like, I don't think even more people I know are really like that, so… Well, I'm more aware of it now. It doesn't, it doesn't affect what I do.

Interwoven in Liesel's response is the significance of incorporating both self-awareness and acceptance during the treatment process for AN. While she expressed feeling "annoyed" about being monitored by staff and/or others for what she ate and consumed during treatment for AN, she accentuates how on her own she learned aspects to sustain remission and recovery by implementing a more "critical lens," revealing subset (3. c. Strategies and treatment that helped sustain Ongoing Remission-Self and Active Recovery-Self):

> That was just like, self-directed, self-motivated. No one told me to do that, and that was just kind of stuff I got interested in and sort of just…helped me. …learning more about, um, not just like, eating disorders, but diet culture. I mean, from the feminist perspective and stuff, and that really has had a big impact on my life, but it definitely wasn't part of any formal like, therapy, or program I was ever in…

Eivors and colleagues (2003) conducted a study that highlighted participants' view that a lack of negotiation regarding treatment and a focus on symptoms (rather than underlying causes) were especially unhelpful. Accordingly, the authors suggested that the latter in particular could sometimes facilitate individuals' "strategy of focusing life around food as a means of coping with stress and other life issues, possibly inadvertently reinforcing the eating disorder" (Eivors et al., 2003, p. 98) Given the prospective depth of insights that individuals – in terms of both accessing inpatient and/or outpatient treatment and being a part of it – might have to offer based on their first-hand knowledge of the system. Therefore, the present author/this study genuinely

aimed to begin the process of eliciting participants' view of treatment and healing from AN, as well as the opportunity to reflect their experiences of being treated for their ED. In doing, the present author sought to listen and analyze participants' treatment process and experience, in order to identify existent gaps to further knowledge about treating AN and EDs.

Similar to the previous participant (e.g., Liesel), Lotus reflected on her experience of the treatment process for AN:

> It's a hard process. I think a lot of therapy (*sighs*). I think it took me a long time to realize that I don't really have control over the things that happen around me, but I have control how I react to it. And it was a really difficult process. It took months of me in therapy to realize just…that I guess once of my biggest problems was thinking that the eating disorder... that anorexia…like covered up a lot of my flaws […] I would have to say a lot of people with eating disorders develop eating disorders because of trauma. I don't know, like, it's just…it's not about food. So, often like even in treatment at the hospital like, whichever treatment centre I went to, a lot of focus was about weight […] A lot of it was I guess…it makes sense when you're physically unwell to focus on that at the beginning, but even at the hospital, a lot of it was focused on eating food and just getting stabilized medically and it wasn't…there wasn't a lot of therapy related stuff.

The present author paraphrased Lotus' reflection that AN is not solely about food, but it was coping mechanism for trauma and a perceived lack of control. In this light, the present author asked if Lotus were to make suggestions to treatment programs, if any, what would they be. Lotus responded (subset 3. a. Development of Eating Disorders and Difficulties with Current Treatment for Anorexia):

> Yeah…it's an underlying issue that the food…the weight loss all that stuff for people with anorexia specifically, it's just a symptom, an underlying issue. Its almost like, and I've experienced that myself every time I went to treatment…it was almost like filling…filling a flat wheel with air, without looking at the cause of why the flat…where there was flat wheel in the beginning…there was a hole in it. And the same thing, people

> who have eating disorders…who have trauma or other specific and like events in their childhood that triggered the anorexia, or anything in their life? If you don't focus on the real cause of the eating disorder and just focus on the food…the weight…you're not going to get anywhere and that's where the relapse…the relapse and the numbers are high.

Lotus highlighted how treatment in the hospital setting focused primarily on the essential diagnostic features of anorexia with a particular focus on the physical indications of it and consuming food for an increased BMI. As a result, Lotus proceeded to reflect how a fair portion of her treatment entailed her own formation and integration of self-awareness and a sense of agency:

> You have to allow yourself to do it. It's also…I mean, I work quite hard at learning about self-compassion and self-love in therapy. I think that was the biggest part for me that…I didn't love myself (*laughs*) for a long time. The eating disorder…once started because of control…trauma…or whatever…eventually turned into self-hatred. I wanted to punish myself (*laughs*). And so, when I realize that I don't need to punish myself anymore because I didn't do anything wrong…I kind of shifted myself into self-love and -self-care and stuff like that. It doesn't come easy though.

As accentuated and revealed by both Lotus and Liesel, the objectives of treatment for AN included: (1) Stabilizing weight loss; (2) Commencing nutrition rehabilitation to restore weight. In doing so, it seemingly neglected other aspects both participants required for their recovery and healing from AN such as psychotherapy for other mental health issues (e.g., trauma, depression, anxiety), group therapy and/or medication. Therefore, the participants have intertwined in their responses how treatment requirements and options will vary depending on the individual's needs.

Rose also disclosed aspects about her experience for treatment with AN, whereby she initially began from the guidance of her psychologist. Therefore, she was not in the hospital for treatment at the time:

> So, I talked to my psychologist about…because she always said (*chuckle*), she actually specialized, she specializes in eating disorders. And my friend had referred me not knowing that because I, I saw her for depression […] And then that's, um, my psychologist suggest I do group therapy and that is what I found really helpful. Initially, I was like, 'No, that's so awkward, I won't have anything in common with these people.' So, I did the one for people over 30, so there was three of us and we each had sort of like, a different issue I guess, so that was really nice because everything was different. So, we had the group therapy. It was great. I just realized that I just felt very different from everybody else there because they were all struggling with different things and I wasn't struggling anymore, and they knew it was different because I had a *very* supportive family. So, then I saw a registered dietician. She was great. She was retired from a children's hospital, so she was really good. And um (*pauses*), so she gave me like, a guide of what to eat.

Although Rose expressed some initial reluctance about group therapy, she agreed to attending it and found it "was really nice" seemingly due to the diversity of issues. Rose proceeded to reflect on the "positive" impact that attending group therapy had for in learning about her experience with AN (subset nested 3. a. positive aspects learned from AN):

> Group therapy offered from skills and just perspective. Like, insight that I wasn't (*pause*) when you're too close to something you don't see, and because I had never met anyone who had any eating disorder, or who I knew had, like obviously there are people, but I had never known anyone or been really close to them or experienced it with them […] I like to think of it as something that (*pauses/stops*). Well, something that's past (*quiet sigh*) and not a part of me. But I think it also gives me 'pauses'…I've been reflecting more…because *for me*, it's like, the idea of anorexia…since it's not like, part of my

> identity…it's, it's like, for me, it felt like when it was gone, like, every (*stops*) all my feelings about my body image had been fixed, but I realized they hadn't, right? Like, I still might feel negative about certain aspects of like, my body and stuff. But thinking back on the whole…anorexia experience, um, I guess it's…like, a learning experience in a sense? Rather than like, super negative. That's how I'm trying to look at it.

Towards the end of her response, Rose accentuates how AN "that's past," yet she continues to characterize AN as a "learning experience." Nevertheless, she indicates that she continues to "feel negative" from resultant experiences in relation to her sense of self and body. Interwoven in this response is Rose's sense of ambivalence.

As previously mentioned, women with AN are ambivalent about recovery and thus not always willing to engage (Rance et al., 2017). Rose continued to discuss aspects that she learnt from her treatment process and experience with AN, interwoven in her response below is ambiguity (e.g., "remnants of the experience of anorexia"). In addition, she accentuated both positive aspects – as mentioned above – as well as negative aspects from the treatment process and experience of AN (nested with subset 3. b. negative aspects learned from AN):

> I think it's also important because I still feel…embarrassed [and ashamed] about it, you know? It's still not…it's not like, any other disease you might have, or you know, disorder. It's not something you can just mention because there's still…there's still negative feelings attached to it. Like, when you think of like, society as a whole. Like, I wouldn't mention it to people, and so, that's why it's important that it's not part of my identity as well […] I think I'm feeling more (*pauses*) less positive…like, less positive about it. So, it kind of shifts. It's not just something that happened, you know? It's not just…like, I had a cold. Mmmhmm.

Through paraphrasing, reflection, and immediacy the present author reflected how a cold is a finite thing - you get sick and recover – whereas what she heard Rose say is that there's still perhaps remnants of the experience of anorexia: "Yeah, exactly."

In a study conducted by Rance and colleagues (2017), women perceived the treatment system for AN and EDs as overly focused on food and weight. Paradoxically, they felt that "eating disorders are not about food, they're about life," as well as how a crucial part of treatment is being seen and treated, as a "whole person" (p. 586). Stephanie received treatment in a Residential Treatment Centre for EDs in Ontario. As expressed by other participants, Stephanie also accentuated how treatment was rigid and overly focused on food/weight, including how inpatient treatment focused solely upon weight and food (subset 3.a. Ambivalence and inconsistency in treatment from AN, as well as nuanced with subset 3.c. Treatment as invoking a sense of powerlessness):

> I did not like Ensures[3]. Like, to this day even though I don't have symptoms like, I will never drink an Ensure again (*laughing*). They are just so terrible and disgusting (*laughing*) […] And I remember telling them just like, 'Give me normal food,' like. 'Stop giving me this like, liquid food.' And then, 'Give me a chance to try it out,' kind of thing. So, it, just…they were, I found the restrictions around how, um, I was allowed to try and like, recover was, it was too strict. It didn't allow the flexibility that I needed to…to do it at my pace […] And also, that made sense to me. It was really like, 'This is our program, so this is what we're doing, and you don't have a choice or a voice,' and you know, when I did finally say like, 'No, I'm not drinking that. Oh, here comes the feeding tube' (*laughing*). So, it's like, you really felt powerless.

Stephanie used humour by laughing to mitigate the severity of her experience with AN, as well as the content of her response. For this reason, the present author reflected how it sounded like Stephanie grappled with feeling "powerless." Stephanie nodded and echoed: "Yes, very powerless. And, very much like my (*pauses/stops*) the way that I felt wasn't being considered. It

[3] "Ensure" is a nutritional drink that is often used to help patients gain or maintain weight.

was strictly like, the physical…more medical side of it" (subset 3.c. Treatment as invoking a sense of powerlessness).

Many women's criticisms have been based upon the treatment(s) they had received in the healthcare system, including their belief in the unhelpfulness of treatment that focused primarily on food and weight applied to all treatment settings -inpatient/outpatient (e.g., day programs) (Rance et al., 2017). In retrospection, Stephanie was able to accentuate the necessity of focusing on the medical aspects and risks associated with AN, as well as the lack of treatment for psychological, emotional, and seemingly existential well-being (subset 3.a. Ambivalence and inconsistency in treatment from AN, nuanced with subset 3.d. Feeling lost and overlooked during treatment):

> So, I think now, in retrospect, um, the way that I make sense of it is that, um, I know that I was medically unstable, and I know my heart rate was very low, it was like in the low 40s. I know that my weight was very low. And so, I can understand why they were *so* concerned about the medical piece. Um, however, it wasn't explained to me. I mean, clearly, given the symptoms, and the way I was feeling about my weight, I'm not going to have the same concerns as they had. So, I think, um, although I understand their intentions, and it makes sense to me as an adult, I think back and I would have really benefited from a more (*pauses*) let's say holistic, um, approach to care? In which, yes there are these people who are taking care of the medical aspect, but they're also – whether it's the same people or different people – who are making sure that the way that I'm feeling…*(stops*). And my more, you know, psychological/emotional state is also being attended to […] And I think, so when I was discharged (*inward inflection*). I think the very, um (*pause*s/*stops*). I find, the notable impact that it had was that, um, I was

> discharged with my, um (*pauses*), kind of (*pauses*) restriction that I had to come back for outpatient treatment? Um, but I (*stops*) because of the way that that the inpatient went, I was not motivated to continue this in an outpatient way? And I just, I just didn't show up for the first outpatient session? And nobody ever followed up with me. So…it's kind of like, I just kind of…got lost. I like, fell through the cracks, and I went years without treatment. I only understood the suffering that I felt with it.

The present author repeated how Stephanie mentioned that she only understood "the suffering," so she asked for additional reflection and clarity. In particular, the present author heard how Stephanie felt she "fell between the cracks" when she was discharged, so she explained how she resumed treatment in a unique strategy with her physician and other professionals (subset 3. e. Treatment and professionals' flexible, attentive, and knowledgeable in information outside of AN – which is mainly focused on body, weight gain and restoration, nested with subsets 3. e. 1. Her need to be in contact with people 3. e. 2. The need for human connection):

> I was put on the waitlist for another eating disorder program here in a hospital and because the waitlist is *so* long, um, my family doctor decided to try and do an alternative kind of, way for treatment. And, she said, 'You know, typically for an eating disorder program you'll have the physician, the dietician,' you know, 'the psychologist and your psychiatrist and nurses. So,' she said, 'Why don't we just make our own team of non-specialists in eating disorders, who are dietitians and psychologists and me as the physician?' And I agreed to it. And that…*that* is the reason that I was able to become, like, be in remission and recovery because…*all* of these people who have some necessary knowledge to educate and guide me in the different aspects of an eating disorder…were there, they were present, there were attentive and, they brought all of that knowledge and skill without the component from the eating disorder team of….you know, inflexibility and…forcefulness and, like, a bit of harshness (*laughs*). So, to me, it (*stops*). Like, the

> fact that they weren't specialized in eating disorders *was* like, what I needed, personally. I needed people who…didn't have that knowledge of like, how a program runs…

In her response and explanation, Stephanie expressed how she needed people; conceivably, human connections and less of an approach focusing mainly on her body and weight gain, especially as that is one that forgets about the importance of connections. Exclusion affects everyone, and Henri Nouwen understood this personally (Lazarus, 2021). He realized that those who seek to exclude others have engaged in competition rather than compassion, destroying any sense of community for those left on the margins. Similarly, Stephanie highlights how she felt excluded, and she required a sense of connection with others. As Nouwen (2009) later wrote: "Going to L'Arche [a community including people with mental disabilities] and living with very vulnerable people, I had gradually let go of my inner guards and opened my heart more fully to others" (p. x).

In a similar manner, Hannon and colleagues' (2017) study found that participants in treatment for AN felt different from others and "isolated" as a result. Moreover, the "emptiness" and loneliness went along with being unable to trust others; therefore, they kept their struggles to themselves and sought to cope on their own. However, individuals with AN during intensive community treatment recognized the potential value in connecting more with others, and most participants began to view this positively: "To feel connected to others it seemed important that "the other" understood them and was non-judgemental" (Hannon et al., 2017, p. 289). Common themes reported by women with AN describe the process of treatment and recovery from it as dealing with a fragmented sense of self, a reclamation of self through meaningful relationships, and self-acceptance (Stockford et al., 2019). Stephanie proceeded to accentuate the significance

and relevance of human connection with other women and professionals for her treatment process with AN (subset 3. e. 3. Connection and trust with others and increased sense of self):

> I think the role that, um, other people who have eating disorders, who I've connected with. Like, the role that that's played in my life […] And, so before that I didn't really have…people to connect with where I felt like they understand. Like, I don't have to explain anything to them. I don't have to explain to them like, why this one particular food is you know triggering, whereas you know with friends who don't have experiences eating disorders, it's like, there's this sense that they *try* to understand and they love me and they *want* to be there for me, but it's hard when you don't get it. So, I've found that *really* helpful to be able to kind of (*stops*) those connections? To be able to feel like, I'm not the only person here. Like, I'm not alone in this. To feel validated and also…to feel like, I guess it's validating like […] And so, when somebody else is able to look at the same situation and be like, "It makes sense that this is difficult," like "Let's not…let's not try to invalidate that," and "let's just like, work on it," you know, "use self-compassion and everything." It makes it a lot easier, and it takes away the judgment.

After receiving a diagnosis of AN, Geraldine disclosed: "I had…I'd gone to this support group for eating disorders and then my eating disorder just sort of really spiralled, and then they referred me to, um, which was on campus, was the university, um, hospital" (3. a. Attended a support group and spoke to a physician and was referred to an eating disorder unit and attended it but was in denial). Although Geraldine joined an eating disorder support group, she clarifies that it "really spiralled," indicative that her AN symptoms amplified the and ED got worse for her at the time despite that she was in the hospital on the university campus. Accordingly, the present author gave her additional time and space to reflect deeper into her initial experience of the AN treatment process (subset 3. b. Met with doctor, who referred her to a dietician, who spoke about her behaviours, in which the dietician claimed it was not normal, as well as subset 3. c. Since it was on campus, she did commit to the treatment and support; nested and nuanced with subsets 3.

c. 1. Decided to attend the unit to see if it was real due to being very underweight; 3. c. 2. Since it was on campus, she did commit to the treatment and support; 3. c. 3. She received medications for depression; 3. c. 4. Did not want to let treatment team down, but felt absolutely hopeless and attempted suicide):

> And so, there's an eating disorder unit there in the hospital and they were like, "Just go talk to this doctor or whatever, and just see what he has to say." And I guess, I don't know, I was *very* underweight, so why I decided to go, I'm not really sure, maybe just to see if it was real, to see if maybe I did actually have what they…they thought I had. And the doctor set me up with a dietician, and she was really interesting to talk to and she was talking about my behaviour as if it were like, very deviant, I guess? Like, "This is *not* normal," but she was *so* kind, and so, we set up that I could come to the hospital for breakfast, lunch, and dinner, and eat *there*. And I was really hesitant about it, and I, I did commit to it. And, um, (*long pause/stops*). Then also, like, sort of altogether in a whirlwind, I also was put on Prozac and…another trazodone, I think? I think I just started saying "yes" to everything and I don't know if it, if it was a week or if it was a month or two, but I…guess internally I had, I…that…it…I couldn't do it anymore. I couldn't…I couldn't eat…and be ok with it. But I also couldn't let these people *down*. Because they were trying to *help* me, and I didn't want to disappoint *them*, and I, it was…I…it's hard to explain, it's more of a feeling like, like…I…*I felt absolutely hopeless*. And so, I ended up, um, attempting suicide.

Geraldine put an emphasis on various words, which signifies the impact and importance of them: "*I felt absolutely hopeless."* The word "*absolutely"* is a maximizing word, which highlights the gravity of her hopelessness. Additionally, she continues to provide an example of ambivalence and incongruity, as she battled between engaging in perceived "very deviant" behaviours or pleasing the treatment team: "I couldn't eat…and be ok with it. But I also couldn't let these people *down*. Because they were trying to *help* me, and I didn't want to disappoint *them.*"

Furthermore, she states, "I guess?" in the tone of a question, indicative of both hesitancy and ambivalence.

Geraldine continued to expand on what she perceived was "missing and lacking" in treatment for AN. She identified how she sought an internal sense of agency and control by reaching out to her treatment team (subsets 3. e. Asked and arranged for a meeting with her treatment team, as well as 3. e. 1. Needed to do treatment or felt she would not survive, nuanced with subset 3. e. 2. Came to realization that she had freedom of choice):

> So, I went to the unit and I asked for a meeting, and so my doctors and were there and I said, "I know that I've come in many times and asked for help, but, um, and I'm sure you hear this all the time, that this time is different but I'm…this is, I need, I need to do it this time because I wont make it." Like, I'm either going to *die* trying or I'm going to make it and…and hopefully I make it." […] I wanted to get better, but I…wasn't completely sold on the things that they wanted me to do. I've tried to recover lot's of times. Um, and I think for many of the times there was always a component missing, I would say. I remember, you know, crying over it and being like, "I just want to be better. I don't want to have this burden, I…I want a life! I don't want to have to spend my days in a hospital," And there was just *so* much that felt like it wasn't my decision, like I did *not* get *any* decisions. Like, I didn't get decisions about when I was going to eat, what I was going to eat, and when I could go to the bathroom. I think there was sort of this revelation that I was allowed…to make…I had the freedom of choice. But I…decided to say like, "Thank you, and I'm, I'm going to do this on my own." And, um, it was ***epically*** difficult, and I would go back for the first little while. I went back just to see the dietician and, um, we would just have like a quick little meeting. She would weigh me, but we wouldn't talk about it. Recovery is so much more than weight restoration (*laughs*). There's *so* much more to it, right? Um, I think for, for everybody, but, um, finding meaning I think probably would be the big…the big…way to help treat people.

In Geraldine's account of her treatment process with AN, she expressed her perceptions of aspects of AN treatment in particular (treatment access, treatment structure and treatment providers), as well as her desire for treatment that focuses on her as a "whole person" and "finding meaning."

Interwoven in her response, Geraldine alludes to existential anxiety (EA) and specifically, the known example of death anxiety (van Bruggen et al., 2017). With the exception of the fear of a concrete threat (e.g., becoming fatally ill), people can also become affected by anxiety regarding the finitude of life as such (van Bruggen et al., 2017). Some additional examples of EA include anxiety in relation to the experience of meaninglessness and feeling unconnected to other people (Yalom, 1980). Understood in this context, Geraldine's response emphasizes how the focus on weight restoration in the course of treatment for AN seemingly deprives finding meaning for sufferers. Therefore, she puts an emphasis on how "finding meaning […] would be the big…the big way" to assist in treating people. Furthermore, she expressed having "freedom of choice," which is indicative of her opportunity and autonomy to perform a chosen action (e.g., her remission/recovery process) unconstrained by external parties such as the treatment team (Frankl, 2006).

4th Superordinate: Experience of Remission and Recovery Process

Relapse after treatment for anorexia nervosa (AN) is a significant clinical problem (Dawson et al., 2014; Khalsa et al., 2017). Given the level of chronicity, morbidity, and mortality experienced by this population (Khalsa et al., 2017), it is imperative to understand some influences behind relapse, as well as some of the experiences for the remission and recovery process. For this reason, the present author asked participants about their experience of the remission and recovery process after their discussion and exploration of their treatment process.

As previously mentioned in the literature review, remission and/or recovery from AN is a complex phenomenon that has been explored from a variety of approaches. More specifically, most research in this area has been conducted from the fields of psychology and medicine, which largely adopt a medical model approach to recovery (Dawson et al., 2014).

As clarified in the previous superordinate sections, during the interview process the participants discussed their diagnosis (superordinate 1) and experience of AN (superordinate 2), as well as their resultant experiences with the treatment process (superordinate 3). In addition, they revealed qualities of their experience concerning treatment, which led to the present superordinate [4. Experience of Remission and Recovery Process]. Additionally, participants clarified how the medical treatment overlooked their psychological issues such as trauma, negative coping strategies and concomitant disorders (e.g., trauma with participants Stephanie, Geraldine, Lotus; as well as concomitant disorders with participants Liesel, Rose, and Stephanie). On the contrary, participants highlighted how the treatment focus was on weight restoration and seemingly lacked the knowledge and expertise of EDs such as AN and/or BN. The subsequent section examines segments of participants' experience that were influential in determining their remission and recovery process in superordinate [4. Experience of Remission and Recovery Process].

Liesel stated (superordinate: [3. Anorexia Treatment Process] accompanied by subsets 4. a. self in remission, as well as 4. b. continuum): "I kind of gradually like…yeah, even while I was in that treatment program, I was like, I mean everyone was really happy that I was doing, so I was doing it." For additional clarity, the present author paraphrased how Liesel mentioned that initially she was doing the treatment program and treatment for other people. Therefore, the present author inquired if there was there a shift towards remission or recovery for herself. If so,

what did it look like for Liesel, and what was that process (subsets 4. a. self in remission, as well as 4. b. continuum, nested with 4. b. 1. Cognitions and 4. b. 4. Affect):

> Yeah, at a certain point I was just like…I was just like, "Ok, I don't need to do this." It was almost like…I just, again, no specific point in time, but at a certain point I think it just felt like…it felt like I came to my senses in a way, where I was like, "Ok, it's just easier to…. just you know, eat enough." And just like, "This is fine." […] It's kind of like….it…yeah, your mind is not your friend (*laughs*). It…kind of tricks you in a way. So, you know, I felt like I was in remission, and in terms of being obsessed with restricting my food and quantities and stuff that was pretty much gone. Well, I mean I wasn't happy, right? It was taking up way too much of my time. Definitely.

A "turning point" is recognized when awareness of the negative consequences of AN results in a commitment to take responsibility for recovery (Hannon et al., 2017, p. 280). A process of then reclaiming the self through self-acceptance and engagement in validating trusting relationships is described (Dawson, Rhodes, & Touyz, 2014). Liesel accentuates this continuum of remission and recovery, including the necessity of claiming of sense of responsibility and internal agency (subsets 4. b. 5. Attaining a sense of internal control and agency in ongoing recovery process, nuanced with 4. b. 6. Self-awareness):

> Looking back, I'm just like…that is sick thinking…that really is the eating disorder taking over. I think the eating disorder in a way is like…it's a coping mechanism for this kind of out-of-control stuff that was happening with my health [colitis]. I was always trying to think of like, what's the next thing that I can do to prove that I'm recovered, but I hadn't had that moment of just being *truly* exhausted but like, all the like…it's just like this feeling of being exhausted by all of the effort you're putting into something…that I had it, that I truly had it, where I was just like, "Ugh, I can't do this anymore," like I don't…or it's like, "I don't want to do this," like, "I'm just…I'm just done."

Intertwined in her words, Liesel reveals how she felt compelled to prove she was recovered and used the past tense in describing her experience with the recovery process. She wanted to prove it to herself; namely, that she was doing it herself and owning the recovery process. Therefore, she highlights an inner sense of agency and developing self-awareness, which is evidenced by her subjective awareness of initiating and executing her own meaning-making in the world.

While she previously stated that she received hospital treatment in an Eating Disorder Clinic in the previous superordinate, she proceeded to describe themes of reaching a tipping point; understanding the function of the illness (e.g., "it's a coping mechanism for this kind of out-of-control stuff that was happening with [her] health"). In addition, she described establishing self-awareness and understanding, finding an internal locus of control, perseverance, and practice in the pursuit of change (subsets 4. b. 6. Self-awareness and 4. c. Link with recovery, nested with subset 4. d. Onset of recovery):

> The start of my *real* recovery. Like, I had a gradual like, recovery in terms of like, restoring weight and not restricting, not doing the restrictive behaviours, not doing the fitness type stuff, Yeah, kind of. It was more like an awareness, it was just like, just like…um, yeah, it was just like, a general awareness. It wasn't so much that I was actively like, "Well is this what I want to do," it was more just like, a feeling like, a snap second, a second after I have the thoughts like, "Maybe I shouldn't do this," it just automatically was like, "No," like, "I just want to be able to do this," you know. It's just, "Who cares. Who's making this rule for me? No one," like, "I'm just…I just made that rule in my head…that's a stupid rule," like, you know. It was like, for the first time…feel good about myself (*laughs*) for the first time to be honest. It was like…and it's not like (*pauses*) it was even just like, all of a sudden that I felt good about, it was more like, I've figured out ways to support myself and my recovery, that would…you know, if *I* didn't feel it, like I'm reading content about it and… Once you are saturated enough with that, like because you're so saturated in diet culture and stuff, so once you actually…change

> that, and you try to eliminate that, and you know, saturate yourself in actually positive messages and like, you know, kind of understanding where all this…this thinking about our bodies 'being wrong' in the first place comes from, then that's…it's like, it's like changing the paradigm completely. Right.

In the aforementioned excerpt, the reader sees how Liesel highlights her pursuit for change, insight, and owning her recovery, which was not part of the treatment program. The notion of her "real recovery" is intertwined with her focus on herself and her own needs, as well as a sense of agency.

The modern medical paradigm and many well-intentioned clinicians conceptualize pathology through a diagnostic, problem-solving perspective (Grynick, 2018). While the merit of evidenced-based practice is not to be dismissed, the present author continued to use paraphrasing with Liesel for her to further expand on her process of remission and recovery (subset 4. e. Significant aspects of healing and recovery; nested with subsets 4. e. 1. Self-awareness, 4. e. 2. Real recovery involves having realizations and being completely internally self-motivated, 4. e. 3. Recovery involves a personal decision and wanting it for yourself):

> My experience of people who are in recovery from eating disorders is that there's a lot of relapse because it's a lifetime thing. And so, I know like, it's very rare for someone with an eating disorder to never engage in a behaviour again. It's not to say they're going to um, go back far into their eating disorder, but most people will have a day or two here or there where they engage in it. […] But I honestly think it's a mental health thing and I just think you constantly have to kind of work on it. It's like a self-care like, constant thing […] So, spirituality, I haven't really had a lot of spirituality in my recovery. It's been much more just…just like, getting in touch with myself in certain ways and just like…getting real with myself and…yeah. Just acceptance […] I just know, and I just…I personally…I really believe that until you have like, some sort of realization, like I had, like something that is completely internally motivated, I don't really think people get

> like, real full recovery. Just because you have to want it for yourself and you have to at least…it's whole 12-step thing, right? Like, you have to admit and know you have a problem and accept that you are powerless…in the face of your problem.

Liesel confirms that spirituality was not included in her recovery; therefore, she did not know how to integrate or include it. However, implicit in her response includes self-acceptance and self-knowledge, including assisting her in understanding what she values and how she is perceives the world around her (e.g., aspects of spirituality). Interwoven in her response is also the lack of the medical community on this aspect of the healing and recovery process. She proceeded to confirm that what was important for her was the connection with herself (subset 7. b. Seeking understanding in life): "Yeah, definitely. I'd say so."

While Liesel frequently used the past tense to describe her experience with AN, recovery continues to be an active and ongoing process for her:

> Well, like, I don't know if that even really applies to me because I feel like I don't have any compulsions around trying to restrict or anything like that. Like, I certainly don't have that anymore. Ever. Um, but even up to a year ago I probably still had a few…you know, it's a very gradual thing. *But* I still do…um, get like, the thoughts and I still get, um, some like, thinking patterns and compulsions more around the exercise side of it. So, like, I don't think it fully goes away, it's more just like…I become more able to recognize it […] It's not that you *always* have to deal with it, but you always have to be like, on guard kind of and um, constantly doing things to support yourself. And I know that in, um, eating disorder recovery, in general, like, relapse is just *super* high. Like, the rates of relapse are super duper high. So, yeah.

Similar to other participants, Liesel identifies how recovery is an ongoing process, and it is neither linear nor finite. Therefore, her recovery from AN is still in progress and ongoing.

In medical terms, 'remission' refers to a temporary or permanent decrease or subsidence of manifestations of a disease or syndrome (D'Abundo & Chally, 2004). Remission rates vary

widely depending on the definition used (e.g., partial remission and/or full remission, according to the criterion in the DSM-5). Remission is associated with quality of life, and often approximates scores for women who do not have an ED.

After discussing her experience with the treatment process for AN (e.g., previous superordinate 3), the present author asked Lotus she would describe her initial experience with remission, up until the present time (subset 4. a. Ongoing Remission):

> I never thought I would be where I am now to be honest. I thought I would be a rotating patient…in and out, in and out, like I was before. For the first, I would say, 6 months, that I went into remission, I had a lot of doubts…obviously it was ups and downs as well…it's not linear. But as time went by, I just kind of…it became natural to just get up and like have breakfast and like, do the things that I need to do. I can't say that I don't have thoughts. I mean, I have them every day pretty much, at least once every day. Um, that's why I say I'm in remission.

Given that Lotus reflected that she continues to "have thoughts," the present author inquired if she could further describe and clarify "those thoughts," which may possibly emerge for her during the day: "Yeah, so sometimes I think, well, I can always go back to my eating disorder. I can always relapse. Um, I could purge. I could restrict. Might make me feel better today if I do that. Those are the kind of thoughts."

In the context of Lotus' "thoughts," which she stated emerged for her, the present author asked how she determined herself to be in remission from anorexia (subset 4. d. Initial Onset of Remission in Treatment):

> I realized that I was in remission I think when I was no longer terrified of food. And that I didn't necessarily feel like I needed food to control the events around me or how they made me feel. When (*pauses*) yeah…It's a hard process. I think a lot of therapy (*sighs/laughs*). I think it took me a long time to realize that I don't really have control

> over the things that happen around me, but I have control how I react to it. And, it was a really difficult process. It took months of me in therapy to realize just…that I guess once of my biggest problems was thinking that the eating disorder... that anorexia…like covered up a lot of my flaws […]. Because of my albinism I felt like… if I became really under weight and emaciated than people would be more… noticing that part of me rather than be noticing the albinism. Yeah…which is really sad to think about.

Although Lotus laughs and sighs (using humour) possibly to minimize the depth of her statements, she acknowledges that she used AN to seek control or "cover up a lot of [her] flaws." Moreover, Lotus acknowledged how "sad it is to think about" using AN to distract others from her albinism. It is also notable that she used the active and present tense at the time of the interview in reflecting those parts of her experience. Accordingly, the present author asked Lotus when she said it's "really sad to think about," if she could further clarify her sadness. Lotus replied: "I was killing myself in order to hide who I am. It's just really sad that it got to that point of me thinking of myself so low…" While Lotus did not express having suicidality, she does allude to the fatality of AN and existential concerns in terms of identity and death.

The present author proceeded to ask Lotus how she determined herself to be in remission. Indeed, she disclosed that she received confirmation from "[her] psychiatrist," so the present author inquired more about her own experience and progress of the remission process (subsets 4. b. Self and Recovery-Self (transforming) and 4. d. Initial Onset of Remission in Treatment; nested with 4. d. 1. Day in remission):

> When I decided to start building a life worth living in a way. Like, I went back to school. I was doing things outside of just treatment and recovery, you know what I mean? Like, it wasn't just solely…go to therapy, go to appointments. I started doing other things in my life that gave me joy and that's how I knew that I was stepping away from the illness and I was moving towards remission. I was going to college and last year was probably the

> best year I've had. It was the first year of remission. It was really great. I mean I was doing well; I was in school doing something that I loved. It was really great.

Lotus' response accentuates the onset of meaning-making and purpose. More specifically, she has interwoven in her response is that the process of meaning-making and seeking purpose outside of activities related to the eating disorder recovery process. The present author reflected how Lotus indicated that at the time when she started to "build a life," as she said, "worth living," she realized, "I'm stepping away from the illness…," whereby she responded and confirmed: "Yes." Furthermore, Lotus continues to reflect an interaction between meaning-making and the development of a less fragmented self towards a more integrated self, comprising of a more compassionate self: "With remission and recovery, I just found myself being able to be a compassionate person that I am." She continued to accentuate and expand on her response (subsets 4. f. 2. Positive dimensions/growth and 4. f. 3. Remission and recovery transforming the self):

> One thing that I definitely do realize – that I've noticed over the past two years – is that I have become so much more compassionate and understanding. Not just for other people, but myself. I think for a lot of people who struggle with eating disorders, when you're in the depth of it, with that…it's not purposeful, you don't do it on purpose, but you kind of just isolate yourself […] I felt like there was so much emptiness way back then. Now that I think about it, it's funny because my eating consumed every part of me, and I still felt so empty.

Interwoven in her response, Lotus highlights how recovery is not a static process. She pauses in her response, indicative that she is processing her thoughts and resultant responses, offering increased vigor and depth. She also expresses a sense of her Dasein by her presence and "being-in–the-world" (subset 4. e. Understanding of Initiating and Maintaining Recovery):

> Recovery doesn't happen behind close doors and in a safe place. It really happens out there the real world, where you're challenged. Because (*pauses*) I know a lot of people who after treatment and after recovery they were kind of protecting themselves all the time. And, in a way, they just live in this safe, boundaries space, and they don't kind of face things in the world. And I don't think that's…for me, that's not remission. For me, it's getting out there and actually getting triggered and facing the triggers, and (*pauses*) I guess facing the challenges every day. And that's how you recover […] I realized that my eating disorder was a way to cover up my disability. It was a way for me to appear to people…not visually impaired, not albino. But someone who was sick, I guess. And so, it was like a mask. And that was keeping me sick, so I had to separate it and just realize that it's something…and this is something.

Lotus emphasized the significance of separating herself from AN; however, she proceeded to discuss the relevance of how AN was "for a long time, it was my identity." For this reason, she identified how she had to engage in the process of "letting go" and grieve AN and the associated identity (subset 4. f. Grieving process involved in remission and recovery from anorexia):

> I guess I was just someone who had anorexia, and was underweight, and was in and out of hospitals…that's what the identity was, and like the community I met through my journey the eating disorder community. So, at the time, I started kind of distancing myself from that identity. I had to let go of a lot of those things to kind of figure out who I am without the eating disorder.

The present author inquired how Lotus' experience of remission and recovery invites her to see herself as a person now: "I'm a strong person […] I've actually grown a lot stronger, and I can…I am able to handle things that are difficult. To be in remission, for myself, means that I have to be able to love myself enough to not hurt my body like that. (*Long pause*)." The longer

pause from Lotus conveys that she is deeply processing her responses, and is indicative of paralanguage, meta-communication, and nuanced meaning.

The process of remission, as Lotus shared with the present author, had really impacted the way she viewed herself (subset 4. g. Metaphor of Remission and Understanding Insights obtained from Active Remission-Self):

> Yeah. And the more…the more I distance myself from symptoms and anorexia itself, the more I was able to take distance and just be able to look at myself differently, I guess. It was almost like foggy glasses I had on all this time and as soon as I took them off and with time, I was able to start seeing myself…differently, I guess.

In describing her remission and recovery experience, Lotus used a metaphor of "wearing foggy glasses" when she had AN, whereas now she sees herself more clearly. This is a powerful statement and realization, especially given her visual impairment. Additionally, it conveys that the remission and recovery process have been impactful for her, as well as an ongoing and active process.

Similar to previous participants, the present author inquired how Rose would describe her initial experience with recovery up until now, as well as what the process had been like for her (subset 4. a. recognition of remission and recovery process, nuanced with subset 4. f. 2. recovery had the greatest impact on her life when she was able to donate organ):

> I talked to my, um, psychologist about it like, "I don't really feel like I need…to see you anymore." Like, I had kind of sorted everything out. Um…so yeah, I think we finished in May and I was like, in remission I guess, as of April/May and then…she basically said like, "Come and see me again if you need to." And, I went through another severe episode of depression the following year like, a year and a half later. Um (*pauses*) and I donated um, part of my liver. Um…obviously don't put this in because it's like, it's like

> (*laughs*) very few have people have done this (*laughing*). So, I was like, an anonymous organ donor and um…it was after that it's actually apparently really common after surgery, if you like, a propensity to get depression, but it was interesting because I hadn't seen my registered dietician after I was in remission.

Rose shares that "very few people have done this," accompanied by laughter. To donate means to give something —to some cause, such as a charity. The word has a more altruistic meaning than does simply "giving"; it suggests that you do not expect anything in return for the contribution. Rose was also an anonymous donor. Moreover, this is an accurate application of one of the three sources of meaning according to Frankl; namely, a project of creativity that comes from her, transcends her, as well as connects her with another person (Frankl, 2006). Given that she was an anonymous donor, she is indeed regaining a sense of ownership over her body by deciding to give away an organ. Accordingly, Rose is the one making the decision, not the AN, not anyone in her environment, but rather, she is choosing the course of action. It is parallel to her saying, it is her body, and she has the right to make that decision, but this time instead of being an "unaware decision" like the one of becoming AN, it is very much an informed decision.

Through additional reflection in the interview process about her remission process, Rose accentuates "the mindset" of AN. More specifically, the "anorexic mindset," in which she focused on using a scale to ensure weight loss: "I would want to weight myself to see what I was at." Furthermore, Rose expressed that she was "knee deep in it," meaning fixated and preoccupied with AN (4. b. remission and recovery mindset vs the AN cognitive characteristic):

> I wouldn't even think to buy a scale, I'm like, "Where would you put it in your bathroom?" Like, it would take up space, which is like, the mindset I had before. Because like, what would be the purpose of weighing yourself. once I was able to say like no to things and now that I know myself a lot better…and I don't…I'm not in the mindset that

> I was. Like, it seems so long ago and like, it's because I had so much therapy and I've just done a lot in the last five years that (*pauses*) I just don't even…it's funny because you think back, you're like, "How did I even think like that?" The (*pauses*) mindset…but that's how I was (*mumbles/whispers*).

In terms of additional stressors during the remission and recovery process, Rose articulates how she shifted her coping mechanisms: "If I get really busy at work or like, really stressed I won't eat, but not (*pauses*) not consciously. I'll be like, "Oh, I'm really hungry" and then I'll eat" (subset 4. c. impact of stress since remission and recovery from AN).

During the interview process, the present author reflected how Rose spoke about her history and experience with anorexia, but also with remission/recovery (superordinate 4). Therefore, the present author queried if there was anything that Rose wanted to expand or touch on (subset 4. d. recovery-self nested with 4. d. 1. a shift of sense of self since AN):

> I feel like (*pauses*) *before* it's like, I didn't think of myself? And now it's like, I think of like, what *I* personally want, and like, just like, more about me. And like, what meaning means to me and more (*stops*). Like, I don't just do things for other people. I do things for myself that make me happy.

Rose is now cognisant that she often thought of others: "*before* it's like, I didn't think of myself? And now it's like, I think of like, what *I* personally want, and like, just like, more about me. And like, what meaning means to me and more […]"

Correspondingly, Rose identifies that she is no longer engaging in self-sacrifice to please others. Although she enjoys helping others, she will no longer do it at her own expense (subset 4. d. recovery-self; nested with subsets 4. d. 1. a shift of sense of self since AN; 4. d. 2. challenging to reflect back on the AN self; 4. d. 3. shift from the AN self to the self in remission and recovery):

> So, it's like helping others, but not at the expense of myself. Whereas before I think I was willing, a lot more willing to do things for other people like, at my personal expense When I look back on it. It's all very (*pauses/stops)* It's hard. It's sort of a blur? I think like, part of like, anorexia (*pauses*), like, for me it's like, it's more like, I wanted to disappear. It was part of those feelings. Mmhmm. Whereas now I don't feel like so…mmhmm. It's like, I don't, I don't think of stuff in terms of accomplishments anymore. I think of it more like, "Oh, am I enjoying myself? And do I feel fulfilled?"

After Rose reflected on her experience of the remission process, the present author inquired if she could expand on who she is now and if this has changed since experiencing recovery (subset 4. e. remission and recovery shifted her perspective and sense of meaning and purpose in life, nuanced with subset 4. e. 1. recovery enabled her to return to setting and establishing goals):

> I feel that I'm very different because I recognize, um, I guess…I just feel much more self-aware than I did before, and I've been able to identify my goals and things I want to do in ways that I couldn't before. Um (*long pause*). I feel like recovery just kind of made me see myself as a whole person. Not just as like (*stops*). I guess, when I was sick it was more like, it was just like a fragment of myself, where I felt…I felt fragmented. And then in recovery, it just opens up life again, and I just saw like, my whole self rather than just a part of it. And so, now that I'm recovered…I have, I *do* feel that I have a purpose, whereas I didn't when I was sick at all. Like that was…that was it. That was my existence, basically. I remember going through it and coming out of it and thinking like, "Oh, now I can…I can do things, I can get back to the goals of my life. I can experience things." Like, "I can have a purpose, this isn't just my purpose." It's not…this isn't my existence just…dealing with anorexia. Like, I returned to my life and the goals and everything. Mmhmm.

Rose takes a long pause, in order to think and process the question and her response. Recovery-self sees herself "as a whole person" now, whereas the anorexic-self was more "fragmented."

The present author also reflected how during the interview process (e.g., see table 2 in subsection 5.1) Rose reflected how "[anorexia] became a part of [her] identity," which was a difficult component for her: "Yes, yes. Yeah, definitely. Because I like to think of it as separate from who I am. I just think of it now as an experience, but when I was in it, it felt like it was part of my identity." Therefore, the present author asked Rose, "What does that mean for you to have that "separate" from you now? Separate from your identity?" In some ways, Rose uses deliberate language and past tense, stating "I *had* experienced it…I *had* it." Subsequently, she is creating a separation from it. She further accentuates (subset 4. h. recovery as an ongoing process; nuanced with subset 4. i shame-based perception of AN, as well as subset 4. j. implications of relapse):

> Yes, and I think it's also important because I still feel…embarrassed about it, you know? It's still not…it's not like, any other disease you might have, or you know, disorder. It's not something you can just mention because there's still…there's still negative feelings attached to it […] Shame. Mmhmm. Like, it's not like, a good experience I've had, but since I have had it, I think it just kind of adds more…depth and more understanding of what people are going through, and so I can shift it into a positive experience. Now that it's past… thought I was more impervious than I was? And I think…and that's how some people relapse, right? They think like, 'Oh no, I'm good…it's not going to happen to me.' I'm still recovered…it's not, I haven't relapsed, I'm still eating […] Fear of going back (*nods*) and fear that…I think if it, I fear if it happens again, it's the idea that…there is no meaning attached to it. Yeah, rather than, um, it's almost like, rather than seeing it as 'a slip,' it's a complete lapse…And *that's* what I'm fearful of…

Through the current study and interview process, the present author analyzed the complex web of emotions and behaviours revealed by Rose, as well as how the focus on control resulted in a "spiral" of self-blame and shame leading to thoughts and behaviours that hindered the recovery process:

> What I do is like, I spiral with all those thoughts and just feel worse and then worse and then start comparing myself to others. It was like, 'Oh,' you know…like, 'Why was I not strong enough not to go through that?' So, it's like, negative spirals also attached […] I think confronting feeling like a failure. It's like sitting with that…those thoughts. Because what I do is like, I spiral with all those thoughts and just feel worse and then worse and then start comparing myself to others. So, when I feel negative about having experienced anorexia is that…I'm comparing myself to those who haven't. And, you know, 'They're stronger.' Yeah. It's like, 'They're better for having not experienced this…' (*mumbles/whispers*).

Acknowledging the shame that underlies AN is important because it contributes to explain one seeming paradox of anorexia: the more starvation weakens the person, the more emaciated the person is, the more she feels in control and strong (Klyop & Howells, 2019). Some of these paradoxes are interwoven in her response, as Rose identified some of the values and benefits of recovery (subset 4. e. 3. significant aspects of enhancing recovery, nuanced with 4. g. nurturing and sustaining recovery):

> Like, our bodies are much stronger than we think. And in the negative way too, like obviously your body can handle *a lot* when you put it under stress, but I remember thinking like, 'Wow' like, 'these are the benefits of recovery,' like, 'I'm able to do more for myself, but also give more to people.' It's kind of just sharpened…my…um, compassion for others, but obviously not for myself, but um, I don't think it's changed how I perceive things or…I still feel like, life should be about…well, I guess before it was like, more about giving to others and less to myself and now it makes me think, it's both. You can only give so much to others if you give to yourself too.

Stephanie highlighted challenging aspects of her experience with the remission and recovery process, as well as opportunities for growth. As previously mentioned, the remission and recovery process are not linear, as it can include partial and/or full remission (Dawson et al., 2014). In a study of women with AN and their experiences with remission, Espíndola and Blay

(2013) concluded some significant factors involved with remission: (a) empowerment/autonomy when remission seems possible through a sense of autonomy, self acceptance and increased involvement with religion or spirituality; (b) media related factors when remission is considered possible through the aid of diverse media such as personal records, journals, conferences, the internet; and (c) treatment factors such as various biological or psychological approaches. The present author inquired about Stephanie experience of remission and recovery up until the present time (subsets 4. a. Challenges, nuanced with 4. b. Growth):

> I'm not saying it wasn't difficult, especially like, the first few months are…it's ex…exhausting because of how difficult it is, because it's really like, you are like…you're fighting…you're fighting yourself, you know. It's like, every single thought that's symptomatic that comes up you have to just like attack it and stay on it. Otherwise, it…it brings up symptoms […] And something I've personally found…particular about my experience with remission and recovery is that (*pauses/stops*). Um, it first started with a very big low, where my symptoms became very severe and um, my family doctor wanted me to be hospitalized because of my past experiences with it. So, I may have still been having thoughts such as, um, for example, the urge to go and body check. But if I didn't act on it, then for me, that wasn't symptomatic. For me, as long as I'm not acting on it, and as long as I'm able to understand…that is an eating disorder thought, and I'm able to know like, that has *nothing* to do with me, per se? Um, I think recovery had such a great impact on the way that I'm able to look at myself and how I perceive my self-worth. And I think, in that sense, when I have an accomplishment in life, whatever that's stems from, I don't relate it at all to the weight that I have lost or gained, or to my appearance.

Interwoven in her response, Stephanie highlights how she no longer made associations with her physical appearance during the remission and recovery process. Moreover, she integrates both the challenges of the remission and recovery process, as well as the growth that she experienced.

She provided many examples of how her personal growth and success is no longer related to AN or symptoms (e.g., "when I was accepted into my master's program"). Recovery and remission have permitted her to differentiate: "So, I think that's been something that's been really *massive* and great for me because it's helped, it's helping me to recognize, um, attributes and strengths that I have that are just inherent to me, or that are a result of hard work."

In addition, Stephanie also reflected the values that she developed from her experience with remission and recovery (subset 4. c. Personal values and qualities seen in remission and recovery are not contingent upon Anorexia):

> It feels really good to able to look at myself or just think of myself and feel like, 'I like who I am, I *love* who I am.' Because of all of these things and none of it has to do with the way that I look or how much I do or do not eat. Or how much I exercise. It has everything to do with the person that I am? And what I feel that I'm able to contribute to, you know, life to society. And the person, like, the values that I have, and the way that I…I…carry myself through life. And that is *so* much more rewarding than saying like, 'I'm happy with myself because of…how much weight I've lost this week.'

After she took the time to respond, the present author reflected how those values and qualities Stephanie now encompasses in her life, "they do not have to be contingent upon anorexia," in which she replied: "Yeah, yeah (*nods*).

Stephanie also reflected on dynamics that assisted her experience of the remission and recovery process, which was accompanied and interconnected with themes of trust, connection with others, and empathy, and compassion. Moreover, she accentuates how the catalyst for recovery was comprised of support and openness from others (subset 4. d. Dynamics that assisted in Remission and Recovery nuanced with subset 4. f. 3. Remission and recovery transforming the self):

> I would say, something that helped me was having people around me who were able to like, look at me and say like, 'I acknowledge and I can see how difficult this is for you.' I needed a lot of compassion and a lot of (*pauses*) self-compassion, which is…you know, not something that came easily to me, and it was something that I had to learn. So (*pauses*) it was just like, I think my springboard was made out of many people, who believed in me and, you know, really voiced that. And who were willing just…like, help me in any way that I needed without…being too pushy without being judgmental and…by making me feel like they saw me for me, and not what I looked like.

She also revealed how she was able to "let go of [her] anorexia symptoms," in order to maintain her remission and recovery process (subset 4. e. Maintenance of remission and recovery):

> I feel like – and this is also how I've maintained recovery and remission – I've had to become *extremely* like, assertive and much (*stops*). I had to become louder than anorexia […] it's just like, continuously proving to myself and to anorexia that like, 'I will be ok if I don't do these symptoms.' It has been like, what has helped me to get there, and maintain it.

In regard to recovery, existing research illustrates that recovery from AN is an on-going process that required internal motivation, belief in the capacity to change, the ability to develop trust and the expression of emotion (Rance et al., 2017; Shohet 2007; 2018). In contrast, relapse was characterised by uncertainty, reluctance to change, difficulty asking for help, intense negative emotion, and a pervasive sense of worthlessness (Federici & Kaplan, 2008). Stephanie highlights how she experiences fear of relapse, as well as how remission and recovery is an enduring process (subset 4. f. Remission and Recovery: An Enduring Process nested with subset 4. f. 1. Particular fear associated with remission and recovery):

> I also think that, and I think this is something that I struggle with like, even kind of looking to the future, and remaining hopeful is that, 'Yes, I'm in recovery, yes I'm in remission and my goal is to continue to be,' but I think like, there's always going to be like, I'm always going to have to work at it. It's not something where once you're in

> recovery, that's it, like, it goes away, and it doesn't come back. I guess, like because I determine remission/recovery as an absence of symptoms, like an absence of acting on thoughts or behaviours. It doesn't mean that I don't have thoughts Like, I think there's always going to be difficult days, where you're going to have to push back, and you know, really work hard to not to fall back into the illness. I see that as being…just kind of like, the rest of my life? Like is, like, those thoughts *will* slowly speak up. It's about how you react to them. And so, I guess, that's why I see it as a lifelong like, having to actively, continuously work towards, um, not acting on the thoughts. And like, I do think that will become lesser, less frequent less intense with *time*, but I'm not sure if I'm like fully convinced that they'll fully disappear.

As conveyed in the quotation, Stephanie defines remission and recovery as not only the absence of symptoms, but also not acting on those thoughts and behaviours. However, she continues to have anorexic thoughts, remaining doubtful thinking it will ever fully dissipate. Therefore, she sees remission and recovery as an enduring process of not acting on the eating disorder thoughts that might emerge. While she thinks that thinking will become less frequent with time, she remains doubtful it will ever fully disappear.

The present author inquired how Stephanie would describe herself now and if this has changed since experiencing remission and recovery, including how remission and recovery invites Stephanie to see herself as a person now (subsets 4. f. 2. Positive dimensions/growth and 4. f. 3. Remission and recovery transforming the self):

> One word that comes to mind is 'balance.' I see myself as a much more balanced person. And, a more rational person in the sense that I feel like I'm able to see the full picture, whereas before with anorexia it can feel like you're really just looking through a straw and you can't see anything outside of it. So, I think those of two things that certainly come to mind. And, also, just kind of like, a happier more easygoing, more inviting person as well. More compassionate, more willing to connect with others.

The shift from the experience of anorexia to remission, as well as recovery parallels a grief reaction in some participants. More specifically, Geraldine expressed the difficulty to grieving AN was required to move forward in her remission and recovery process (subset 4. a. Grieving the loss of anorexia during remission and recovery):

> I call him [anorexia] 'Ed.' Yup. It was….it was my everything. It was my everything. And then, I mean, so in recovery as well, or like, trying to…get to even the idea of recovery, having to *give up* this…*relationship* was like an astronomical ask. Like, not only is it your *best friend*, he becomes your partner. It, it is *you.*

The present author paraphrased and reflected how remission and recovery implied a loss of Geraldine's perceived relationship, which led to grieving because as she said, "Ed was a part of [her]." She replied without hesitation, "Mmhmm. I very much still mourn it…"

Grief is defined by a sense of deep sorrow that is usually expressed when an individual dies (Yalom, 2009). However, the loss of a relationship or one's sense of self during their ED recovery can also result in feelings of grief (Pugh et al., 2018; Ling et al., 2021). Therefore, the present author asked Geraldine: "How do you make sense of that? When you say, "I very much still mourn it." What do you feel you're mourning?" Geraldine clarified (subset 4. a. Grieving the loss of anorexia during remission and recovery):

> Um (*long pause*). I…for some reason, I…I…loved…I… (*stops*). I don't know why I don't remember really any of the horrible parts of my eating disorder. I'm pretty sure your body probably does that because, you know, because it's trying to survive. But um, I…*loved* the feeling of control that I thought I had over my life. I…I *loved* the person I was *trying* to become. I *loved* the drive that I had. The…the ability to – at least in my mind – be as close to perfect as possible. And to continue to strive to…to that standard? Um, so, functioning now in life, *for me,* when feelings of perfectionism, um, for example, come up, I…I have a lot of problems because I, I *love* it. I get scared and excited at the

> same time because (*stops*). 'Is Ed going come" (*stops*). Is Ed going come back, am I letting him back in? Am I…am I going to go back into this process?' Because I mean, we've all relapsed. If there's somebody who's had an eating disorder and they haven't, I'm so happy for them, but all of my experiences with everybody else that I've met, especially at the unit, like, relapse is just, that's just life. That just happens. It happens without…it's, it's built into it too.

Letting go of "Ed" meant she was letting go of her sense of self-control over body image and food (Pugh et al., 2018; Ling et al., 2021). As a result, the grieving process for the loss of her perceived sense of self with AN was deemed the same as if she lost a loved one like "Ed." With the transition from grieving the perceived loss of AN or Ed, Geraldine accentuated how 4. b How Remission and Recovery has changed her sense of Self and Identity):

> So, like, 'I want to do something with my life, I'm ready to create,' I guess, 'my own identity.' And maybe I was scared of that for a long time? I think maybe that had a lot to do with it because there were all these identities that everybody else was throwing out.

Geraldine described some challenges and growth she experienced during her remission and recovery process, as well as the active decision to engage in the recovery process (subsets 4. b. 1. Growth and 4. b. 2. Challenges, nuanced with 4. c. 3. Grieving the loss of Anorexia nested with subsets 4. b. 3. Active Remission-Self; 4. b. 4. Behaviour for Initiating the Active Remission-Self; 4. b. 5. Determined Recovery-Self, as well as nuanced with 4. b. 3. Liberation of Recovery):

> I have all of this freedom now. Basically, I have the whole day that I get to decide what I want to do, and it's like, 'Oh, well I know that I work at this time, but I can do these activities, or I can watch this movie,' or you know, 'I can spend my time…' (*stops*). The freedom of being able to spend your time without all of those negative perseverating thoughts. Yeah, it's *so* wonderful. I can go (*stops*). I think I still…there are moments still

> in recovery that I grieve. That I…I'm sad? I'm sad that it's…it was such a huge part of my life. I devoted *so* much energy to it. For *so* long. And, and it's hard to just…it's hard to let that go, I think. Yeah, I need to change the narrative because right now how this is going, it's not going to go much longer. Like, 'This has an end.' And I didn't want it, and I remember doing those body checks and just thinking, 'This is…what am I doing.' Like, Why am I counting my ribs, why am I getting joy from that? Why, why do I need to feel my collarbones, like the way that they are?' It's a life that I mourn, but I don't want […]. Sometimes I'll even look at the clock and I'll be, 'Oh, I would still be at the hospital if I was still in treatment,' which is a *huge* drive for me obviously to not need to go back, but it's…*so* much freedom to be able to be in *my* space, doing *my* activities, being…being free. It's, ugh it's so wonderful. *So* good!

Given what Geraldine said about her life before experiencing AN, as well as what she said about her life currently at the time of the interview, the present author inquired how she understood AN's role in her life (subset 4. b. 5. Seeking Meaning and Understanding of Anorexia's Purpose):

> Um well (*pauses*) I don't think I'm ever going to be thankful for having an eating disorder, um, because it has…(*stops*), but it has made…It has made me the person that I am.

This is a powerful statement that speaks to the continuum of her relationship with AN, a relationship that has molded her identity. She proceeded to expand of AN in her sense of meaning:

> Um, yeah, but I wouldn't…I, I think it's made me a lot more understanding like as a person. Um, I think my, my empathy level has increased, and I also think my awareness of um, how prevalent mental illness is in society or how um…important choice of words can really be. Um, so, in a way, like, I guess I'm glad that I've experienced what I've experienced. Or that, that I've had anorexia. I mean, that sounds so weird. I, I, I wish I, I never had it. Like, I, I feel like, I mean I don't know who I would be without it because it

> has defined my life in so many ways. That I've really, I would have no idea, um, what I would want from life if I…or what I would expect from life if I…you know, didn't, didn't have it. But yeah.

The present author reflected how Geraldine shared that AN "became a part of [her]identity," including how it seems like it is difficult for her to envision what life would be without AN because it has been impactful for her (e.g., she was able to develop "empathy" and understanding for other people):

> Mmhmm (*sighs*). It's, it's so weird. It's…I guess maybe it's…I would compare it to somebody being married almost their whole life and…you know, and, you know, asking them, 'Well, what would it be like if you didn't have…if, if you weren't married?' It's just *so* hard to conceptualize.

Geraldine sighs and said, "Like, I, I feel like, I mean I don't know who I would be without it because it has defined my life in so many ways." She stated that it would be "so hard to conceptualize" herself without it. Understood in this context, AN played a part in her identity. What is striking is how she reiterates and compares AN to a relationship, a marriage even. As AN is comparative to marriage, Geraldine highlights the relational aspect of it; namely, how "Ed…" really took a relationship for her: "Yeah, complete commitment to each other." Consequently, she accentuates the type of relationship between Ed and herself. Although she said "complete commitment" what made this commitment deleterious was less because it was complete and more because it was rigid, controlling.

Interwoven in Geraldine's responses includes some paradoxes, accompanied by the continuum and fluidity of the recovery process (4. d. Continuum and Fluidity of Recovery 4. d. 1. Ambiguity and Flexibility of Recovery Process):

> Like this disease is ***horrible*** (*laughs*) because it impacts…. there's no safe place. There's no safe conversation. Um, ever. Like, everything could potentially be a trigger and so, I

> think maybe that's another reason why recovery is <u>*so*</u> scary and staying in that jail cell looks better and better some days (*laughs*).

She expressed "recovery is so scary," but the jail cell seems more familiar; therefore, there is a paradox associated with recovery. Moreover, the fluidity and continuum are quite striking in Geraldine's statements. She proceeded to accentuate the fluidity of the recovery process (subset 4. d. Continuum and Fluidity of Recovery):

> I think a lot of people even though they, they *say*, 'Oh well, it's not linear, it's ok.' The disappointment and the…the sadness and the <u>***guilt***</u>, for sure the *guilt* of you not being able to get your life together, I guess, which is how they see it. Um, that is just…that's a weight. It's terrible. Because I think they, they really do think it is linear. 'Well, you're either better or not. Well, you're either starving yourself or you're not. You're either purging or you're not.' And that's *so* difficult. Life…with an eating disorder is measured sometimes in milliseconds.

The present author reflected how Geraldine accentuated that recovery requires more flexibility, whereas with AN "there's that control, rigid beliefs or whatever accompanies it." Geraldine confirmed and stated:

> With recovery, it ebbs and flows. You're not able to anticipate everything. What might unsettle you or rattle you. Um, there's…it's…yes, its more like ambiguous that way, I guess. Mmhmm! And how do you prepare yourself for that?

5th Superordinate: Metaphors for Anorexia, Remission, and/or Recovery Process

Metaphor, as a fundamental process of thinking, has been systematically applied to understand a vast array of human experiences such as time, causation, events, emotions, the self, morality, and disease (Deng, Yang & Wan, 2021). For example, in their study of 27 Wuhan

adults (12 men and 15 women), participants for Deng et al. (2021) employed metaphors to communicate about their lived experiences of the Corona Virus Disease 2019 (COVID-19) pandemic. Moreover, the data analysis described participants' different kinds of emotional states and psychological conditions during the pandemic. An assumption of embodied cognition is that "the mind is not simply in the head, but is organismically embodied, contextually embedded, and environmentally extended and distributed" (Littlemore & Turner, 2020, as cited in Deng et al., 2021, p. 3). Hence, Deng et al. (2021) argue that "metaphor can provide functional and concrete cognitive patterns in articulating and constructing participants' subjective lived experiences, offering in-depth insight into their emotional states, identifying personal mental health issues and ultimately promoting positive changes" (p. 3). In the context of their results, it alludes to how the metaphors of the present author's study are used to conceptualize embodied experiences of AN, as well as the remission and recovery process.

Metaphors, as carriers of conceptual meaning and as a product of language (Lakoff & Johnson, 1999), are a powerful tool to transmit knowledge and beliefs, and to understand the phenomenological experience (Bates, 2015). As shown in contemporary work on human cognition, culture, and communication, metaphors "can cast light on why we understand ourselves as we do" (Potter & Wetherell, 1987, p. 108). In Garrett's (1996a) words, "metaphors help create the self" (p. 1496). Accordingly, metaphors can become instrumental in uncovering how participants in the midst of their experience with AN made sense of their identity, including during the remission and recovery process, as well as active agents in their respective making-making process. In the case of mental health disorders such as depression, there is a large body of literature on how metaphors shape the experience of illness and recovery (e.g., Fullagar & O'Brien, 2012). In the domain of EDs, however, few studies have been devoted to the

metaphorical meanings with which individuals explain these syndromes (Bates, 2015). The subsequent section examines segments of participants' metaphors for AN, remission and/recovery in superordinate [5. Metaphors for Anorexia, Remission and/or Recovery Process].

As highlighted in a previous subsection -5.1. Part 1: Individual Participant Experiences), particularly in Table 2 [Subset the complexity and lived experience of AN, as well as coping and identity], AN functioned as a part of participants' identity. During the interview process, the present author offered an opportunity for participants to reflect on the meaning of their experience with AN and remission/recovery, as well as meaning in life. More specifically, in the third and final interview (e.g., see Appendix B), the present author stated, "We will strive to look at how the situations in your life interacted to bring you to your present understanding of anorexia, remission/recovery, and meaning in life." Therefore, one of the questions for participants included: "Are there any words or metaphors that come to mind when you think of remission and/or recovery?" (Prompt: If you try to describe remission/recovery in just a sentence or just a few words, what would you say?)

The present author asked this question to Liesel concerning remission and/or recovery, whereby she confirmed there were "words" that emerged in relation to both AN, as well as recovery for the present superordinate [5. Metaphors for Anorexia, Remission, and/or Recovery Process] subset 5. a. Being derailed during the experience of AN, nuanced with subsets 5. b. Being present in yourself, the world, and situation; 5. c. Words for remission and recovery consist of acceptance and neutrality):

> Yeah, I think it would have been better. I mean, I think I would have probably been more productive and more focused. Less, you know (*stops*). I probably would like, (*stops*) it sort of just kind of…I feel like, [anorexia] kind of derailed me for a while. Um (*pauses*). Like, being, being able to be present (*pauses*). Not really metaphors, but just like, getting

> out of yourself, and being so much in yourself kind of being present, being in the world and the situation. I think acceptance is a big piece of it. *For me*, I don't know about for other people, but *for me,* um, I like the term […] I'm starting to learn more about like, body neutrality. Its kind of, it's part of the movement, but it's…kind of to me, is much better actually because it's not about trying to be *positive* because that is, it makes it still about the *body*. It's more about like, *neutrality*. Like, its just one thing about you, kind of thing, so I really like that.

It is noteworthy that Liesel uses words to describe the self-transformation that she experienced from AN into the remission and recovery process. In particular, she indicated that AN "derailed [her]," which is indicative that it obstructed the process of her life. She confirms this sense of derailment in additional reflection, as she states:

> Well, it did because I started out a program, couldn't do it, like, had to take time off from working entirely. Basically. For a while I didn't work at all. And then really, I was like, kind of like, drifting and…I did, you know, like one day a week type job for a while. Like, these were years when I could have been…like, um, I don't know, at least finishing grad school within like, a shorter timeframe. I just think of all the time and energy like, when I think back to like, the whole idea of the pie chart, you know, and having the time in your life to devote to a lot of different things versus all the time and energy that went into like, my…looks and just it's, sort of like, shameful in a way? That I've put that much effort and time into it even though like, *I know*, it's you know, it's out of my control and everything, but *still*. I think, well, if that's the case now than obviously if I wouldn't have had it, I also would have had all this time and energy to put into other things and, um…

This parallels another participant Rose's experience in the previous superordinate [4. Experience of the Remission and Recovery Process]. Intertwined in Liesel's response is shame, as she questions the "shameful" aspects of AN. While she is questioning it in her tone, she is attempting to minimize the sense of shame with emphasis on her current self-awareness and knowledge

(e.g., "I *know*"). In Liesel's response, however, she does refer to the notion of AN being "shameful in a way." More specifically, the time and energy she devoted to it, emphasising how it was out of her control, so she did lack a sense of internal control with AN and it tried to fill that gap for her in many ways.

The notion of filling in a gap parallels a metaphor used by Lotus (e.g., highlighted in a previous subsection and superordinate [3. Anorexia Treatment Process]) in subset 5. Metaphor of Remission and Insights attained from Active Remission-Self):

> Yeah…it's an underlying issue that the food…the weight loss all that stuff for people with anorexia specifically, it's just a symptom, an underlying issue. Its almost like, and I've experienced that myself every time I went to treatment…it was almost like filling…filling a flat wheel with air, without looking at the cause of why the flat…where there was flat wheel in the beginning…there was a hole in it. And the same thing, people who have eating disorders

Given the metaphor that Lotus used (e.g., "filling a flat wheel with air"), the present author inquired how she would describe her process of filling that tire:

> Yeah. It wasn't treatment at the hospital. Definitely it wasn't…I mean I've been through 12 rounds of treatment over the past 10 years. It wasn't…it helped me in numerous ways, but the real, real help that I got was when I received trauma therapy. That was it for me. And everyone's different, but for me, receiving individual therapy was a huge help for me.

Lotus revealed experiencing "12 rounds of treatment," which is an extensive amount of treatment and subsequent relapses from AN. Further examination of research indicates that childhood experiences of neglect (Dalle & Grave, 2011) and sexual abuse (Wonderlich et al. 2001) are

associated with emotional abuse and related to EDs behaviours. Given the experience and impact of trauma, individuals have shown to develop dissociative coping styles, such as binge eating (Perry et al. 1995) or seek to regain control through limiting food intake (Schwartz & Cohn, 1996). Therefore, childhood neglect and sexual abuse have been identified as risk factors for EDs.

The challenge for women who have experienced trauma is not exclusively a matter of how the body is perceived by themselves and/or others; it is also the inability to take ownership of and inhabit a body compromised by trauma (Malecki et al., 2018; Young, 1992). It is the painful realization that the woman's body is not her own, but is "the body for others" (Malecki et al., 2018, p. 937; Coombes, 2019; Sartre, 1958). In other words, her experiences are drawn from the perspective of the observer (*le corps-vu*) and inscribed onto her body (Malecki et al., 2018, p. 937; Coombes, 2019; Sartre, 1958). There are high rates of trauma history in all forms of EDs. For instance, Molendijk et al., 2017) report on the negative influence of abuse on the severity and complexity of EDs. Therefore, when trauma merges with AN, it places a unique mark on the intricate network of material–bodily systems that affect the way women experience and respond to their bodies.

As previously mentioned, EDs are not entirely about food, but rather a way to control that specific aspect in a person's life. An individual may feel out of control or powerless after experiencing a traumatic event; consequently, they use restricting or binging behaviors to control that aspect of their life in order to hide their feelings of shame, hopelessness, and fear (Malecki et al., 2018). As identified and shared in Table 2, Lotus stated: "I think I just internalized it, and turned it into, "I can control food that's the only thing I can control, and no one can take that away from me" (subsets 2. a. Coping mechanism; 2. b. Entity). The present author also inquired

with Lotus: “And what would you describe as the greatest struggle you might experience in making your life feel meaning? What’s the greatest challenge would you say?” Lotus replied: “Um (*pauses*) trauma from childhood. I think that the specific trauma of sexual abuse really shook me, and it really made me feel like there was no meaning…” As Lotus disclosed, she experienced severe trauma, which “really shook [her]” as well as her sense of meaning in life. As tersely stated by Malecki and colleagues (2018), “The effects of trauma pervade nearly every aspect of human functioning” (p. 946).

With additional reflection, the present author paraphrased how Lotus’ process of remission, as she shared, had really impacted the way she views herself (subset 5. a. Metaphor of foggy glasses with Anorexic-Self and clearer vision with Ongoing Recovery-Self):

> Yeah. The more…the more I distance myself from symptoms and anorexia itself, the more I was able to take distance and just be able to look at myself differently, I guess. It was almost like foggy glasses I had on all this time and as soon as I took them off and with time, I was able to start seeing myself…differently.

This is a powerful statement, as Lotus previously disclosed that she is visually impaired. While she states, “I was able to start seeing myself…differently,” it is a symbolic statement of her sense of inner agency. The present author continued to query if Lotus attempted to describe in just a sentence or a few words remission, what she would say: “Hmmm (*long pause*). It’s worth it. It is.” After some additional time to expand on her response, Lotus explained how remission (and healing) from AN is a gradual and ongoing process, accompanied by existential contingency of the importance of human connection/personal relations to address existential isolation and loneliness:

> No matter how hard it is, it is worth it because in the end…no matter how lonely and awful you feel, and you feel like no one cares about, there are people who do care. And if they're not immediate, if there not right there with you at that moment then they probably will be there at some point in your life. There is always someone who will love you.

According to Yalom (1980), the four most important existential givens are the inevitability of death, our existential social isolation, the lack of pre-given meaning in life ('meaninglessness') and, related to the latter, the inescapable freedom to choose in life. Given unsettling life events such as trauma and AN, confront individuals such as Lotus with these existential givens, damaging fundamental assumptions (Hartog et al., 2019; Janoff-Bulman 2010) and meaningfulness, but also opening up new possibilities and meanings, as well as interpersonal relationships and connections, as she shared in her reflection. Lotus also alludes to existential anxiety (EA) and aspects identified by Van Bruggen and colleagues (2017) such as guilt and identity in addition to meaninglessness and isolation. For guilt that is a "differentiated and complex concept in itself," they chose "to focus on the experience of not being able to fulfil one's own expectations about life" (Van Bruggen et al., 2017, p. 1693). In addition, Lotus accentuates AN in relation to identity, which Van Bruggen, and colleagues (2017) explain is "not having full knowledge of oneself along with the inconsistencies in the experience of oneself and the world" (p. 1693).

Lotus also reflected on the synthesis of the remission and recovery process being similar to "a puzzle." She accentuates "a piece of a puzzle" that required her to essentially disassemble and reintegrate by putting those pieces and integrating them together for recovery (subset 5. b. Metaphor of recovery journey being a puzzle):

> It was a process, like a weekly process I'd say throughout therapy and like treatment and stuff. Like, it took a long time for me to be able to I guess shed some of that layer of just (*pauses*) hatred towards myself and pain…I had to shed that in order to…its almost like, I've always, like when I was younger at the beginning of my recovery journey, I used to compare of it to a piece of puzzle and often like I just felt like there were so many puzzle pieces that were missing from my life. And with remission I started to find those puzzle pieces I guess…to myself, and I guess those puzzle pieces relate to my childhood and traumas because my brain blocked a lot of them, and that was why I ended up going up to the eating disorder every time. There was still pain that I wasn't dealing with.

The present author queried with Lotus, "Would you say now that you're still putting that puzzle together? With those pieces?" Lotus accentuated the fluidity, as well as the ongoing nature of the remission and recovery process in her response (subset 4. b. Self and Recovery-Self (transforming)):

> For sure. I'm getting close to the full picture. Yeah. It's different for everyone. Some people prefer not going back there and dealing with it, but for myself, I always felt like I just needed to face that fear that I had from my past to be able to move on from the eating disorder […] In the past couple of months I've had a lot of things come up and I've remained in remission. It gives me a little bit more hope, thinking that perhaps if I saw the full picture, I have enough strength to keep going.

The present author inquired during Rose's interview, "Are there words or metaphors that come to mind when you think of recovery? If you were to describe it perhaps even in a sentence or two." Rose indicated: "When I think of recovery, I think of like, the lights being turned on again, or… (*long pause*). Oh, I don't know…I don't know how to describe it really" (subset 5. a. lights being turned on again). For this reason, the present author reflected: "Mmhmm. Well, if we take that image of the lights being turned on…it allows you to step out from…well to see…?" Rose reflected: "Mmhmm […] to step out of…darkness." Rose proceeded to indicate:

"Mmhmm. Yeah, I think that's a very good way of describing it. There's like, a dark passenger with you. That's what it felt for me having anorexia" (5. b. Anorexia is a dark passenger). Given that Rose used the present tense by stating that, "there's a dark passenger with you," the present author inquired: "So, 'a dark passenger.' Is there still 'a passenger' with you?" Rose procced to build on her response and reflected (subsets 5. a. lights being turned on again, nuanced with 5. b. Anorexia is a dark passenger):

> Ugh, no, not in that sense. But I do feel, I think for me, before when I thought of recovery it was like, 'Gone, done. I'm done. I'm amazing. I don't have to deal with this anymore.' But…but that's like, super optimistic me. And then I kind of, but out loud was reflecting, I was like, 'Oh no, I still do have a bit of this?' But it's more just negative self-talk. It's not…it's not like, the wanting not to eat and that kind of thing. It's not the…yeah, it's not all encompassing. But it is, it's still there in a way that I didn't think it was.

The present author proceeded to reflect and paraphrase to Rose: "And you say, "Not as much as you thought…" Can you tell me about that?" (Subsets 4. h. recovery as an ongoing process; 4. j. implications of relapse):

> Um…yeah, because for me, when I think of anorexia, I think of…the behaviour. I don't think of the thoughts, um, I think of like, the compulsions and behaviour and what you do. I don't think of how you think. And so, for me, anorexia was just thinking 100 percent, but I guess I could see, I think I understand now more how people would relapse. Because I thought like, 'Oh, I would never get into that frame of mind ever again,' like, 'It's done.' But I can see how (*stops*) because like depression you can relapse into those behaviours. Mmhmm. Yeah […] Um, so it was like, I guess, trying to find things, um, to distract myself and then focusing on what my dietician had said and psychologist, and then you know, I guess forcing myself to eat […] Um, but yeah, I did relapse, I remember thinking like, 'Ugh oh.'

Similar to Lotus, Rose also reflects on the fluidity and continuum of the remission/recovery process, indicative of the difficulties participants and individuals with AN have described in traditional medical models of care. Accordingly, the focus predominantly on physical needs, of which nutrition is just one; namely, weight gain should not be the only focus for individuals seeking treatment from AN. As this study explains and further discusses in the next section (i.e., 5.3 Discussion of Findings), the notion of core human needs (e.g., psychological needs, love and belonging, self-actualization) and basic human motivations (e.g., safety and interpersonal connection) and understanding the role AN has in interfering with meeting these needs have been left unsatisfied. Moreover, consideration of existential givens, metaphors, and spirituality for individuals with AN is sparse. Therefore, the findings of the present study provide a framework and model for understanding the fluid continuum process of remission and recovery from AN.

In addition to the other participants, Stephanie also shared metaphors that emerged for her pertaining to AN, as well as the recovery process (subsets 5. a. Metaphor of Anorexia presented as a friend at first; but shifted to a poison upon entering recovery; nuanced with 5. b. Increased insight shifts AN to the enemy, as she enters recovery):

> So, I think in like, let's say, my darkest moments with anorexia it definitely…disguised itself as a friend and as, you know, something that was there to…take care of me. That was there with good intentions. Um, it never like, I would say, it only started to feel like something that was working against me when I tried to recover from it. And when I started to make those efforts and *that's* when I started to feel like, 'Oh my God this is like, poison.' Like it's, it's so difficult to get rid of. And it's just like, 'It's in me and I don't know how to like, suck it out kind of thing' (*laughs*). And so, I feel like it's like, when I was very symptomatic with *no,* almost no insight into the illness that it felt like it was very much a friend. Very much like, I was very happy that it was there. And it's only

> when I started to gain some insight and like, work against my anorexia that it started…like, I felt like, it was like, the enemy.

In her response, Stephanie put emphasis on how she had "*no,* almost no insight into the illness;" specifically, she repeated the notion that she had no insight into AN. Moreover, she accentuated several paradoxes, in which she put emphasis on "my anorexia," but compared it to "a poison." According to Guarda (2008), "Anorexia nervosa is a behavioral disorder characterized by ego-syntonic self-starvation, denial of illness and ambivalence towards treatment" (p.113). As a result of the ambivalence towards treatment and poor insight, treatment is frequently viewed as comprised of two phases, weight restoration and normalization of eating behavior followed by relapse prevention (Guarda, 2008).

In addition to those metaphors, Stephanie also reflected on the significance of her values since being in recovery from AN. Interestingly, she used the phrase of how remission and recovery nourish her by "feeds" aspects of her life:

> I think it like, for me now, it feeds back to things like effort to…um, kind of just like, who I am at my core – because it depends on exactly what it is – but I think it just feeds who I am as a person and what I'm able to offer, and you know, and when I'm able to succeed because of my *perseverance* because of my *dedication* and my *passion* like it, things that are more about *me* as a person. My characteristics, my personality, my values, my…my morals.

Stephanie reflected on how these are aspects, which are inherent in her without the existence of AN. Moreover, she reflected on the importance of recovery in allowing her to reflect on her values, characteristics, and morals. The present author, therefore, asked Stephanie how she would describe herself now in terms of what she stands for and what matters (subset 5. c.

Metaphor of recovery is opening a door to life, imbued with empathy by reaching back to help others through that door):

> Um, the things that matter to me, kind of it may vary, broad picture, I guess, kind of are really like, like, kindness, compassion, respect, treating others the way that you want to be treated and like, really something that is huge for me is kind of that…I guess it's like, metaphoric, but if you're able to open a door in life, like, make sure you're reaching back to bring others with you through that door. So, that's something else that is really important to me is you know, we're all kind of like, in this together, and life is pretty difficult, so if you're able to make it through some difficult circumstances like, make sure you're finding ways to support others to…to keep going with you.

Given that Geraldine refers to "we," or "we're" in the previous excerpt, it is important to make a distinction. "We" is personal pronoun, a word that takes the place of a noun (e.g., name) for specific people; namely, Geraldine is the person speaking about one or more other people. In the midst of her responses, the present author reflected: "The focus is on the physical from what you're saying, and not on the personhood…" Geraldine proceeded to expand on the response and paraphrasing of the present author:

> Yeah! Sure, yeah! Not like, 'Hey [Geraldine], what did you do today? Or like did you see anybody? Did you have school going?' Or like, 'What's new and exciting?' Um, just, 'Did you eat? Well, how much did you eat? Well, did you get weight on? Did you go to the hospital? Ok, what are your electrolytes like?' And it's just (*pauses*) it *reinforces* being *nothing*. Being that *ghost*. It's *so* hard to get of that when my parents call me and talk to me and my aunts and uncles, who haven't seen me in a long time (*pauses*). I'll get the… '*Oh* ok! You're looking better, you're looking better,' and all it does is…talk to my eating disorder […] I think there needs to be some sort of dialogue. Um (*pauses*) where…it says, 'Hey I'm, I'm still a person,' you know? It's like people with AIDS like, nobody wanted to hug them because they were like, 'Oh, we're going to get aids.' It's almost the same thing. There's like this, this way that people talk to people with mental illness. And you're not actually talking to the person. And it *hurts so much.*

Geraldine continued to state how others continue to "talk to my eating disorder," confirming that the remission and recovery process is ongoing. Furthermore, this statement accentuates that AN is her Dasein and remission/recovery is a fluid process on a continuum.

During the interview process, Geraldine integrated metaphor responses concerning the process of accentuating the experience of AN, as well as the remission and recovery process (subset 5. a. Active Recovery-Self compared to Anorexic-Self):

> Like, looking back. It, it really is sort of like, look *through* that, you know, like, that clouded glass because…um, you *forget* a lot of the horrible things. Um, everything is almost…not sugar coated, but it's just, it's just very cloudy […] everything was apocalyptic. Um, yeah, so it's *so* much better on the other side, but that being said, I'm *definitely*…I'm definitely still impacted, um, by…my life from before. Like, my, for example, my partner said something you know that really isn't that hurtful at all.

The present author simply responded by using empathetic listening and stating "Mmhmm." In doing so, Geraldine continued to expand on what the experience (subset 5. a. Active Recovery-Self compared to Anorexic-Self):

> *Um*, and…I couldn't handle it. Like, I was in tears for hours. I couldn't…catch my breathe. I, I was so upset and then I thought about it and it's…my *past.* It's me being, it's my anorexic mind that was reacting to that and not my current recover (*stops*) like, sort of quote on quote, 'recovered mind.' *So*, it's a lot of work and it's definitely an uphill…climb. But I feel like even though like physically I'm in recovery sometimes mentally, um, I come across sort of these pitfalls. Um, where maybe I'm not as recovered as I thought?

It is striking that Geraldine terms it the "anorexic mind," compared to the "recovered mind." She also puts emphasis on how it is "… my *past*." Moreover, she pauses (e.g., …) and puts an emphasis on how AN is "[her] *past*;" consequently, it is italicized. However, it is uncertain that AN remains in the past since Geraldine still seems in the Active Recovery-Self state. Physical recovery suggests body weight maintenance, but she questions her recovery process here: "Maybe I'm not as recovered as I thought?" Accordingly, Geraldine identifies that she may not be as recovered as she thought; therefore, she is recovery and the sense of self that accompanies it is an active state as she continues to experience challenges.

The present author proceeded to inquire "if is there a sentenced or a few words that would say to describe remission and recovery?" Geraldine stated: "*Hmmm.* It…it is a sense of freedom, which is really nice" (subset 5. b. 2. Liberation of Recovery). She continued to accentuate the allegory of AN and recovery in greater detail, denoting with rhetorical effect a process to suggest a likeness and analogy between AN, as well as the recovery process. Geraldine is seeking to provide clarity and identify obscure similarities between AN and the recovery process in her metaphor (subset 5 .2. b. Metaphors of Anorexia and Recovery, nuanced with both subsets 5. b. 1. Imprisonment of Anorexia, as well as 5. b. 2. Liberation of Recovery):

> Um, I think, the best would be…the sort of what we already said was, you know, being in prison that…I would extend it to all mental illness. Um, but definitely with an eating disorder….and it feels *so* far away because your on-death row. Recovery feels or parole or (*breath*) whatever that freedom it…you don't even know what it looks like. There's no windows in your cell. You know? You are there 24/7 every once in while maybe somebody comes along with a meal or whatever, but…maybe there's little glimpses of hope that…you are *so* sick. You don't know which way is up *and recovery* is like, a big

> old open field. And the opportunity….to live is there, which is *so nice*, and I think that's also something. That's also *very scary* for a lot of people who've had their eating disorder for a long time because they know that jail cell (*pauses*). And they know the comfort even if it's minimal, but they know the comfort that they can get in that cell. Um, and their very close with it and they know how to survive within those confines. Um and so, even recovery is a very scary topic for a lot of people with an eating disorder because it brings with it SO many new experiences. And I…truly feel ill equipped to…deal with most of them. Um, and… but I'm going to do it anyways because it's worth it. It's *worth it*. Yeah, but I think maybe that would probably describe it best. And I think for somebody whose never experience an eating disorder I think that…they can at least feel the weight of what it would be like to have a death sentence.

In the context of Geraldine's analogy and imagery of prison, the present author reflected: "To be in segregation in many ways. To be confined to those cells you described, yet with the structure which, in some ways, as you highlighted, brings comfort." Geraldine emphasized that, "There's comfort in knowing your surroundings." The present author inquired how Geraldine would say experiencing recovery, has it impacted, if at all, the way she views the world or how she fits into the world now: "I feel like, I'm allowed to be in the world now. I don't think I ever felt like I was in the world before. I don't think I was worthy enough to be in it" (subset 5. b. 2. Liberation of Recovery).

6th Superordinate: Spirituality

As the participants conveyed in the preceding superordinate [5. Metaphors for Anorexia, Remission and/or Recovery Process], metaphors are carriers of meaning, transporting one system of meaning to another context signaling how "patterns of meaning in the world intersect and

echo one another" (Zwicky, 2003, p. 6). Metaphors carry meaning from one perspective to another in an abbreviated way; therefore, "metaphorical thinking is embodied, imaginative, and holistic" (Mathieson & Hoskins, 2005, p. 261). In the subsequent section, the reader will examine segments of participants' spirituality in the present superordinate [6. Spirituality], which are conveyed in the findings of subsets from this superordinate and further described below. As previously mentioned, (see subsection 1.3.6 Spiritual and Existential Factors p. 31) in the current study spirituality refers to the quest of seeking meaning and understanding in life (Akrawi et al., 2015), as well as strength and connection with the transcendence (Pargament, 2007; Pargament & Exline, 2022).

The present author will also focus on participants' understanding of spirituality, as well as some of the spiritual struggles, which are interwoven into the experiences of participants during the remission and recovery process. As stated by Pargament and Exline (2022), "though many of us wish for smooth predictable lives, our days are punctuated occasionally by change, transition, and turmoil" (p. 5). Furthermore, the questions and concerns embedded in spiritual struggles are often existential in nature: "Who am I? How should I live my life? How can I make sense of and deal with suffering? How do I come to terms with my own frailties and finitude?" (Pargament & Exline, 2022, p. 6)

During the interview process, the present author offered an opportunity for participants to reflect on the meaning of spirituality, as well as what was the role of spirituality, if any, in participants remission and/or recovery process. More specifically, in the second and third interview (e.g., see Appendix B), the present author queried with each participant, "What was the role of spirituality, if any, on your experience with anorexia and your remission/recovery process? Please tell me more about what spirituality means to you." The present author

integrated this question into the interviews as IPA questions are directed towards phenomenological material: specifically, questions "focus upon people's understandings of their experiences" (Smith et al., 2009, p. 47). For this reason, questions should be open and exploratory, and the aim of interviews is to "enter the participant's lifeworld or allow the participant to recount their life experience" (Smith et al., 2009, p. 58). Accordingly, the participant is the "experiential expert on the topic in hand and therefore they should be given much leeway" and flexibility in processing and answering questions during the 3 semi-structured interviews (Smith et al., 2009, p. 58).

Liesel reported (superordinate: [6. Spirituality] accompanied by subsets 7. a. Seeking meaning in life, as well as 7. c. Strength and connection with the transcendence and 7. b. Seeking understanding in life, nuanced with 7. e. Mindfulness):

> How I define it is…um, connection with or feeling of, or belief in something larger than yourself. I think (*stops*). We don't know enough to say whether there *is* more than just what's here, um, you know, God or some other realm, or some afterlife or reincarnation. So, that's kind of my position is that I'm open to the possibilities either way […] I'm just focused on living my life. I mean, obviously, I do have moments like most people I think, where I'm kind of have a feeling of a bigger picture of there being something else […] I did do a 12-step program, so they really emphasize spirituality. And that was like kind of a stumbling block, and it is for a lot of people. Um, the way they kind of frame it though, um, if you are someone who doesn't necessarily have like, a strong belief in God it doesn't resonate with you. It's just more about being open to the possibility that there's a power greater than you.

Liesel's response clarifies how religion was an obstacle – "a stumbling block" – for recovery. Moreover, she accentuates how spirituality focuses more on the present moment, mindfulness, inner peace, and connection (subset 7. e. Mindfulness):

> But yeah. So, spirituality, I haven't really had a lot of spirituality in my recovery. It's been much more just…just like, getting in touch with myself in certain ways and just like…getting real with myself and…yeah. Just acceptance. Spirituality hasn't…I don't know…

As mentioned earlier, she validates that spirituality was not included during her treatment process; consequently, she reportedly did not know how to include and/or incorporate it. In addition to her experience of spirituality, Liesel disclosed her religious upbringing and background. While religion is challenging to define, "spirituality is closely connected with religion but not exclusively contained by it" (Van Niekerk, 2018, p. 10). Adherents of spirituality criticize religion for its archaic teachings that are deemed patriarchal and dogmatic; imposing rules from above; and being generally institutional, making it narrow, rigid, and prescriptive (Van Niekerk, 2018). Most people, especially those who come from monotheistic traditions (e.g., Liesel as Roman Catholic) think about the sacred in personal and relational terms (Pargament & Exline, 2022) People seek a relationship with what they perceive as Divine. However, divine struggles can emerge, which revolve around questions, conflicts, and tensions about the individual's understanding of and relationship with the divine (Pargament & Exline, 2022). Liesel accentuates her religious upbringing, alluding to her spiritual struggles, including her questions around it due to the prescriptive nature of it (subset 7. d. Questioning around religiosity):

> It's really hard for me to believe, like, for example, in like, God, like some entity that's like, God. For me, it's…that's very strange. But, I mean, I did…growing up because I was raised Catholic, you know, and all this stuff. I just, it's not so much that I *really* believed in it, but I didn't question it too much. It was just like, "Ok, this is the way it is." But, I mean, I definitely remember as a kid being like, there was some stuff where I was like, "Yeah right." You know, like, "Whatever" (*laughs*). I just went along with it

> because that what you were supposed to do. I mean, organized religion, I'm not interested… I was raised Catholic and like, I've read the Bible so many times, like, I could quote so many pages from the Bible, it's like, literally like, it was hammered into me, and I really bought it. And I don't think there's anything wrong in the Bible. I think that…I do have a sense that there are some larger principles that guide the world and guide the universe and stuff.

Interwoven in her response is her ambiguity and uncertainty about the existence of God. It is important to note that doubts are not the same as disbelief (Pargament & Exline, 2022). "Unbelief, like belief, involves a level of certainty and conviction, but in the case of unbelief, the certainty focuses on what one doesn't believe" (Pargament & Exline, 2022, p. 215). Some people may "intentionally adopt a doubting or skeptical attitude as a stable approach to religious or spiritual matters" (Pargament & Exline, 2022, p. 215). Understood this way, Liesel has seemingly adopted a skeptical attitude towards religion, but integrates and links mindfulness into her experience and understanding of spirituality (subsets 7. e. Mindfulness and 7. f. Meaning-making and recovery process, as well as subsets 7. g. Understanding and significance in her life and recovery process):

> I *actually*, like, with like, Jesus' teachings like, all of it to me, is about…living in the here and now and doing the right thing in the here and now I do think that just accepting things and, reality and, um, being able to just not fight and struggle with every single thing is a form of spirituality for me? I mean, it's not like, again like, I don't do it perfectly (*whispers*). It's not even a conscious thought most of the time, but it's like, definitely something where um, it is like a sense of being in touch with yourself. I'm trying to think if there is anything more about spirituality, but…because I'm not closed off to it, you know. I don't think of myself as a person who's not spiritual because it doesn't really feel true. I do think though that there are like, as I said, some universal principles that do apply. It's like…it's what gives life meaning. I wouldn't

> say…definitely I'm not super spiritual, like…I don't know, I'm just like a big, "I don't know…anything is possible," you know, "we don't know enough to say whether there is a God, and we also don't know enough to say conclusively there isn't." So, I'm kind of like, in the middle of that, but…I've definitely felt at times more inclined towards like, "Yeah, there must be a God." So…spirituality has some role.

For Lotus, the present author reflected how in the Demographic Questionnaire, there was a question that said, "Do you define yourself as a spiritual person," and Lotus wrote, "I associate spirituality with nature." Accordingly, the present author inquired if Lotus could reveal more about what spirituality means to her: "Spirituality to me means connecting to deeper things." The present author used paraphrasing, as well as open-ended question to elicit additional reflection from Lotus, pertaining to her experience of spirituality (subsets 7. a. Role during AN, as well as 7. b. Role during recovery process, nested with subset 7. c. Connection, Nature, and Hope):

> Like, ah (*sighs*) when I was really sick that wasn't…I wasn't…I guess I lost my spirituality for a long time. By the time I got better, I just started to realize that the place that I feel most comfortable in, and happiest in, is nature, most often alone. That's what I like to do. I often just…part of my self-care to be honest, I just walk to the park and just sit on the swing. Like, I've done that while it's pouring, right? I just go on and get soaked, but I still do it because to me that connects me to earth. That makes me feel grounded like I have a purpose. The world still exists I guess, no matter how sad I feel. Things are still moving; the trees are still swaying. Seasons are still coming and going, so that to me, that kind of connects me to earth and makes me realize that the world is still going on.

The present author proceeded to ask Lotus, as she did with other participant's during the interview process: "What would you say was the role of spirituality, if any, in your remission process?" (Subset 7. b. Role during recovery process, nuanced with subset 7. c. Connection, Nature, and Hope):

> Nature often connects me to art… and for a lot of people…a lot of art is finding the happiest place for them (*inaudible*) is nature in art. Doing art, I mean. I do a lot of nature kind of based landscape drawings, so to me I guess, I capture pictures in my brain from nature and then I draw it. That has really, really helped me in my recovery.

Upon reflecting about her experience with AN, Lotus also shared a sense of gratitude: "I'm grateful for what I've experienced." Therefore, the present author inquired: "How do you make sense of having that gratitude for your experience? Lotus replied (subset 7. c. Connection, Nature, and Hope):

> I think, for me at least, its always been important to focus on gratitude and things that are going well in my life and things that are…that for me, helps me a lot to keep going because most of the time things aren't going well, so if I keep focusing on those things, I don't think I would make it. And so, to me, I just…it's probably part of my spirituality as well. I just feel like I have to appreciate the good things in my life and see positive in everything, so that I don't slip back into depression. I can still appreciate the little things that are around me. And that's spirituality to me. No matter how shitty you feel, still appreciating the smallest things that are around you […] guess in a way I just feel like (*sighs*) the Universe itself has put me on this earth for a reason, and so, I owe the Universe, I owe the people around me something.

While much attention has been given to how hope is maintained, sustained, and restored in individuals or patients, the spirituality dimension has received less attention (Espedal, 2021). Accordingly, Lotus' subset (7. c. Connection, Nature, and Hope) for the present superordinate [6. Spirituality] requires additional exploration and explanation for the reader.

To begin, "hope is described as a spiritual way of seeking and striving to find meaning" (Espedal, 2021, p. 2772). Some literature equates spirituality with seeking, striving, and forward movement (Wills, 2007); therefore, the present author will proceed to describe how Lotus' experience elicited spiritual hoping in various phases. Firstly, the distress of a syndrome and/or

the distress associated with the possibility of no longer being anorexic, and so the possibility of recovery generated a dramatic situation of uncertainty and despair for Lotus ("I hated it [the diagnosis]. I mean, I did not want that taken away from me. The control that I had over food….and my weight"). Secondly, the situation established Lotus seeking and striving for meaning and becoming one with myself ("I couldn't let myself die. I couldn't let myself go because I still felt like there was a purpose for me on this earth"). Thirdly, the narrated self-generated hope and a notion of sacredness through doing small steps of refiguring meaningful activities in everyday life together with others (Espedal, 2021). The present author inquired "What was the role of spirituality, if any, on your experience with anorexia and your experience with remission?"

> I couldn't let myself die, and so that led me to remission. That gave me kind of motivation to start remission. This body…wasn't mine. I had to…I can't like, completely destroy it when it's not completely mine.

Therefore, the present author inquired, "When you say it's not completely yours, can you tell me a bit more about that?" Lotus replied: "I guess in a way I just feel like (*sighs*) the Universe itself has put me on this earth for a reason, and so, I owe the Universe, I owe the people around me something, so I can't just take it like that."

Interwoven in her responses, Lotus highlights features of existential theory: (1) 'Mitwelt,' meaning 'with-world,' constituted by our interpersonal relationships; (2) 'Eigenwelt,' meaning 'Own-world', which refers to our subjective, personal experience and mode of relating to one's self; (3) 'Überwelt,' the 'spiritual/philosophical,' which refers to "how an individual thinks it will be to exist in the world of connecting to the more abstract and metaphysical ways of living from meaningful rituals, spirituality, and making personal meaning from their life" (Rozzi, 2020, p. 37). Lotus revealed how she perceived her body "was not [her] own," so she owed it to "the

Universe" (e.g., Überwelt) and "people around [her]" (e.g., Mitwelt) to continue in remission and recovery from AN. Accordingly, she highlights her Überwelt, which corresponds to one's relationship with the spiritual world. Lotus also accentuates her Eigenwelt, which "is our lived experience, which is the unique ways we experience ourselves living through situations" (Rozzi, 2020, p. 29). Furthermore, she stated how "the Universe itself has put [her] on this earth for a reason" (e.g., Überwelt), as she reflects on having a sense of meaning and purpose for her existence.

In the Demographic Questionnaire, Rose wrote "a mixture" in response to the question: Do you define yourself as a spiritual person? Accordingly, the present author inquired if Rose could say more about what spirituality means to her:

> Um (*pauses*). Yeah, so (*pauses*). I guess, it's changed over time. So, when I was younger, like, I grew up Catholic, we went to Church every week. Um, and I really enjoyed it. Like, I alter served for 5 years and I had very positive experiences. But I was very, um, I remember, I was very scared of, again, probably again the perfectionism and obsessing, I was going to go to hell for various reasons (*laughs*). I had no concept of what sin actually was. (*Smiles*). Um, and that's what it was to me, was like, all…was guilt. Like, classic Catholic guilt (*mumbles*).

The notion of "classic Catholic guilt" refers to the reported excess guilt felt by Catholics and lapsed Catholics. Habitual obsessive guilt over trivial or imagined sins is the error of scrupulosity (Stotts, 2018). As stated by Stotts (2018), "Catholics inherited the culture of Catholic guilt and collaborated in its maintenance for centuries, passing its language and obligations on to their children" (p. 12).

In light of the notion of "classic Catholic Guilt," Rose did not expand upon it. On the contrary, she identified and shared aspects of religion and her faith that were helpful: "I do like reading the Bible and different scripture and like, reflecting on it." Given Rose's reflection on religion, the present author inquired: "And what was the role of spirituality or religion, if any, in your recovery process? Rose candidly shared (subsets 7. a. role during AN; 7. b. role during recovery process, nuanced with 7. d. religious practices accompanied by reading Biblical passages provided her with a sense of connection, validation, normalization, and compassion):

> It's interesting because everyone kept being like, "Oh, I think you just need to go to church more, you like church. Church makes you happy, so you should just go" (*smiles*). And it did, like, doing the Bible studies with my friend was *really* helpful. Like, our Bible studies are great (*smiles*). And we did it in university, we joined some Protestant Bible study, um, and so, we did like, our own. Yeah, so that's kind of like what religion and spirituality is for me. I would find a Bible passage that really…meant something to me and my remission. Like, for each week. And then I would sort of make that my reflection for the week and how I carry that out. I do like reading the psalms and proverbs, particularly were helpful, especially proverbs. Um, and Job was a bit much and Ecclesiastes and knowing like, "Ok, this is…this is" like, "the human condition. This isn't unique." Because I remember thinking when I was sick that – when I was anorexic that – (*pause*) it felt like, I was the *only* person going through it? Like, it was like, *no one* could quite understand like, my specific struggle. That's why the group thing was good. And then reading the Scripture. It's hard to remember because (*pauses*), I know I felt completely desolate in my religious feelings. Like, it was very just, it was awful. And then coming out of it, I remember feeling much more connected to God, much more spiritual.

The present author asked Rose to clarify her use of the word "desolate". Rose replied (subset 7. a. role during AN, as well as nuanced with subset 7. b. role during recovery process):

> So, I guess…(*stops*). And maybe…I just feel like, I guess, my spirituality has broadened. And part of that is like, "Is that connected to anorexia or is that just more getting older and experiencing more of life?" Um…mmhmm. When I was sick, it felt…I guess, because God felt very far from me…um, my prayer life was much more, well my prayer life was even much more narrow. And like, everything narrowed, and so did like, my prayer life and spirituality. Because I just wasn't able to…um, because I wasn't able to read, I wasn't able to focus, it felt like my spirituality was also just…almost nothing, really. It was like reading the same Psalms and Proverbs, or whatever. So, in a sense, in recovery it just felt…it felt so much more expansive.

Similar to the other participants, the present author inquired how Rose would define spirituality (subset 7. c. Spirituality represents openness, colour, compassion, and understanding):

> I think, for me, spirituality is…as I reflect on it more, it's…like, what is my…guide, like, spiritual path. Like, what gives me (*pauses*). So, for me, I think of like, certain…I guess, Bible quotations? Like rather than thinking (*stops*). Before I was just like, "Oh, Catholic, that's my spirituality," whereas now my spirituality is more broad, and it's based on like, I guess, various teachings? Different religious teachings that all have the same end. So, it's like, "Ok, how do I love people more, but love myself more too." It's like before I kind of cut out the love yourself as your neighbour or love your neighbour as yourself. Um, because I didn't love myself when I was sick. And I, I…and I think, um, that's much more the tenant of my spirituality, I guess […] I feel like life is just like, life is very complicated and its not easy and I feel when people try to make it…black and white…that's when things get…like, that's when people lose understanding and tolerance. And for me, that's what spirituality is, *for me*. And *that's*…I think I gained more and more of that through my various experiences.

The present author reflected how Rose's spirituality is more "broad" and integrative now from what she shared, in which she nodded and said, "Mmhmm."

Similar to other participants, Stephanie also reflected on her experience of spirituality. She also explained her experience of religion and spirituality, which parallels Rose's experience of religion/faith and spirituality being associated in a manner (subset 7. a. Spirituality and Faith):

> I grew up religious. Um, I grew up going to a like – as a Christian – going to church and I think that my relationship with the Church never really formed or stuck in the sense that I mean, I, I respect everybody's like, own values and visions and the way that they connect with spirituality or whatever it is that they do. It's just, for myself, like, I very much saw the Church as an institution. I don't know if God exists, but I do feel like, I'm able to…speak to whatever it is that exists (*laughs*). And just like, say like, "This is what I'm having a really hard time with." Like, it gave me like, this almost you're, like, it gave me someone or something to speak to and to feel heard. And to feel not so alone. Like, I felt like, you know, there's something with me and just like *that*; being able to take away from my feeling of loneliness made *such* a *huge* difference because it can be so isolating. And I think, I also personally, really like, believe in like kind of, the energy of the universe and, you know, all of that.

Given Stephanie's reflection on her faith, as well as touching somewhat on spirituality, the present author inquired how would she define spirituality (subset 7. a. Spirituality and Faith):

> I really do believe that it's different for every person, and I think it really depends on like, what your relationship is with to God or to spirituality. I would say for myself spirituality is… believing in something that's bigger you. The reason I don't feel strongly about religion is that I've always, I remember even from a young age, when people like, a priest or whoever would speak about like, sin and stuff like that. I was just like, "I don't believe that. I think God is here to love us." Like, no matter what. And I found such a great comfort in that because I felt like, even in my most difficult and darkest moments, even if I did something sinful, God would always love me. I define spirituality is just like, it's just positivity, it's positive energy, it's positive messages and it's just… this like, support. Something that just, you know, is around us.

In contrast to Rose, Stephanie did not express or identify experiencing religious guilt (e.g., "classic Catholic guilt" as Rose stated earlier). On the contrary, Stephanie accentuates how she does not conform to a specific organized religion within Christianity; however, she continues to keep herself open to the concept of faith and being heard "I don't know if God exists, but I do feel like, I'm able to…speak to whatever it is that exists."

Throughout religious history, especially in the Christian tradition, transgression and reconciliation have been a prominent theme. In his descriptive study, Tsakiridis (2018) conveyed that the path to reconciliation in the Christian tradition mirrors the path of guilt/reconciliation found in our biological and psychological makeup, pushing for further dialogue between these two realms. Interestingly, Stephanie identified "Even if [she] did something sinful, God would always love [her]." Accordingly, the present author reflected that, although the image of God may have been presented as punitive at a young age for Stephanie, "It was a loving, merciful image," which "shapes [her] spirituality." Stephanie smiled and responded: "Yeah, absolutely […] I could always like, turn to God […] I was just like, no matter what I would always like, have that love and comfort and…that was important for me."

Stephanie continued to reflect on the role of spirituality in her remission and recovery process. She began with a long pause in the excerpt below, which is indicative of her processing the question and taking time for reflection (subset 7. b. Meaning and Significance of Spirituality in remission and recovery):

> Um (*long pause*). I think, if anything, it was being able to connect with myself through that spirituality. So, being able to kind of look at the role that that played with (*stops*) played for me when I felt like, I could connect with God in that way. And being able to be like, "Ok, so why was this helpful?" This was helpful because it allowed me to reflect on things. It allowed me to feel unconditional *love* and unconditional *compassion.* "Ok,

> so how can I take those things and turn it towards myself?" I can be the provider of that instead of feeling like, it's coming externally. "Ok, so, I'm going to ensure that I'm reflective, I'm going to give *myself* this unconditional love and compassion. I would say that's how the role that it played.

Stephanie accentuates how her spirituality was interwoven with compassion, and therefore she put an emphasis on the significance of integrating self-compassion in her remission and recovery process: "I'm going to give *myself* this unconditional love and compassion." Interwoven in her response, however, Stephanie highlights both Eigenwelt and Überwelt.

Van Deurzen (1988, 2012) describes it as the private world in the land of intimacy, which includes intimacy with self. Stephanie discovered her Eigenwelt during the remission and recovery process by developing increased compassion and self-compassion. Moreover, her response accentuates how she was able to use Eigenwelt to shift into Überwelt: "I think, if anything, it was being able to connect to myself through that spirituality. As previously mentioned, (e.g., section 1.1.4 Existential-Phenomenological) the spiritual world (Überwelt) refers to "the domain of experience where people create meaning for themselves and make sense of things" (Van Deurzen, 2012, p. 87), Stephanie highlights how she was able to implement Überwelt, in assisting with her remission and recovery process. As Van Deurzen (2012) articulates and explains:

> When people rediscover their inner connectedness to something greater than themselves, to some ideal, which will lift them beyond their everyday struggles, a new motivation flows inside of them, which can carry them through difficulties with unerring purposefulness (p.87).

Stephanie accentuates the importance of the spiritual practice of self-compassion, as well as alluding to the significance of Überwelt for her remission and recovery process from AN.

Stephanie also highlights how her Überwelt – "I felt like, I could connect with God in that way" –was intertwined with her Dasein: "This was helpful because it allowed me to reflect on things." Given the growth of her Überwelt, her *Dasein* prospered, as she was able to reflect on matters; specifically, the notion of a ''living being'' through their activity of ''being there'' and being in the world (Cerbone, 2009).

In addition to identifying and revealing the meaning and significance of spirituality in remission and recovery, Stephanie also discussed some of her initial fears of ambiguity of letting go of AN with remission and recovery. She also accentuates the impact of spirituality on her healing and recovery process (subset 7. c. Initial challenges and fears with spirituality in remission and recovery, nuanced with subset 7.d. Spirituality represents connection with something outside of oneself, providing a sense of comfort and trust, as well as subset 7.e. Spirituality signifies coherence, continuity, synchronicity, and permanence):

> I don't feel like spirituality was very present during when I was symptomatic because because like, I said, I just kind of feel like (*stops*). There's so much that feels that it exists outside of anorexia. But I think in like, recovery…and remission I think the role that it's played is like, when you're going into recovery and remission it is…like, it feels like there's a lot of uncertainty. It feels like you're letting go of the control that you have fought so hard to get. Um, and so, it's kind of that sense of being like, "Ok, I'm just, I'm going to let go and just *trust* that it's going to be ok." Like, "Even though every fiber in my body is saying, 'Do not do this,' I need to trust that there's *something* out there (*laughs*). That's like, like, "This is the right thing to do, and I'm going to be ok." And I think spirituality played a big role in the sense that it's kind of this comfort. Like, "I can let this go into the universe," and like, like, "I know something, or someone is out there to like catch it and help me."

From what Stephanie shared, spirituality had a role in remission and recovery in the sense that it allowed her to trust in that process; namely, to enter ambiguity with conceivably some fear and anxiety, but to enter into that process:

> I think it's like, what resonates is the anxiety around it. That…like, being able to let go even though you have that anxiety. Being able to let go even though you have that fear because you kind of believe that there's something bigger than you. And there's like, there's someone who has your back no matter what kind of that feeling of like, I'm being supported even though I can't see it even though I can't feel it. I know it's there […] Um, I had to let go of my need for control, definitely. I had to let go of the ideologies that came and that really grew with the illness. Um, and I had to let go of this feeling of like, fear of vulnerability because when you're in recovery and remission you're very vulnerable because you are trusting professionals to guide you and to give you orders that are supposed to be in your best interest even though you do not feel that's in your best interest. So, it's like, it's a very vulnerable place to be in, so you have to be willing to let go of that control and give it to these other people. So, I guess, that's kind of what I mean.

Interwoven in her response is Stephanie's Umwelt ('around world'), as she entered into the physical dimension and "trusting professionals to guide [her]" in the healing and recovery process. Accordingly, she trusted and behaved in an instinctual manner to "let go" of the ED, in order to be in Mitwelt and 'with the world.' Although it was initially difficult for Stephanie to trust in spirituality and the belief that there is "something bigger than you" (e.g., Überwelt, rediscovering something that is Greater than the Self). Therefore, she identified letting go of control as the most difficult aspect of connecting with spirituality during the beginning of remission and recovery from AN (7. c. Initial challenges and fears with spirituality in remission and recovery, nuanced with 7.d. Spirituality represents connection with something outside of oneself, providing a sense of comfort and trust):

> I mean it's, vulnerability is like (*laughs*) vulnerability is one of those scary things where I think until you've experienced it as a positive thing it feels very negative and it feels very scary. So, once you see and like, at least for me, once I was able to experience and see that vulnerability is actually like, a super huge strength and it's really important component to life. It felt like, the *worst* thing ever, whereas now I'm just like, it's one of my biggest strengths and it's one of those things that *allow*s me to connect with others and to connect to something I value so much.

The present author reflected how Stephanie had to "let go of control," and how she "touched on vulnerability earlier, sharing that in some ways it's allowed [her] to connect with people." Although Stephanie laughed when I accentuate how vulnerability has seemingly allowed her to connect with others, she makes an insightful distinction that it is a strength.

Geraldine reflected on the impact of religion and spirituality in her remission and recovery process, as well as how religion impacted her upbringing:

> My family is *very* religious. Um, my Mom is Roman Catholic. My Dad is Protestant. Um, we were raised Roman Catholic, so…went to Catholic schools, Catholic high school, um, went to Sunday school. Like, you name it, we probably did it. Um, all of our holidays were…were centered around…well, all of our family get togethers, I would say, were centered around religious holidays. Um, and I, I honestly never batted an eye at it, it seemed completely normal, especially because I was going to a Catholic school, so like that was just life. Um, and…I, I would say it wasn't until I got into university, where you know, I wasn't going to church anymore on Sunday because I was in university

As an adult in university, Geraldine reflected on how she no longer attended Church on Sundays, and therefore, her religious involvement changed. Derezotes (1995) defines religious involvement as "A system of beliefs, rituals, and behaviors, usually shared by individuals within an institutionalized structure. It is an external expression of faith" (p. 1). As articulated in the following excerpt by Geraldine, her religious involvement changed during university and had an impact on her life (subsets 7. a. Experience of Religion; 7. b. Questioning religion and faith):

> I remember, I think somebody asked me about…or there was in my fourth year we had to take some sort of class where we ended up asking the existence of God, like, "Does God exists or something." Something really harmless, and I kind of thought about it and like, "Well, wait a second" (*laughs*). "This is *really* interesting…I, I *don't* know? Like, I never thought that I could *question* that before. So, I…sort of went home and was like, "Do you know what?" Like, "I don't know if religion is *for me*?" And…I was almost immediately excommunicated…from life […] My mother said, "I have one daughter and a son. I don't have two daughters. It's going to be so terrible because when we all die…you're going to be burning in hell and we're going to be in heaven and we're going to be so sad that you're not there with us." Like *horrible* statements that I *never* thought would come out of my mother's mouth. It honestly….it was like, my life had changed in an instant and I…didn't know how to handle it. *At all.* Um, I *really* leaned into my eating disorder, really, because I was… "Well, *this* isn't working anymore. I need to do more. I'm not being enough, so if I do eat, I'm going to purge." "Because *that*…that's the *only* way that I can…keep up with this, and still be this perfect person for them." I ended up moving away. I couldn't be near my parents.

Geraldine expressed really "leaning in [her] eating disorder," and therefore, accentuates with emphasis on Mitwelt ('with-world,' established by social and interpersonal relationships), which is "anorexia and [her] are best friends" and "[she] calls him Ed." Geraldine also disclosed some life-changing religious experiences in her religious participation and belief, amplified by her mother's "horrible statements" about questioning her religious beliefs. As a result, she "really leaned into [her] eating disorder" and started purging and contemplating bulimic behaviours and tendencies in addition to AN. While Geraldine claims AN provided her with a sense of control, she seemed controlled by the ED with the emergence of BN symptoms. Moreover, Geraldine was questioning the existence of God (attachment figure), she could no longer rely on her mother (attachment figure), so she turned to AN (friend or "Ed" an attachment figure).

Geraldine presents as having anxious attachment, and one of the characteristics of anxious attachment is excessive seeking of reassurance (Homan & Lemmon, 2014; Shaver, Schachner, & Mikulincer, 2005). People who are highly anxious about the acceptance of important others (like parental figures) — including God—tend to be uncertain about their own worth, and thus frequently look to others for validation.

After Geraldine's response, the present author reflected how it seemed she was obedient to religious beliefs until she began questioning them in university: "Yet, when you had that moment of ambiguity, and when you said you were ok with that, in some ways, you felt unsupported and perhaps punished?" Geraldine proceeded to accentuate and expand on the manner in which her experience with her mother's religious beliefs, comments, and behaviours impacted her overall well-being and life (subsets 7. a. Experience of Religion, nuanced with 7. b. Questioning religion and faith):

> Very much punished. *Very* much. I think I'm still sort of dealing with all of it. I remember my Mom saying to me, um, "Something horrible needs to happen in your life, so you can come back to God and come back to our family." And, I remember thinking, "YOU are crazy!" Like, "Who wishes something terrible to happen to a family member so that they…come back?? I remember saying, "I'm still a good person," like, "I'm not a bad person, I just have a question mark over my head right now, but what should that matter?" "I'm still your daughter, nothing has really changed except that I said that I don't know if I necessarily believe what you guys believe." I ended up moving away, and the relationship was *super* strained. It wasn't until my parents were contacted…when I did attempt suicide and was admitted, *somehow* my parents were contacted. My Mom flew in and… I remember her coming to my bedside and just being like, "Finally, something bad has happened." She put a cross over my neck and said, "You're going to be coming back."

In their research, Homan and Lemmon (2014) provided evidence that attachment to God may fulfill the same psychological functions as a human attachment relationship. Furthermore, their results closely parallel the findings on human attachment, social comparison, and ED symptoms (Bamford & Halliwell, 2009; Ty & Francis, 2013):

> This congruence supports the idea that human attachment figures and God meet similar needs and function, to some extent, in analogous ways. Attachment to God may be a reflection of human attachment relationships, a way to compensate for insecure human attachment, or a combination of the two (Homan & Lemmon, 2014, p. 355; Kimball et al., 2013).

Given that Geraldine experienced insecure attachment with her mother, she grappled with the existence of God, as conveyed in the excerpts on page 158. Furthermore, God's love did not compensate for a void left by the insecure attachment with her mother. However, she selected the pseudonym of her grandmother for the thesis, which proposes a more secure attachment of a maternal figure. Nonetheless, across the life span, individuals seem to prosper when they have an available, loving, and responsive attachment figure, and/or a well-developed mental representation of that figure (Homan & Lemmon, 2014). For this reason, Geraldine proceeded to thrive with her Umwelt ("around World)," as she is likely to behave in an instinctual manner and distant herself from her mother and allow her Überwelt ("spiritual/philosophical world") to flourish, which is conveyed in the excerpts below.

After Geraldine accentuated her experience of religious beliefs and practices, she proceeded to share her understanding of spirituality, as well as the values she associates with it (subset 7. c. Spiritual Beliefs and Values):

> I feel there ***is*** a bigger purpose. I don't think I went through all of these things in my ***life***….to…***not*** share them. I really do believe that…. a purpose is of mine is to as best as I am able to ***share*** and ***help*** other people in similar situations. I feel as though…there's that

> sort of overwhelming or overlining greater purpose there. I feel as though everybody is connected. We're sort of all in this human condition together, and I would call that spirituality. And it is ***my*** responsibility, I feel it's everybody's responsibility to ***help*** other people, if they ***can***. Maybe the fact that I'm learning to be a much more gentle, kind and positive person. Maybe simply asking somebody how their day was instead of being so overly consumed – you know – like I was with my eating disorder. Maybe changing my behaviour ***that*** simply is going to help somebody else. And if ***that*** is, if ***that*** is ***everything*** and ***all***. That is perhaps my purpose in life.

She highlights "being overly consumed" by AN, including how she perceives the experience and remission/recovery has led to a sense of purpose. Interwoven in her response, Geraldine conveys how her Eigenwelt was to some extent abducted by AN, as it "consumes" and takes every single space; physical, psychological, and spiritual. Van Deurzen (1988, 2012) highlights that some challenges in this world of Eigenwelt include: Person (identity and freedom), Me (strength and weakness), Self (integrity and disintegration), and Consciousness (confidence and confusion). In many ways, AN consumed Geraldine's Eigenwelt and subsequently challenged it those aforementioned areas. Geraldine's statements convey how her Mitwelt (e.g., akin to her being in a relationship with a demanding partner with AN), impacted her Eigenwelt and how she relates to her own subjective experience of her sense of self.

In addition, Geraldine reflected on how her experience of AN impacted her spirituality, including her process with remission and recovery (subset 7. c. Spiritual Beliefs and Values):

> You lose ***everything*** with Ed. You lose ***everything***. Most importantly, your ability to connect with other people and connect with ***yourself***. You have ***no*** connection. You are ***absolutely*** alone. You *can't* even rely on yourself. Being able to be in a world where I am able to connect with other people and not just connect for the sake of connection, but to do it to make somebody *feel* better. To make a stronger connection or a positive one to ***amplify*** the good work that they do in their life. If I'm able to do ***that***, and that's….

> maybe is that the reason why I had to go through everything that I went through. I mean I don't know, but I ***hope*** that there is a reason. I ***hope*** desperately that there is a reason why I went through everything I went through. It just happening to people, and it is killing people because that's ***terrible***. It just hurts. It breaks my heart. That I would be able to… (*breath/sigh*) interact with other people […] because of my spirituality because of my ***connectedness to*** people are, are amplified.

It is important to note that she highlights, "I still go through it […] because it happened," since in her demographic questionnaire she indicated that she has been in remission/recovery for 12 months; therefore, the remission and recovery process was still relatively recent for Geraldine.

7th Superordinate: Meaning-Making Process and Sense of Purpose

In the preceding superordinate [6. Spirituality], participants shared their understanding of spirituality, as well as some of the spiritual struggles both of which were interwoven in their experiences during the remission and recovery process. Similarly, they accentuated the existential worlds, particularly Überwelt and Mitwelt in their remission and recovery process from AN. They also revealed how if one's identity is wrapped up in a diagnosis or label such as the "the anorexic" or "my anorexia […] my eating disorder" (or if experiencing stigma in the treatment setting/system), it is difficult to find meaning and purpose. Frankl (1984), an influential author on meaning and purpose, evidently believed in personal responsibility, as he said, "When we are no longer able to change a situation, we are challenged to change ourselves" (Frankl, 1984, p. 112). Therefore, the following section reflects how remission and recovery also might include the four-worlds model – the existential worlds.

While treatment programs for individuals with AN are essential to assist with the medical sequalae (e.g., neurobiological and/or cardiac issues), ultimately, the anorexic can decide and/or explore ways to have a meaningful purposeful life by finding or rediscovering what is important.

This can be done by giving oneself permission to think and hope, by exploring and defining one's own valued life goals, and by writing and rewriting one's own story/narrative (Rizzo, 2020. There are also three sources of meaning from Frankl (1977/2006) such as: purposeful work, love, and courage in the face of difficulty and/or suffering. However, as current research conveys and participants in the current study have shared, there exists a gap in treatment for AN/EDs with focus specifically on weight restoration. In the subsequent section, the reader will examine segments of participants' process of meaning-making and sense of purpose in the present superordinate [7. Meaning-Making Process and Sense of Purpose], which are conveyed in the findings of subsets from this superordinate and further described below.

In describing her experience with AN, as well as her transition into the recovery process, Liesel alluded to AN giving her a sense of purpose at the beginning and before AN took over (subset 6. a. Anorexia gave a perceived sense of purpose in life):

> I just felt like…um, it's like I felt like very directionless. Like, it felt like I needed to figure out what…I needed to figure out something to do. Like, something to…throw myself into. Um…and at the time, I was like, I don't think school…like school wasn't working out, that wasn't…I wasn't really enjoying the classes, I wasn't like, passionate about it […]. Um, everything was me just like going through the motions, and just…I managed, you know. I somehow, I managed to do it. It all worked out.

The present author paraphrased how "what stands out for [Liesel] is going through the motions," in which she replied: "Yeah, totally. And I mean, this is like aside from even the eating disorder, I would say. I feel like the eating disorder was kind of like…like a distraction or something to focus on." Interwoven in her response she confirmed how AN provided a sense of direction; therefore, AN was a diversion for a life without purpose, and meaning. As previously mentioned, Liesel highlighted how school was not working out and colitis was an issue as well.

Therefore, her response conveys that her Eigenwelt ("own-world") and Unmelt ("world around") were being challenged: (subset 6. a. Anorexia gave a perceived sense of purpose in life):

> I think, like, well, one thing is when you are really sick with it…any kind of mental illness, well, I'd say eating disorders or things that are similar to addictions, I think that to get better you have to put the level of energy into your recovery, as you did into your eating disorder or like, you need to put that level of focus and attention on it. So, definitely when I was first…you know, getting into recovery, I wasn't putting that into it. So, I was still…the anorexia was still dominating. But, over time, when I actually really, really was like, "I actually want to do this," and I put the energy into it, then…it like, took over…it's like, you have to have something to replace it, right? Like, you have to have something to replace that type of thinking and behaviour… So, I just felt like I…I was in like, the wrong life or something.

Liesel mentioned AN being similar to addiction, so the focus and attention given to it required shifting it towards the recovery process for her. She also stated, "getting into recovery," so it was a process for her; however, AN continued "dominating" her focus, sense of meaning and purpose. It required another replacement and sense of direction (subset 6. b. Anorexia as an Identity Crisis):

> Well, I think a big thing that a lot of people encounter at the beginning of recovery is like, kind of like, an identity crisis, almost? Like, um, I had this and I don't even know how to articulate it, but it was like this feeling of like… "Who am I…if I'm not…" like, "the really like…this really skinny fit person?" Like, because that was just *so* much of what I did and, and who I was and I thought who I was to others, you know? So, that's a *big* thing and I think *a lot* of people have that in recovery. Like, there was kind of an identity crisis. And that's like the first step until you really realize how much of an opportunity it is. Like, to be able to let that go?

Liesel accentuates how shifting from AN as a sense of self into recovery is akin to "an identity crisis" at the beginning of recovery. Hence, her Eigenwelt and subjective experience of relating

to herself during the beginning of recovery was originally challenging (e.g., posing questions about the self in relation to the body). Moreover, her Umwelt was confronted with questions posed about herself independent of her body.

With additional reflection, Liesel also reflected on what the experience of remission and recovery process brought into her life in terms of meaning (6. c. Developed from Remission and recovery):

> There are a lot of positive things that it's brought to my life in terms of like, just connecting with people. Like, once you get past the isolation because really – when you are sick – it's a very isolating thing. Um, but, when you're in recovery everything is very much like, it's something for you to connect with other people about. Um, so that's a positive, you know […] Also like, being like, getting so much help and realizing how many good people there are that are trying to help people out there […] And realize, like, what…who you are and what you can be? So, *for me,* like, I mean, in a lot of ways – maybe in most ways – I'm the same person I always was, you know? *But,* just with more wisdom and experience, basically. And having gone through something *really* hard like…yeah

She identifies how she was able to connect with others throughout the treatment process and healing, which she endured. Given that connection is part of the meaning-making process, she also refers to an important existential variable: her Dasein and being-with. Thus, she highlights how the recovery process entails enhancing her Mitwelt and connection with other people in interpersonal relationships. Liesel also accentuates the significance of both Überwelt and community, as highlighted by Nouwen (2009); specifically, it can make us sense "a quality of heart that "grows from spiritual knowledge that we are alive not solely for ourselves but one another" (Nouwen, 2009, p. 23). In this way, Liesel highlights the sense and development of both Überwelt and Mitwelt.

Liesel also reflected on the impact AN had on her sense of meaning and purpose during her experience with the syndrome (subset 6. d. Former sense of meaning and purpose from anorexia):

> I mean, when you're really, in your eating disorder like, your purpose and your targets are…always moving targets. Like, when you're trying to like, you're never going to be satisfied with what you 'achieve,' you know? Like, 'achieving,' being oriented towards like losing weight or, you know, like I was always (*stops*). I was obsessed with certain things like, fitness. So, in that sense, like, your purpose is just…unrealistic half the time. So, at least when you let that go you can hopefully set some…achievable goals for yourself. You don't see how sad and like, pointless it is. It's like, a lot of pointless activity towards something that's never going – (*stops*).

Interwoven in her response is how there is a lack of purpose with AN, which she considers "sad" as she reflects upon it. In addition, she considers it "a lot of pointless activities," which is seemingly in reference to ED thoughts, behaviours, and symptoms.

She also proceeds to reflect on some ways that recovery has impacted her sense of purpose in life (subset 6. c. Developed from Remission and recovery, nested with subset 7.e. Mindfulness):

> Hmmm (*long pause/sighs*). Um (*pause*). Well, I think, honestly, before recovery and maybe always I've had this, this like…this feeling of like, you need to have some concrete…purpose and direction in everything. And I honestly think the big thing of recovery has taught me is just accepting things as they are and not…not being so worried about, just…I don't know, the…trying to get somewhere or pushing and struggling to make things happen? So, that's something I guess about purpose

Liesel's *long pause/sigh* demonstrates and suggests that she is deeply reflecting on her response to this question. She reveals the importance of acceptance in giving her a sense of purpose with

recovery; namely, it sounds like acceptance, as well as relinquishing or surrendering some of that control has been beneficial for her Eigenwelt and resultant recovery process.

In terms of when remission and/or recovery had the greatest impact on her life, Lotus alludes to aspects of Frankl's tragic triad, as well as tragic optimism (subset 6. a. Remission and meaning—making, as well as nuanced with subset 6. b. Challenges to sense of meaning outside of Anorexia):

> I'd have to say that would be related to school because last year was the first year, I was in remission…like, in full remission and I realized that I mean, my passion for that was so much more noticeable because it wasn't blocked by the eating disorder because I remember previous years where I was sick and in school. There was something missing for me…I did love the career path, I did love the education, but it seemed like, I was just so concentrated on other things. Just couldn't connect with it, and with remission, I just found myself being able to be a compassionate person that I am. One thing that I definitely do realize – that I've noticed over the past two years – is that I have become so much more compassionate and understanding. Not just other people, but myself. Like, I know what I need at certain points. I think for a lot of people who struggle with eating disorders, when you're in the depth of it, with that…it's not purposeful, you don't do it on purpose, but you kind of just isolate yourself and not…you seem to be too self-concerned about yourself and not others around you.

Frankl (1963, 1992) refers in accordance with Jaspers (1971) to pain, guilt, and death but names this inevitable suffering the "tragic triad." The tragic triad activates the development of the tragic optimism, that is, a person's ability to make the best out of an unchangeable overwhelming situation (Wong, 2020). As aptly articulated by Ewalds-Kvist & Lutzen (2015, p. 171):

> Life's negative aspects can be turned into something positive: by revolving [inescapable] suffering into an achievement; by deriving from guilt the opportunity to transform oneself for the better; and by drawing from life's transitory nature an incentive to take meaningful action.

As accentuated by Lotus, AN took on a new meaning during remission and recovery: "[anorexia] it's not purposeful." Moreover, she describes and expresses her "passion" in the previous excerpt, as well as her compassion towards other people. She identified three sources of meaning derived from Frankl's theory: (1) creating a work or doing a good deed (e.g., Lotus is helping others in "child and youth care"): (2) by experiencing something and/or encountering someone; and (e.g., Lotus said, "Nature often connects me to art […] I expressed my feelings with art, so I would share it with my therapist and my psychiatrist and my supports And, it was just the easiest way to tell people how I felt, and it was…it was good"): (3) by the attitude we take toward unavoidable suffering (e.g., as Lotus stated, "people who struggle with eating disorders [they] don't do it on purpose"). In her response, Lotus also highlights how both her Mitwelt (e.g., interpersonal relationships began to flourish) as well as her Eigenwelt (e.g., she was able to connect with herself and others through Mitwelt) during the remission and recovery process.

With additional reflection about her remission and recovery process. Lotus continues to reflect on aspects of the existential worlds, including Überwelt:

> I just feel like I have things to do. I still have things to do now, while before I just felt like this life (*inaudible*)…it was just all about controlling what I ate and what I didn't eat. And…I guess now, it's just, I feel like I have something to do on Earth. Sometimes I don't know what it is. Deep inside I know something…something I need to do…there is something I need to do now.

In addition to Überwelt, intertwined in her response is both Eigenwelt and Umwelt, as Lotus articulates how she subjectively feels compelled to do something in the world.

With additional reflection, Lotus highlights a paradox in the excerpt below as she expresses that AN both filled some needs (e.g., "control"), while it "emptied" her of others

(subset 6. c. Impact of Sense of meaning and purpose with Anorexia, nuanced with subset 6. d. Impact of Sense of meaning and purpose):

> I felt like there was so much emptiness way back then. Now that I think about it, it's just… and it's funny though because like, my eating consumed every part of me, and I still felt so empty. And it was…no matter how many people were around me, I was just constantly feeling lonely and empty. And that's the difference now is that I can actually be around people and feel like I'm whole, like I have people surrounding me. Even when I'm on my own now. I live alone, so to me, I actually love it.

The reader can see the shift for Lotus now; namely, the Anorexic-Self felt constantly "alone and empty," whereas the Recovery-Self feels "whole." Accordingly, Lotus highlights that in the midst of her experience with AN she felt not only alone, but also deprived of connection and meaning. In contrast, she presently feels "whole" and connected with others since her Mitwelt and Eigenwelt are more vast and expansive in remission and recovery now. She also accentuates the impact of addressing Umwelt ('world around') in establishing recovery from AN (subset 6. e. Remission and Meaning-making process):

> I know a lot of people who after treatment and after recovery they were kind of protecting themselves all the time. And, in a way, they just live in this safe, boundaries space, and they don't kind of face things in the world. And I don't think that's…for me, that's not remission. For me, it's getting out there and actually getting triggered and facing the triggers, and (*pauses*) I guess facing the challenges every day. And that's how you recover.

Lotus also alluded to growth and flourishing since being in remission and recovery from AN, as she was able to engage in activities of her choice: "I started traveling and went back to my home country. I went there and I had a lot of fun, and I could not have done that if I was still sick." She proceeded to further reflect on her experience:

> I think the eating disorder has always promised control. Promised a lot of things, but the only thing it did was take the control out of me. I couldn't control anything. Started with feeling like I had control over every situation, bad situations around me because I had control over food, but ultimately, I had no control whatsoever. It took the permission away from me. From everything…

In stark contrast, Lotus is able to identify without hesitation how AN or the Anorexic-Self "promised control," but seemingly took it all (internal and external control) away from her. Therefore, the present author paraphrased how "it sounds like at the time, [Lotus] thought anorexia had given [her] something, which for [her], was "control." How does remission, if at all, play into that?" Lotus continued to reflect and disclose the sense of "hope" that she obtained from remission and recovery, as well as her sense of meaning (subset 6. f. Remission process instills and provides hope, nuanced with subset 6. e. Remission and Meaning-making process):

> It gives me hope. Yeah. It really does because (*pauses*) I think about it and I actually don't wake up on the morning happy that I didn't die overnight, and I don't go to bed thinking that was…I'm going to die anymore. I feel like this is one of the things that I've always wanted to do. I just, I remember my Dad one time told me that I should never let my struggles go to waste. And now, like it's just…it's just right there in my brain and I'm like…maybe…this is…maybe my struggles and the years that I've struggled with anorexia…will help other people in a way. So, I just… his words got to me, and I think, I think a lot of us should really not let our struggles go to waste. I chose the mental health profession because I get it, and I've been through it, in a way, to help others.

Lotus indicates in her response how she is making meaning from her suffering of AN by helping others through the mental health professional in "child and youth care." Accordingly, she is honouring and developing her Mitwelt by helping others in her interpersonal and interprofessional relationships. Furthermore, her Eigenwelt is now thriving as she wakes up in the morning and is engaging in something she has "always wanted to do." Frankl (1984) put

forward that what really matters in what seems to be a context of inescapable suffering is a change of attitude that we courageously choose and need to adopt. As succinctly asserted by (Ewalds-Kvist & Lutzen, 2015, p. 170):

> Life's negative aspects can be turned into something positive: by revolving [inescapable] suffering into an achievement; by deriving from guilt the opportunity to transform oneself for the better; and by drawing from life's transitory nature an incentive to take meaningful action.

Lotus accentuates how she is taking her experience with AN and other resultant mental health issues to work in the helping profession and to connect, as well as help others. Therefore, she is making meaning of her experience from AN, particularly since being in remission and recovery from the syndrome.

Similar to the previous participants, Rose also reflected on her sense of meaning and purpose: "I feel like I have sort of an overarching sense of purpose now that I didn't, like, I always had this idea of a sense of purpose, but now I feel more connected to my sense of purpose." Rose proceeds to accentuate how she was bereft of meaning and purpose during her experience with AN (subset a. AN self had no meaning or purpose, whereas the recovery self has meaning and purpose):

> When I was sick with anorexia and depression it's like there's none of that. You can't see anything. Like for me, it was just like, every day was *awful* and there was *no* purpose. I had *no* sense of purpose. I had *no* sense of meaning. It was like, it was like, I read somewhere, and this how it feels like, all the colours are gone, you know? You see like, life becomes gray. Not even black and white. Just gray.

She puts an emphasis on how there was *no* meaning or purpose when she was ill with the diagnosis of AN and depression. Life became bleak and gloomy, which is emphasized as she said: "All the colours are gone, you know? You see like, life becomes gray. Not even black and

white. Just gray." Nevertheless, she uses the notion of colour and a resultant shift to express how since remission and recovery: "Life is more vibrant now."

Remission and recovery also involved Rose's growth of self-trust and self-awareness (e.g., Eigenwelt), accompanied by trusting and connecting with others (e.g., Mitwelt) (subset a. AN self had no meaning or purpose, whereas the recovery self has meaning and purpose):

> And even taking like, risks at work. This position that I have, at first, I didn't think, I didn't feel qualified. I was like, "Oh, I don't know if it's a good idea for me to take it on." I talked to my manager, and she was like, "Oh you can do it 100 percent." So, it's also trusting other people because you know how you see yourself as very different from how others see you. So, when I finally realized that I was like, "People don't see me how I see myself." I feel like I have meaning now. So, for me, I've realized it's not about how much money I make or what my position is. For me, it's like, just doing things I really enjoy. Like, I want my job to have like, to be useful and have meaning. Because I hated my last job, so I love my job right now because it feels meaningful. I feel like, I'm making a contribution to society.

Rose proceeded to identify the continuum of her experience in remission and recovery from AN, this was accompanied dimensions of growth from her experience (subset 6. b. recovery, dimension: growth, nuanced and nested with subsets 6. c. Meaning-making with metaphor of recovery and AN, as well as 6. d. Meaning-making: how it relates to life prior during and after AN):

> I did relapse, I remember thinking like, "Ugh oh." And it's *very* scary. I found it very frightening when I relapsed. I was like, "Ok, I'm just going to fall back into it." And then I was like, "Oh no, that's literally all-or-nothing thinking…" I think recovery (*pauses*) is what has framed my kind of, framed my life? And my purpose and meaning. I think recovery is what allowed me to create the framework. Not allowed me, but gave me the space because I was better… I feel *so* much better. And *that's* what it felt like in my

> recovery. I had the space, and the time to sit down and think like, "Ok, I've gone through all of this, now what do I want to do with that experience?" Recovery… for me, was an evolution and the meaning like, how I find purpose and meaning in life – the core of it – it's the same, but how I carry that out or how I experience that has evolved as well. It's just an evolution. It evolves and it gets deeper, that's how I feel like, my meaning in life. My purpose and all that, it just gets deeper as I progress through life. Yeah…and it was like, dormant.

Rose describes how the core sense of meaning and purpose was "an evolution;" specifically, her sense of purpose evolves and gets deeper as she progressed during life and the experience of AN. Rose's sense of meaning and purpose in life is present in recovery, but it was "dormant" and latent with AN. Accordingly, her response accentuates how her Eigenwelt ('Own-world') that is her subjective, personal experience and mode of relating to her self is now awake and conscious in recovery (e.g., Eigenwelt is no longer "dormant" like it was from AN).

Given her process of remission and recovery, Rose expresses a shift in her Eigenwelt and being detached from AN: "Well, something that's past (*quiet sigh*) and not a part of me. But I think it also gives me 'pauses'…I've been reflecting more…because *for me*, it's like, the idea of anorexia…since it's not like, part of my identity." In light of Rose's statement, she presented with contradiction. For this reason, the present author reflected: "I remember during our last interview you said that "It [anorexia] became a part of your identity, which was a difficult piece for you." Rose continued to reflect on the separation and shifts that she experiences since being in remission and recovery (subset 6. e. shifts and changes since recovery from AN, as well as nuanced with subset 6. f. impact of AN on sense of purpose and meaning):

> Yes, definitely. Because I like to think of it as separate from who I am. I just think of it now as an experience, but when I was in it, it felt like it was part of my identity. Um…it just doesn't take up as much space in my head. I think that's really what it is. And I

> don't…because I don't *define* myself as…having been in it…anorexic, you know? I was, I *had* anorexia, or I had dealt with an eating disorder, but it's not like…if I look back on the scope of my life it's not something that really comes up. Now I can…I can do things; I can get back to the goals of my life. I can experience things. Like, "I can have a purpose, this isn't just my purpose. It's not…this isn't my existence just…dealing with anorexia. I returned to my life and the goals and everything. Mmhmm. And so, now that I'm recovered…I have, I *do* feel that I have a purpose, whereas I didn't when I was sick at all. Like that was…that was it. That was my existence, basically. [Anorexia] it feels very far removed from my life.

There is now differentiation of Rose "*having"* anorexia and "*dealing*" with AN. More specifically, she put an emphasis on the past tense in her description and reflections of her experience of AN, including how she "does" have purpose since being "recovered." Accordingly, she is engaged with her Eigenwelt since recovery from AN, stating how she can establish goals in her life. Rose is also engaged with her Umwelt and the world around her, particularly since she is no longer feeling constrained by the "identity" of AN or being "anorexic." She now accentuates Dasein (being-in-the-world) and truly in the present moment and 'being there' with existence:

> I feel like recovery just kind of made me see myself as a whole person. Not just as like (*stops*). I guess, when I was sick it was more like, it was just like a fragment of myself, where I felt…I felt fragmented. In recovery, it just opens up life again, and I just saw like, my whole self rather than just a part of it.

In addition to expressing Daesin, Rose also accentuates what Jaspers called "Existenz," the realm of authentic being: "Self-being is another important term used for one's inner self. The real core of self-being is another way of expressing one's mode of Being as Existenz" (Peach, 2008, p. 36).

Stephanie also explored and identified her meaning-making process and sense of purpose. As previously noted, the notion of connection with others who have struggled with EDs such as AN or comprehend them has tremendous power to assist in healing (Pugh & Waller, 2017). Nouwen states that one of the saddest characteristics of our time is our isolation from others (Lazarus, 2021). In her experience of remission and recovery, Stephanie reflected on the significance of human connection (subset 6. a. The need for human connection):

> I was able to become, like, be in remission and recovery because…*all* of these people who have some necessary knowledge to educate and guide me in the different aspects of an eating disorder…were there, they were present, there were attentive and, they brought all of that knowledge and skill without the component from the eating disorder team of….you know, inflexibility and…forcefulness and, like, a bit of harshness (*laughs*). So, to me, it (*stops*). Like, the fact that they weren't specialized in eating disorders *was* like, what I needed, personally. I needed people who…didn't have that knowledge of like, how a program runs…

Stephanie needed people – human connections – and less of an approach focusing mainly on her body and/or weight gain, which overlooks the importance of connections and Mitwelt. As a remedy to human isolation, Nouwen affirms that community is essential for people (Lazarus, 2021). Additionally, other authors contend that: "We are alone, but we are not alone. We can be protected from isolation, according to the existentialists (Søren Kierkegaard, Gabriel Marcel, Karl Jaspers, and Martin Buber) if we can connect as a community with others who find themselves in the same situation" (Hernandez, et al., 2011, p. 60). It is notable that Stephanie conveys a significant sense of agency (Eigenwelt) with subjective awareness by choosing to be in community and connecting with other people in a relational context (Mitwelt). Stephanie reflects deeper about her sense of meaning and purpose, accompanied by the need for human

connection (subset 6. a. The need for human connection, nuanced with subsets 6. b. Motivation and/or Inspiration; 6. d. Sense of Meaning and Purpose from Remission and Recovery):

> I think (*pauses*) meaningful…So, I think there…there's kind of a need. I think there are two sides to it. I think there's the one side, where it's, I kind of think of, you know, what are some of my purposes in life. And, for me, I'm a very value-based person and I'm also, um, I find a lot of purpose when it comes to helping others. And so, I'm a pediatric emergency nurse, and I'm also very involved in the community (*pauses*). And so, in that sense I find that, I can find a lot of purpose in my life and even in the research that I do as a graduate student and hopefully when I'm a professor some day (*smiles*) you know. I try to strive to do impactful work, and so, I've (*stops*). I find that those are things that make me feel like I have purpose and meaning in life in general. And then I would say the other side of it is more…the meaning that I've had in my personal life and that's *really* based in my relationships and connecting with others. That's where I really, like, I would say that's where the *heart* of the meaning in my life comes from.

Stephanie accentuates how her Eigenwelt, Mitwelt, and accompanying meaning is based on her connection with others in her role at work, as well as her personal life. Connection with others is essential in repairing existential anxiety of dread and isolation (Hernandez et al., 2011, p. 60):

> The community of others can repair the effects of isolation and dread. Though they use different terms (Kierkegaard's "love," Marcel's "exigent self," Jaspers' "encounter," or Buber's "dialogical principle"), the optimistic existentialists together show that a person has the best chance to triumph over the hopelessness of existence by banding together through shared interests, commitments, and vulnerability with others.

In addition to her sense of meaning and purpose since recovery, Stephanie also reflects on various challenges (subset 6. c. Greatest Barriers to Meaning):

> I think the greatest challenge for me has been, um, it's really been convincing myself that I am…that I'm good enough…that I'm doing enough. That the things that I do to find purpose are, you know, are good enough. It's really, I think around self-esteem and self-

> confidence and…even perfectionism. Like, I know that that's something I've had and still continue to have some difficulty with. Um, so I find those are the greatest barriers…is to just not be so hard on myself. For me, if it's like, even if it's something that brings meaning if it wasn't done good enough, if it wasn't done the very best that I could possibly do it, then there's…it's not good enough, you know. Its not meaningful *enough.* (*stops/laughs*).

Perfectionism seems to heighten and challenge Stephanie's sense of meaning. "It's not meaningful enough." She also uses humour to minimize the impact of this statement, perhaps as a defense mechanism or a sign of a detached self; namely, people are capable of resisting and confronting dreadful conditions through self-transcendence by detaching themselves, at least momentarily, from the situation (Ewalds-Kvist & Lutzen, 2015). For example, the use of humour is a sign of a detached self (Frankl, 1963; 2006).

The present author inquired for additional clarification from Stephanie about her sense of awareness of when "it is enough." She proceeded to use humour and laugh in her response:

> Um (*pauses*). *That's* a question I've been asking myself for a really long time (*laughing*). So, I think, although I love school for many reasons, like, I sincerely do like research and all of that. Something about school that really feeds that perfectionism is being able to measure myself against criteria, right? And sometimes also just taking a step back and being like, "I just need to chill out" (*laughing*). "I don't *need* to always…do everything as best as possible." I've actually like, in the last year, I have really valued moments of perceived failure because it's allowed me to have experiences where I can challenge that perfectionism and be like, "Look, look. I didn't do perfect on that and I'm still alive…" It's been really empowering.

From what Stephanie has shared, she is embracing her Eigenwelt and developing a sense of acceptance and value for "moments of perceived failure."

In addition to her sense of meaning and purpose from remission and recovery, Stephanie accentuates the impact of her Umwelt, as well as her Eigenwelt in the progression of remission and recovery (subset 6. e. Former sense of meaning and purpose developed from AN, nuanced with subset 6. f. Influence from remission and recovery):

> When I was diagnosed and symptomatic…I felt the most…purposeful and meaningful things in life had to do like, with my…with the number on the scale with, you know, being successful and eating less than this certain amount of calories. So, it was really difficult to find meaning and purpose in life outside of anorexia. Whereas *now* I think because I can…like, I see myself? I'm able to…find meaning and purpose completely aside from my anorexia symptoms or (*trails off*). Remission and recovery…it's allowed me to define what meaning and purpose can look like and mean for me. I have the energy to do what I need to do in my work, in my life. And so, I, I have the energy to…work towards those things that I find meaningful and to…to be engaged and to be present. That makes a huge difference.

Stephanie is able to describe how remission and recovery has "allowed" her to "define what meaning and purpose can look like for [herself]" outside of AN. Therefore, she is allowing her Eigenwelt to flourish from this experience and derive meaning and purpose from it.

Viktor Frankl (1963) proposed that people are driven to find meaning in life, and he termed this motivation the *will to meaning.* Parallel to other participants, Geraldine accentuates how her Eigenwelt has developed since being in recovery form AN: "My defining characteristic isn't me trying to…*find* recovery. *Now*, I'm in this sort of state of recovery, and I'm almost allowed to be myself now." As the participants have conveyed, people who have found meaning in life have some insight into why their life is meaningful and what gives it meaning (subset 6. a. What Makes Life Meaningful, nuanced with subset 6. b. Meaning and Purpose since being

diagnosed with Anorexia, as well as 6. c. Impact of Remission and Recovery on Sense of Purpose):

> It's nice now to not feel the *need* or the, um, the necessity to really even identify with the label anymore. I do have meaning now, which is, is weird to…sort of think of because of I mean how do you live without meaning, right? But *before* my meaning was sort of this blind following; the wrong idea what perfect is. I mean, the…*weight* of *all* of that is…for the most part, gone. Recovery is so much more than weight restoration (*laughs*). There's *so* much more to it, right? I think for everybody, but, um, finding meaning I think probably would be the big…the big…way to help treat people, perhaps. Um…(*pauses*) if you had asked me when I was sick if I had like, meaning in life. If I had purpose or if I had a goal. I would say, "Of course I did." = I didn't. I really didn't. I was void of meaning. I didn't do something *unless* it would bring me to be more perfect. I never did anything really *for me*. Now I've made this identity of who [Geraldine] is and what [Geraldine] wants. My life has so much more meaning now. N*ow* I'm participating in my life. My life is mine. I am making decisions for me to do things, whereas before Ed was making the decisions.

Geraldine highlights the significance of meaning-making and finding-meaning in the recovery process. She also makes statements and does not stop and/or pause as much as she did previously, which suggests that it is authentic in her response. However, Geraldine does pause and stop, as it is difficult for her to highlight the negative impact that AN seemingly had on her. She identifies as being "sick" when she had AN. In many ways, she no longer identifies with it or Ed as she did earlier.

Geraldine is now actively participating in her life – Eigenwelt and Umwelt – whereas she was not before with AN since it consumed her life or "Ed" controlled her. In various ways, Ed took over Geraldine's Mitwelt (e.g., as it constituted an interpersonal relationship), as well as her Dasein and being-in-the-world: "It, it led to isolation. There…there was no friendships, right?

You weren't participating in your own life." People have a need for belonging, social connections, and community, as previously mentioned by Nouwen (Lazarus, 2021).

Studies have conveyed that a sense of belonging was influential in people perceiving and experiencing higher levels of meaning in their lives (Lambert et al., 2013). Furthermore, the Recovery-Self has given Geraldine a new outlook on life or perhaps a different one, as she is developing her own goals and identity (Eigenwelt) outside of the ED: "Now in recovery I have friends (*laughs*). *So* weird!! I have friends (*laughs*). It's great, I have *so* much more meaning in my life" Recovery has enabled Geraldine to establish these relationships (e.g., "my partner") and connections, which has giving her a sense of meaning and importance to her life. Before she shared it was very much affected by Ed or, as she said, "toxic relationships," which created disconnection, and now her life is infused with connection and meaning.

5.3 Validation Process: Discussion of Findings

It is important to specify that validation was incorporated throughout the interview process by frequently checking for understanding, clarity, and by asking for assurance that the present author understood participants' experience correctly. An iterative process, one based on analysis and participant feedback, helped to ensure that the present author accurately elucidated the essence of participants' lived experiences in remission and recovery from anorexia nervosa, as well as the presence of, and search for, meaning and purpose in life.

As mentioned on page 84, participants were also contacted after completion of the analysis, in order to offer them an opportunity to view and discuss the findings. Indeed, the intention of the follow-up interview was to validate participants' response and clarify concerns. Two participants responded to the present author to check for accuracy and resonance with their experience (Birt et al., 2016). To ensure quality and accuracy of the participants' experience, the

present author completed follow-up interviews to clarify superordinate themes, as well as subsets that emerged from data analysis. The present author spoke with Lotus by telephone, and with Stephanie virtually through Zoom to validate their responses and clarify any concerns that might emerge for them.

After scheduling and speaking over the phone to Lotus, the present author was able to explain the IPA process, including superordinate themes and subsets, accompanied by the analysis of findings from her three interviews. The present author invited Lotus' feedback and reflections, in which she shared the following statements, alluding to the fluidity of the recovery process, as she stated:

> If we think we are completely cured, it isn't accurate. The brain wiring is off, after an eating disorder for so long and we always need to be cautious. A physical diagnosis like diabetes or cancer doesn't just disappear. A slip with symptoms doesn't mean relapse [...] there is good and bad treatment.

Lotus pointed out the lack of individual psychotherapy, as well as the challenges of group dynamics.

Lotus also identified with the superordinate [2. Experience with Anorexia Nervosa] particularly (subset 2. b. Entity), as she highlighted the significance of an identity outside of AN:

> I struggled with anorexia for 13 years. I didn't know any world outside of it. There were so many challenges. My dad saw beyond my mental illness. I needed someone to see my worth. "I'm a warrior" and worth so much.

In recovery, she sees she has resiliency, especially after overcoming trauma and her ED.

Since Lotus is attending college in "child and youth care," the present author mentioned and explained the wounded healer (e.g., Carl Jung and Irvin Yalom). More specifically, the

present author shared how Carl Jung used the term, 'The Wounded Healer' as an archetypal dynamic to describe a phenomenon which may take place in the relationship between psychoanalysts who had chosen to go into clinical practice because of their own psychological wounds (Hankir & Zaman, 2013). Lotus confirmed she understood and stated:

> I'm a wounded healer. Sometimes we project it onto others because we want to heal them and ourselves so bad, so we don't hurt anymore [...] Always known what I wanted to do but had an eating disorder.

In addition, to the present author's reflections of superordinate's and subsets from her analyzed interviews Lotus stated, "Life has lined up to exactly what you said even after 2.5 years ago when we met for these interviews."

After scheduling and connecting virtually by Zoom to Stephanie, the present author was able to explain the IPA process, including superordinate themes and subsets, accompanied by the analysis of findings from her three interviews. Similar to the explanation with Lotus, the present author also explained the wounded healer (e.g., Carl Yung) to Stephanie. She confirmed that she understood the present author's IPA research and clarification of findings, stating: "I really relate to that" in particular reference to the superordinate [4. Experience with Remission and Recovery Process], as well as (subset 4. f. 3. Remission and recovery transforming the self). In addition, she reflected on the connection to superordinate [7. Meaning-Making Process and Sense of Purpose], particularly (subset 6. f. Influence from remission and recovery), as she shared the following responses:

> I really love being able to care for others and because I'm in a caring role, as a nurse. That gives me a sense of purpose. I think that purpose also comes from being a student. I really like doing research in my PhD, so it also comes from this self-fulfilment and doing

impactful work. I'm working towards a greater goal that seems far in the future right now.

In addition, to the present author's reflections of superordinate's and subsets from her analyzed interviews Stephanie acknowledged: "It is so amazing to hear my experience and story from our interviews, plus how far I've come that's accurate."

6. Discussion

6.1. Discussion of Findings

The aim of this study was to provide a fuller understanding of the experience of women in remission and recovery from anorexia nervosa (AN), including the presence of, and search for, meaning in life during their process of healing and recovery. The participants also had the opportunity to voice their recommendations for meaning-making, purpose, and treatment, including what they would like the medical community and mental health professionals to discern. Moreover, the participants provided insight into how existential givens and spirituality may impact this process of remission and recovery. The participants' rich accounts of their diagnosis and treatment of AN and subsequent healing allowed the present author to describe the nuances contributing to the complexity of their relapses and the moments of transition contributing to their healing. These findings provide valuable information for the medical community and mental health professionals working toward understanding AN and establishing best practices for holistic treatment, which will be further detailed in the answers of subsection 6.1 Discussion of Findings.

Fox and Leung (2009), as well as Marco et al. (2017) demonstrated that participants with AN and other EDs such as BN and BED (Binge Eating Disorder) have lower meaning in life than the nonclinical population comprised of participants without ED diagnosis; moreover,

participants with AN demonstrated a lower existential well-being score and higher eating psychopathology than comparison groups (e.g., those aged between 18 and 30, and those aged over 30, respectively). These two quantitative studies were the only studies identified in the literature that assessed existential well-being and meaning in life among participants with AN and EDs (e.g., Marco et al., 2017 investigated both AN and BN in their quantitative study). Their results (drawn from responses to the Purpose in Life and the McGill Quality of Life Questionnaire; Eating Disorders Inventory and Eating Attitudes Test) indicated low meaning in life is associated with ED psychopathology, including individuals with AN who appear to experience lower existential well-being than their non-eating disordered peers. They also ascertained that their results may offer some explanation as to why AN is so resistant to treatment efforts (Fox & Leung, 2009; Marco et al., 2017).

Fox & Leung (2009) propose that the symptoms function as a maladaptive attempt to distract attention away from existential concerns. Therefore, Marco et al. (2017) maintain clinical interventions and thus treatment should not only focus on symptom reduction (e.g., weight restoration, binging and/or purging). More specifically, Marco et al. (2017) indicate in their results the need to implement psychotherapeutic interventions aimed at developing meaning in life in participants with EDs such AN, BN, and EDNOS. Fox et al. (2011) also allude to this in their conclusion, stating “It may be that exploring alternative sources of personal meaning and resolving the ambivalence seemingly inherent across eating difficulties may be useful in helping people move towards recovery” (p. 124).

While recent evidence has emerged concerning the functional and existential significance of AN (e.g., Fox & Leung, 2009; Marco et al., 2017), these studies are quantitative in nature, and thus they do not explore the experiences or understandings of the women with AN. Likewise, the

implications of existential givens on the anorexic and her lived experience with the syndrome have not been examined. To date, studies have incorporated what can be deduced as existential givens in AN (e.g., anguish, loneliness, and isolation), but they do not explicitly state them as such (Pettersen et al., 2012) or the four-worlds model – the existential worlds. Given the existent gap with the existential worlds, the present author will provide more details as the research questions are answered below. Likewise, the spiritual dimensions of AN and the anorexic have been proposed (e.g., Richards et al.., 2007), yet without rigorous exploration.

This study contributes to the introduction of other frameworks, or techniques that deal with existential issues called for by Fox and Leung (2009). More specifically, Fox and Leung (2009) encouraged researchers to measure, as well as clinicians to assess: "If anorexia is viewed as a coping strategy that provides a sense of meaning and identity, then it is important to provide other strategies or frameworks to replace this and facilitate change" (p. 29). Accordingly, they encouraged clinicians to introduce techniques that deal with existential issues (e.g., Fox & Leung, 1999) such as those proposed by May & Yalom (1995), in order to enhance individual self-awareness and reduce the need for maladaptive coping strategies such as "the pursuit of the thin-ideal observed in anorexia" (p. 29). Furthermore, they stated that there is a distinct need to present "alternative goals and targets for the anorexic individual besides the pursuit of weight-loss" (Fox & Leung, 2009, p. 30).

The IPA methodology for the current study was pertinent to exploring how the participants themselves understood the diagnosis and experience of AN, as well as the impact on their presence of, and search for meaning in life. It also allowed for the exploration of how existential givens impacted their remission and recovery process from AN (thereby going further toward informing future assessment and treatment practices, as well as decisions than was

possible from Marco et al. (2017) and Fox and Leung's (2009) results). In order to better assist and comprehend women who have experienced the official diagnosis as imposed by a medical team, and relapse of AN, it is crucial to better grasp the complexity of AN, as well as the presence of, and search for meaning and purpose in life, accompanied by the four existential worlds (i.e., Umwelt, Mitwelt, Eigenwelt, Überwelt, including a fifth existential world of Lebenswelt identified in section 7.2), as they offer a promising avenue to pursue for how the anguish (e.g., suffering) of AN can be turned into meaning. The application of an IPA approach allowed the present author to distinguish the phenomenological core of each participant's remission and recovery experience, including how it appeared to inform specific unique recommendations for healing, a connection that will be acknowledged and further detailed in sections below. Therefore, the discussion of participants' remission and recovery process, accompanied by their meaning-making and sense of purpose will be intertwined with a presentation of their recommendations. As previously alluded to on page 275, the connections formed between these core experiences for a given participant could help the medical community and mental health professionals working toward understanding AN and establishing holistic treatment interventions that are best suited to addressing the needs of women in remission and recovery from AN.

The current study takes into consideration Henri Nouwen's (2009) explanation of community (grounded in existential themes of loneliness and social isolation; see description referenced on p. 74), as well as Viktor Frankl's logotherapy (based on the *will-to meaning* principle; see description referenced on page 57) and the four-worlds existential model in order to shed light onto the participants' experience and will be referred to during the course of the discussion. As previously explained on pages 48/56 and recognized by Yalom (1980), May

(1983), as well as extended upon by Van Deurzen (1988, 2012), existential theory provides the four-worlds model for exploring human existence. In this model, people are understood to exist simultaneously in four- worlds or dimensions: physical (Umwelt), social (Mitwelt), psychological (Eigenwelt), and spiritual/philosophical (Überwelt). Accordingly, the existential four-worlds model of explanation and interpretation (each of which will be discussed in later sections) are presented in this discussion as spotlights that can illuminate certain findings of participants' experiences of remission and recovery, as well as suggestions for holistic and non-pathologizing recommendations in addressing their remission, recovery, and healing.

In examining participants' experience of AN and the world, it was beneficial to have a frame of reference such as the existential dimensions to enable the present author to have enough distance from participants' experiences, while also ensuring that all the different aspects of the participants' reality were explored (Van Deurzen, 1988, 2012). As emphasized and articulated by Van Deurzen (2012):

> Instead of using a diagnostic framework, which categorizes and labels personal characteristics, existential therapists use a framework that described the basic dimensions of human existence. The idea is to provide a map of human existence on which an individual's position and trajectory can be plotted and understood (p. 62).

As mentioned on page 220, few studies have been dedicated to the metaphorical meanings with which individuals explain ED syndromes (Bates, 2015). Accordingly, this study addresses the gap in furthering knowledge and understanding of how metaphors can become instrumental in uncovering how participants in the midst of their experience with AN made sense of their identity, including during the remission and recovery process, as well as active agents in their respective making-making process. To deem AN as essentially a physiological disturbance,

a purely psychological one or merely as a sociologically explainable phenomenon, is to ignore the occasion of understanding AN, remission and recovery as a metaphor: namely, food from "poison" (e.g., Stephanie subset 5.a. in Appendix E) to palatable and satiety.

Food refusal, as the participants have revealed, is not a passive act, but the outcome of much determination and resolve on the part of the anorexic woman. It is a refusal born out of potentially deep feelings of perceived lack of control (e.g., Lotus, Rose, Stephanie, & Geraldine), trauma (e.g., Lotus & Stephanie), concomitant disorders (e.g., Liesel, Lotus, Stephanie & Geraldine; as mentioned on page 155) to actual food and what it symbolizes: "The food refusal is an attempt at reparation, at making good out of what is felt to be bad (i.e., oneself- by transforming the raw material of the unacceptable self into an acceptable human being)" (Orbach, 2018, p. 114).

As indicated in subsection 3.2.1 (Study Objectives, p.75-76), the research objectives are, therefore, to explore how women in remission and recovery from anorexia nervosa experience:

1) The presence of meaning
2) The search for meaning
3) Meaning in life
4) The existential givens and significance of recovery and remission.

As indicated in the chapter on methodology, the following questions were developed based on the research objectives:

1) How do women in recovery and remission from AN experience the presence of meaning?
2) How do women in recovery and remission from AN experience the search for meaning?
3) How do women in recovery and remission from AN experience meaning in life?

4) What are the existential givens and significance of recovery and remission for women with AN?

The aforementioned research questions will be answered in the subsequent section, accompanied by reflections on the participant's experiences.

Question 1: How do women in recovery and remission from AN experience the presence of meaning?

As described in chapter 2 – Theories on Meaning in Life and Meaning-Making Processes – particularly in section 2.2. (p. 62), there are various types of meaning an individual can develop or 'make' (e.g., global, and situational). Thus, there are several useful categorizations for understanding some of these common processes. In particular, the meaning-making model (MMM) proposed by Park (2010a, 2013) provides a framework, in which people perceive and understand themselves, as well as their environment (Park & Gutierrez, 2013). The MMM encompasses previous theories to expound the ways in which meaning impacts the coping process and, through coping, impacts psychological and physical health (Park, 2010b). The model identifies two levels of meaning: global and situational (Park, 2013). As previously mentioned in chapter 2 under section 2.2, global meaning refers to an individual's comprehensive beliefs, goals, and sense of purpose, in which situational meaning refers to meaning regarding a specific situation (Park, 2010b).

In the context of the current study, participants pursued global meaning from recovery of AN, particularly since AN was not merely a situation. In contrast, recovery of AN was a continuum and fluid process (see references in section 5.1 for Liesel, Rose, Stephanie, and Geraldine, as well as section 5.2 echoed in superordinates 2, 4, and 5). Therefore, recovery was neither a finite nor fixed state. Accordingly, participants' global meaning derived from AN

entailed the incorporation of their inclusive beliefs, goals, and sense of purpose. Our analysis of the findings in Appendix E, as well as section 5.2. Part 2 (p. 164) suggests that superordinate 7 (Meaning-Making Process and Sense of Purpose) and subsets shed light on the first question.

In order to answer research question number 1, it is important to first reflect on the paradoxes identified by participants in remission and/or recovery from AN, accompanied by their experience of the presence of meaning. Paradox refers to a seemingly absurd or contradictory statement or proposition which when investigated may prove to be well founded or true. Paradox, in the context of existentialism, means thinking above and beyond absolutes such as right or wrong, good, or bad (Doyle, 2010). Existentialism is a philosophy of ambiguity and the absurd. Kierkegaard postulated that human experiences are underpinned by paradox (Doyle, 2010; Strasser & Strasser, 2022).

Paradox is usually spoken about as a position that we find ourselves in that is contradictory, ambiguous, and simultaneously true: "What begins as a personal paradox, as a personal fixed sedimentation, can mutate into a more fluid, flexible principle, allowing more options for alternative choices to be made" (p. Strasser & Strasser, 2022, p. 127). As previously mentioned, (e.g., see p. 209) recognizing the shame that underlies AN is crucial because it contributes to clarify one seeming paradox of AN: the more starvation deteriorates the person, the more emaciated the person is, the more she feels in control and strong (Klyop & Howells, 2019; e.g., Lotus subset 2. e. Paradox of Anorexic-Self and Ongoing Recovery-Self). This echoes what was described in section 1.1.1 Asceticism (p. 8), in which Bynum (1987) explained how women rejected both body and family through food practices to control both themselves and their circumstances.

As previously acknowledged in the findings (e.g., Table 2), AN was a mechanism for participants to establish a sense of control and subsequent coping for various adversities (e.g., trauma, concomitant disorders, etc.). Through the experience of AN – the anorexic experience – the person lives in her thoughts, emotions, and values. However, the person seemingly wants to elevate beyond his/her physical needs by living in their thoughts, emotions, and values albeit paradoxical in nature. More succinctly, AN might appear like a predominantly physical issue, but it extends beyond the body and physical dimension (e.g., Umwelt). For example, as the participants conveyed in section 5.2, AN may provide escape into comfort, may symbolize longed-for love or supreme control (e.g., cognitive level), a reliable 'friend' (e.g., emotional/relational level) or ultimate superiority (e.g., cognitive level): "Because we were *best friends*. Like, when I needed it, I call him 'Ed'. But when I needed him, *he* was there. Always, without, without fail" (e.g., Geraldine referenced on p. 148).

Gradually, the participants absorbed the meaning that their eating behaviours and AN symptoms held for them, and the values that they were trying to pursue through them (e.g., perfectionism, which parallels Überwelt). They understood their efforts as coping strategies in their respective quests for identity, autonomy, and existence, although they were ultimately "meaningless" (e.g., Geraldine stated "directionless"). Insight facilitated "freedom of choice" (Eigenwelt; Geraldine and subset 4. b How Remission and Recovery has changed her sense of Self and Identity) leading to small but significant changes in shifting more into the continuum of remission and recovery as well as Überwelt. As noted in the concluding reflections of participants (i.e., section 5.1: Part 1: Individual Participant Experiences), the discourse of the current study validated participants' experience of being-in-the world, in all its dimensions. This study conveys that these discussions can facilitate possibilities for choice, meaning, and an

increased ability to make sense of contradictions in an uncertain world. The recognition of paradoxes within the experience of AN, in which participants are dominated by the physical realm, destabilized, and disrupted other dimensions. Participants conveyed how the recovery process entailed a self-determined search for identity and truth by giving oneself a choice, a sense of agency and thus empowerment (e.g., Geraldine "I had the freedom of choice")

It is notable that once the participants became more aware of the paradoxes of AN in their lives, for example, increased awareness of their self-definition, a shift began to occur towards recovery. More specifically, findings suggest the ongoing presence of a fluid shift and not a dichotomous shift (i.e., recovery not being an all-or-nothing phenomena). This shift, and fluidity is also included in recovery and remission process pertaining to participants' self-awareness and insight, as well as their definition of the self. That is, participants' sense of self is no longer compromised by the rigidity of AN (e.g., enslaved to perceived emotional, cognitive, and behavioural expectations of AN).

Further, rather than resolving tensions or selecting one demand over the other (either-or strategies), recent research calls for accepting, embracing, and confronting tensions (Putnam et al., 2016). In general, a variety of approaches (e.g., CBT, REBT, Gestalt) exist for embracing tensions, including balance, or finding an equilibrium point between opposites, reframing or developing them into a new whole, transcending them through shifting their boundaries, and connecting them through a dynamic interplay between poles (Putnam et al., 2016). As the current study conveys, the four-worlds model can assist in navigating paradox by recognizing that human experience is holistic, phenomenological, and incomprehensibly vast (Van Deurzen, 1988, 2012). Van Deurzen and Arnold-Baker (2005) state, "The vista of human experience is so

vast and diverse that it is impossible to do justice to it […] the four-worlds of existence offer a framework from which to map out an individual's world or experience" (p. xviii).

Paradoxes are interwoven in participants' responses of remission/recovery from AN. For example, Stephanie stated how AN "consumed [her] life" and she was "obsessed" with the experience of AN and resultant symptoms, but she continued to experience inconsistency and confusion as "good days […] were so few and far in-between." Rose also expressed how with recovery-self she identifies herself "as a whole person" now, whereas the anorexic-self was more "fragmented." Interwoven in Geraldine's responses are paradoxes, as she expressed that "recovery is so scary"; however, the "jail cell" that she associates to AN seems more familiar. In a similar manner, Stephanie repeated the notion that she had "no insight" into AN; additionally, she highlighted several paradoxes, in which she put emphasis on "my anorexia," but compared it to "a poison" (p. 136/228). In addition, Stephanie accentuates how recovery "feeds [her] as a person." Understood in this context, recovery is nourishing her sense of self, while AN deprived her of a sense of personhood. As articulated by Bulik (2002) and previously highlighted (subsection 1.3.3 Developmental Factors), individuals such as Lotus and Geraldine recovering from AN are readdressing developmental tasks, particularly interpersonal tasks involving attachment (e.g., establishing individuality from family, developing trust in interpersonal relationships) to cope with developmental challenges, identity issues, and psychological stress (Maine, 2010; Maine & Kelly, 2005).

As Lask and Frampton (2009) tersely state, "Anorexia nervosa is a condition full of irony and paradox" (p. 165). However, "perhaps we should not be so surprised by our apparently paradoxical behaviour for anorexia nervosa is indeed a disorder full of paradox" (Lask & Frampton, 2009, p. 165). For example, pre-morbidly women with AN have been conscientious

and compliant during the hospitalizations (e.g., Lotus reference on p. 104; Geraldine reference on p. 137), but during the experience of AN they are rebellious and resistant; they see themselves as overweight when they are thin; feel full when they are empty (e.g., Lotus references in excerpts on p. 106). They starve themselves, but then sometimes binge (e.g., Lotus p.160); they appear to be in control and controlling, but feel they have no control or are out of control (e.g., see Table 2). Paradoxically, they perceive their tormenting and destructive diagnosis and experience of AN as friend and a comfort (e.g., Lotus subset 2. b. entity and acknowledged). As previously mentioned in subsection 1.3.2. (Psychological Factors), Schmidt and Treasure (2006) examine the role of anorexic symptoms in facilitating deterrence of negative emotions such as feeling emotionally "numb" (p. 347). As stated by Lotus, AN enabled her to feel a sense of emptiness: "my eating consumed every part of me, and I still felt so empty" (see Table 2; as well as Lotus' excerpts on p. 202). Interwoven in Lotus' notion of emptiness is a paradox. For example, AN and remission/recovery can be conceptualized as two phases in an ascetic rite of passage, which involves a confrontation with death (e.g., emptiness) and an eventual return to a fuller life; for some to feel emptiness before choosing what one wants to fill oneself with a chosen identity that corresponds better to whom they have become. Furthermore, interwoven in Lotus' response is akin to a rite of passage; namely, liminality. According to Van Gennep (1909/2019), all rites of passage are characterized by three distinct phases: (1) separation (leaving the familiar); (2) transition (often called the liminal stage - a time of learning and growth) and; (3) return (incorporation and reintegration). In its anthropological tradition, liminality is a term used to describe a transition between different spaces, stages, and identities (Carlson et al., 2020). The second stage of liminality is a rite of passage, the in-between time in

which an individual has lost their old identity, but has not yet been fully re-incorporated into the community with a new identity (Van Gennep, 1909/2019).

Frankl (1963) advocates that a way to cope with the suffering and the existential crisis is to embrace the contradictions and paradoxes of life in a harsh/hostile world. As conveyed by the participants in the previous paragraph (e.g., see also Appendix E), women in remission and/or recovery from AN initially experienced the presence of meaning as a paradox. For example, we will return to what is conceivably the most detrimental paradox. Clinicians behave as if they have the same cognitive distortion as those with AN; namely, they have a "morbid and excessive preoccupation with [the] weight" of their patients/clients (Lask & Frampton, 2009, p. 165). Medical community members and clinicians appear to be fixated by weight and target weights, as diagnosticians use a specific weight or body mass index (BMI), below or above which a disorder is, or is not, deemed to exist (Lusk & Frampton, 2009). Therefore, the focus and significance on weight or BMI makes neither allowance for personal variation, nor for the fact that the technique used for measuring, setting a static target weight is less than valid, and reliable (e.g., methods commonly used by individuals with AN such as water-loading, concealing heavy objects, pressing down on the scales etc.). The whole process can, and often does, have quite the opposite to the preferred effect; specifically, it may lead to resistance, challenges and/or relapses (e.g., relapses as previously disclosed by Lotus, Rose, and Geraldine). It encourages focus on a construct (weight/BMI) that is a far from a valid and reliable indicator of physical and holistic well-being (Lusk & Frampton, 2009).

As referenced in subsection 2.2.1 Existentialism (p. 55), meaning-in-life is a significant psychological concept; one that relates deeply to all individuals: "To live without meaning, goals, values, or ideals, seems to provoke considerable distress" and "in severe form it may lead

to the decision to end one's life" (Yalom, 1980, p. 422). Understood in this context, it deeply correlates to an individual to the point of being a matter of life and/or death. This was confirmed by participants, whom in retrospect expressed the meaninglessness of AN, including the resultant suicide attempts: "Recovery gives meaning or allows meaning and purpose. Um, because it, anorexia eating disorders, maybe mental illness […] there is *no*…. *there is no* meaning" (i.e., Geraldine), as well as echoed by another participant "there is no meaning attached to it" (i.e., Rose). This sense of anguish led to Geraldine's disclosure that, "*I felt absolutely hopeless.* And so, I ended up, um, attempting suicide."

In response to human suffering, distress, and pain, Frankl (1977) believed that people strive to acknowledge a purpose to life, a goal that gives one a sense of self-expression and unique self-fulfillment. A purposeful life is perceived as meaningful. Frankl (1985) argued that people do not invent a purpose to life, but rather discover it. The participants of this study confirmed that their purpose in life was a process, wherein their remission and recovery process allowed them to discover it. For example, both Lotus and Stephanie confirmed that they are now wounded healers in the helping profession (e.g., see subsection 5.3 Validation Process and Discussion of Findings). The wounded healer is an example of transcending one's suffering while at the same time acknowledging it, coinciding with Frankl's theory. Moreover, Lotus and Stephanie accentuated the relevance of their sense of Überwelt, which included becoming wounded healers.

Liesel also highlighted a purpose to her life, implying an internal sense of personal internal agency and "*real* meaning" that she "got from recovery was just actually being free," and "living [her] life." Rose also accentuated how "recovery… was an evolution and the meaning like, how I find purpose and meaning in life – the core of it." As confirmed by the

findings of this study, every individual has a unique role to take part in life and meaning in life requires assuming responsibility for realizing one's unique potential. The participants echoed Duncan et al. (2015) results that recovery is a complex process that required a self-determined search for identity, as well as the reclamation of personal power and control. Accordingly, this reminds the reader of Van Gennep's (1909/2019) 3rd stage; specifically, the incorporation phase – reincorporation – that involves a new social identity, marking the start of a new period of life. More succinctly, the 3rd stage entails a time of return (i.e., incorporation and reintegration). The participants conveyed this stage of return during the remission and/or recovery process, as they shifted away from the anorexic-self and created a new identity and sense of meaning.

Let us now bring our attention to the word 'existence,' which has its roots in the Latin word *ex-istere* – translated variously as 'to stand out', 'to emerge', 'to proceed forward in a continuous process' (Strasser & Strasser, 2022, p. 3). As accentuated by the participants (i.e., Liesel, Lotus, Stephanie, and Geraldine), remission and recovery from AN was a fluid process. As such, Frankl (1969) posited that each person is responsible for making choices in their lives, especially during times of suffering, and that the ability to endure is a test of one's inner strength. When we avoid responsibility, we may experience existential anxiety, meaninglessness, and guilt (Frankl, 1969; Yalom, 1980). Meaninglessness, or a void, is often created by the inability to make a personal choice or conform to what society or others expect one to do (Frankl, 1969). Existential therapy encourages the person to find meaning, engage in personal freedom, and make choices that will create change in their existence, while concurrently alleviating anxiety and guilt (Iacovou & Weixel-Dixon, 2015). As tersely stated by Geraldine pertaining to her recovery process: "I think there was sort of this revelation that I was allowed…to make…I had

the freedom of choice" (subset 4. b How Remission and Recovery has changed her sense of Self and Identity).

As participants conveyed, their Eigenwelt ("own-world") and Unmelt ("world around") were being challenged, so they sought to integrate Überwelt ("spiritual/philosophical world"), which is the domain of experience where people create meaning for themselves and make sense of things (e.g., Stephanie subset 6. a. The need for human connection). Given that connection is part of the meaning-making process, it also refers to an important existential variable: participants' Dasein and being-with. Nouwen (1996/2012), who has authored many deep reflections on the importance of community, provided the following account portraying the participants' experience:

> Community is a fellowship of people who do not hide their joys and sorrows but make them visible to each other as a gesture of hope. In community we say: 'Life is full of gains and losses, joys and sorrows, ups and downs—but we do not have to live it alone. We want to drink our cup together and thus celebrate the truth that the wounds of our individual lives, which seem intolerable when lived alone, become sources of healing when we live them as part of a fellowship of mutual care.' (p. 63)

The time spent in community in group therapy (sharing their struggles of AN and accompanying ED symptoms in community instead of concealing them in isolation), was a potent antidote to the existential themes of anxiety and loneliness, as well as shame accompanying the participants' lack of meaning and purpose in life. Given that recovery from AN is a fluid process, Mitwelt begins to emerge and assist with the continuum of recovery process. As previously mentioned in section 5.2 (p. 259), the "tragic triad" identified by Frankl (1963, 1992) activates the

development of the tragic optimism, that is, a person's ability to make the best out of an unchangeable overwhelming situation (Wong, 2020).

The participants conveyed the importance of working in conjunction with the medical community. For example, as accentuated and clearly stated by Stephanie: "And, you know, to have someone regulating your eating without telling you why […] who are taking care of the medical aspect Interwoven in this response is indicative of how the medical team taking away control, which in reaction Stephanie decides to rigidify her thinking and behaviour patterns: "Um, it made me so anxious to change *any* eating behaviour that I had? Um, but it was just real confusing because I just didn't understand why they were doing these things." This is thought-provoking phrasing – "taking care of the medical aspect" – whereas the current thesis underscores the importance of taking care of the individual, with her participation so that a community of care be formed, which includes the individual with AN.

As mentioned earlier in section 3.1 (Existential Themes in Anorexia Nervosa), existent research conveys the sense of loneliness and lack of community women with AN experience as they seek treatment for remission and recovery (e.g., Rance et al., 2017; Vance et al., 2017). Existential isolation encapsulates the pervasive innate sense of disconnection between one's self and the world (van Bruggen et al., 2017). This is indicative of the value of developing a sense of community with other people who grapple with AN or EDs, as it can connect them and assist in their healing; namely, a community of people devoted in their experience of the remission and recovery process. Furthermore, it highlights the significance and pertinence of the existential worlds; specifically, 'Umwelt,' literally meaning "world around," signifying the environment; (2) 'Mitwelt,' meaning 'with-world,' constituted by our interpersonal relationships (i.e., community). The participants experience attested to how the level of disconnection eventually

prompted them to rediscover their sense of self (Patching & Lawler, 2009), which involved re-engaging in life and reconnecting with themselves (Eigenwelt) and others (Mitwelt). As explained by Patching and Lawler (2009), "the women all recalled that re-engaging with life required them to re-prioritise the time and energy that they currently reserved for engaging in their eating disorder" (p. 17).

In summary, it is crucial to explore the worldview and relationship with the four dimensions of existence with women in recovery from AN. As conveyed by participants, an exploration is fundamental to discover the individual's inescapable experience of being embodied in a physical world with others (Umwelt); and clarification of their assumptions and beliefs about body size and weight, their meaning and significance for them, and how this is connected to their social and close relationships with others (Mitwelt). As previously mentioned in section 3.1.4 (p. 75), Nouwen articulates how community (i.e., Mitwelt) has many connotations; namely, it can make us think of a "safe togetherness," as well as "a quality of heart that "grows from spiritual knowledge that we are alive not solely for ourselves but one another" (Nouwen, 1997/2009, p. 23). Community made of peers with AN and the treatment team can provide women in recovery from AN with a sense of connection and humility, accompanied by a sense of safety/healing from the stigmatization of AN. Accordingly, participants expressed how a sense of community during ED treatment was a beneficial aspect in the process of recovery in providing a sense of connection and hope.

Frankl's conception of tragic optimism proposed that an individual could sustain a positive outlook on life in spite of adversity and tragic experiences. He proposed that if one presupposes that life is meaningful regardless of circumstance and that humans are capable of transforming life's negative aspects into positives. Furthermore, it is necessary that there is a fundamental

reason or meaning for the individual to remain hopeful in order to strive for a future goal with courage and tenacity. As disclosed by participants, in the midst of suicidal ideation and resultant attempts (i.e., Geraldine), they continued to pursue their lives with courage to face adversity, as well as develop an acceptance of what cannot be changed (Wong, 2020).

A salient component that emerged from the study was the paradoxes of AN in its various forms. The paradoxical nature of AN was identified and described by the study, accentuated by experiences of participants. For example, they starved themselves but sometimes binged/purged. They are emaciated and present as frail, but behave with strength and determination; they perceive their tormenting and destructive AN as "a friend" and "a comfort" (e.g., Lotus). In the depths of the experience and syndrome of AN, they can see only advantages and rarely any disadvantages. As tersely stated by Lask and Frampton (2009):

> Perhaps anorexia nervosa should be renamed, for after all the term is a misnomer. 'Anorexia' means loss of appetite, but rarely is there a loss of appetite. 'Nervosa' implies psychological and yet the substrate is biological not psychological. Furthermore, the term 'anorexia nervosa' fails to capture its subtleties, contradictions and paradoxes (p. 166).

This highlights the clinical relevance of integrating therapeutic immediacy and mindfulness with the anorexic, particularly in highlighting the contradictory and paradoxical nature of AN. Furthermore, through the present author's openness and curiosity during the interview process, the participants became aware of the SFM, including how AN was "meaningless" (e.g., Geraldine stated "directionless") and/or "there was no meaning attached it" (e.g., Rose). As identified by other researchers, individuals become capable of engaging in life authentically, courageously, creatively, and responsibly in accordance with their values (Ostaseski, 2017) by engaging fully in the present moment knowing they have a future of their situated choosing

(Schneider & Krug, 2017). This also arguably applied to the anorexic in her remission and/or recovery process, as well as the clinician accompanying her. This will be addressed in great detail in the subsequent question about how women in remission and/or recovery experience the SFM.

The first research question queried about how women in remission and recovery from AN experience the presence of meaning. As described in chapter 2 – Theories on Meaning in Life and Meaning-Making Processes (e.g., particularly in section 2.2.1), presence of meaning refers to whether people perceive their lives as significant and purposeful. As conveyed in the findings of participants' experience and current response, they experienced paradoxes that perplexed their experience of the presence of meaning. Furthermore, it conveys that experiencing a paradox seems to have fostered the development of self-awareness or at least a greater self-awareness and self-knowledge. With additional time in remission and recovery, they began to experience a search for meaning, which will be answered in the next question below.

Question 2: How do women in recovery and remission from AN experience the search for meaning?

As specified in chapter 2 – Theories on Meaning in Life and Meaning-Making Processes – particularly in section 2.1.2; Steger and colleagues (2016) outlined two dimensions of meaning in life (MIL): (1) presence of meaning (POM), and (2) search for meaning (SFM). For the purpose of the response to the abovementioned question, this section draws the reader's attention to the second component, search for meaning, which refers to the strength and activity of people's efforts to create or increase their understanding of the meaning and purpose of their lives (Steger et al., 2009). In other words, SFM is concerned with an important process ("how can I make my life more meaningful?") (Steger et al., 2009, p. 661). Life-changing experiences

(e.g., AN diagnosis, trauma, concomitant disorders, suicide attempts, etc.)—whatever their advent in participants' lives and however they experienced them—became opportunities for agency, empowerment, and growth during the remission and recovery process from the paradoxical nature of AN. More specifically, the findings of participants convey navigating the nuances of identity, meaning, purpose, freedom, living, and fulfillment become significant existential tasks particularly during and after these experiences. Therefore, clinicians can assist the anorexic in asking him/herself questions that are both inspired and derived from the work of Frankl (1963, 1992): What are my options or what kind of freedom do I have in this situation (Reflection on freedom)? Whatever the circumstances, the anorexic has some degree of freedom or control outside of the diagnosis and syndrome. This was reflected earlier in subsection 1.3.6 (existential and spiritual Factors), whereby Yalom (1980) refers to certain facts of human existence which he calls concerns that included freedom. This is also echoed in subsection 2.1.1 (Existentialism), in which Wong (2020) indicates, "A meaningful life is a responsible one. We must assume full responsibility for our life or for choosing our life goal. Self-determination is based on the responsible use of our freedom" (p. 573). As the study reveals below in the model, treating AN is about conceptualizing the existential worlds and finding the individual behind the "secretive" nature of AN (e.g., Liesel and Lotus) beyond the anorexic-self. Moreover, the study conveyed how it entails accompanying her during the remission and/or recovery process by assisting her in exchanging the desperate and perverse with the free of choice and responsibility.

As described in chapter 5 – Findings – particularly derived from section 5.2: Part Two Superordinates across participants (e.g., Superordinate 7) – participants' responses are salient as they convey that their Eigenwelt ("own-world"), as well as their Umwelt ("world around") were being challenged. More notably, the participants' responses conveyed that they were also

challenged by the diagnosis of AN, the anorexic experience and/or their recovery process. For this reason, it suggests the necessity of integrating their Überwelt during their remission and recovery process specifically, the domain of experience where people create meaning for themselves and make sense of during their remission and recovery process (Van Deurzen, 1988, 2012). The participants conveyed an initial lack of self-awareness and deemed AN as a coping mechanism and perceived as part of their identity (e.g., see Table 2 on p. 92). As referenced in the subsection 3.1.2. Identity (e.g., Chapter 3- Meaning in Life and Anorexia Nervosa), research has revealed the complexity of "giving up anorexia," in the sense that "letting go of an anorexic identity" not only leads to ambiguity, fear, and worry for these women, but also an identity crisis (Conti, 2018, p. 82). This reaffirms the need to shift beyond the medical approach that pathologizes these women to a phenomenological and existential approach that seeks to understand these women's unique experiences with AN, including the meanings made and derived from it. For example, as stated by Stephanie (i.e., referenced in Table 2): "Yeah, I feel like before it used to be like, "I am my eating disorder, its's a part of me." And now I just see it as this…I don't know. It's like, it's a separate person that…that's there too, you know? (*pauses*)." Interwoven in Stephanie's response is another example that the anorexic-self remains presents or at least it does not vanish and/or die; therefore, the recovery process is indeed on a continuum.

Dramatic dualities inform every aspect of EDs such as AN, from good/bad body, as well as good/bad food (e.g., "I have such *bad*, severe body dysmorphia," excerpt from Stephanie on p. 132). Diagnoses of syndromes such as AN, which seize one's entire identity demand a holistic approach that engages individuals at the core of their being. Überwelt and resultant spiritual reawakening can function as healing dynamism in recovery for the emergent sense of

empowerment, inspiration, gratitude, comfort, and belonging "wrought by this soul-stirring process serves as an ideal antidote to the feelings of helplessness, unworthiness, ineffectuality, discouragement," and shame inherent in EDs (Emmett, 2009, p. 20). While Emmett (2009) does not define spiritual reawakening, he focuses on psychospiritual restructuring, stating that:

> Psychospiritual restructuring […] entails a shift in one's fundamental orientation to the world, one's primal understanding of place and purpose in the universe. It redirects one's heart, mind, and spirit vis-à-vis relationship to oneself, others, and the divine. Such a radical existential reconfiguration induces dramatic changes in how one thinks and acts as it stimulates the reawakening of a spiritual identity, humanity's most potent healing force." (pp.25-26).

The phenomenological core of participants' experience of the remission and recovery from AN is captured in the following words: Acceptance, Authenticity, and Paradigm Shift (i.e., Liesel); Hope, Empathy, and Letting Go (i.e., Lotus); Ambiguity, Acceptance, and Insight (i.e., Rose); Trust, Empathy, Perseverance, and Connection (i.e., Stephanie); Resilience, Courage, Empathy, Freedom, and Choice. (i.e., Geraldine). Inherent in these phenomenological cores of participants' experience are essential existential tools (e.g., will-to-meaning, courage, compassion, and "hope," as stated by Lotus) and worlds when confronting the all-encompassing aspects of AN.

As identified from the findings of participants' experience, a holistic approach to treatment/care for AN engages individuals at inherent personal and existential depths of their being. The nature of this process involves not "fixing" a problem by simple removal of eating disorders thoughts and/or behaviours, but rather identifying the symptoms, as well as patiently and respectfully, learning from what the symptoms and individuals' experiences tell us. This brings the reader to the concept of lifeworld (a fifth world – Lebenswelt – introduced and

discussed further in section 7.2), which is a descriptive and/or hermeneutic approach used to explore how everyday experience shows itself in the lifeworld of individuals (Tuffour, 2017). The symptoms of AN and lifeworld's (German is Lebenswelt) are seen not merely as challenges to be eliminated or endured, but as profound opportunities for growth, connection, and transformation. Therefore, the present author suggests that the intake assessment for AN begin by determining, from the individual's perspective, what prompted the evaluation and assessment, in order to allow the clinician/medical team members an opportunity to peer into the individual's four-world struggles as he/she begins the arduous journey of self-discovery through self-reflection.

In addition, an exploration of existential concerns can clarify his/her understanding of himself/herself as an individual (Eigenwelt) and potentially initiate changing eating/not eating/purging behaviour. For example, clinicians or medical community partners can ask, 'How has eating/not eating/purging become a comfort, a form of wholeness, an appeasement, a retaliator in your life?' 'How does this behaviour relate to values, goals, aspirations once held or dreamed of?' (Überwelt). Individuals with AN can also explore the metaphors, images, and feelings associated with their symptoms and arrive at an alternative understanding of them, for example, "freedom" from recovery, whereas there once was "imprisonment" from AN (e.g., Metaphors as identified by Geraldine).

As previously mentioned, meaning-making that involves modifying situational appraised meaning to be more congruent with existing global meaning is referred to as assimilation, while changing global beliefs or objectives refers to accommodation (Park, 2010a, Parkes, 2001). Accordingly, the participants accentuated how they had to change their global beliefs through accommodation (e.g., shifting into a different rite of passage such as liminality, and resultant

identity). As stated in Superordinate 5 [Metaphors for Anorexia, Remission and/or Recovery Process], they no longer wanted to be "imprisoned" by AN, but rather wanted to be "liberated" and "free" from the diagnosis/syndrome of AN. Prior to this thesis, metaphors with regarding the remission and recovery process for AN, have not been analyzed or addressed. This study conveyed a gap, including the metaphoric expression that women (i.e., participants) are seeking to use their bodies, in order to communicate the complexity of their diagnosis, syndrome, and resultant experiences of AN. This echoed the study of Eli (2015), which found that eating disorder symptoms "constitute a metaphoric, embodied expression and negotiation of existential states" (p. 367). Accordingly, the participants of the current study stated to the present author how recovery was "freedom" and "liberating," as they previously felt "directionless" and "empty" during their experience of AN. In view of that, the current study confirmed how the symptoms of AN established a metaphoric, embodied expression and manifestation (Umwelt), as well as compromise of existential states and givens (Überwelt). Finally, Table 2 presented how participants initially perceived AN as a tool for being in control of their life, not that their illness controlled them; specifically, it was paradoxical in nature. Understood in this context, the paradox consumed them, as well as their Dasein during their experience of the AN diagnosis and syndrome. More specifically, AN takes over the individual's cognitions, emotions, and behaviours. Furthermore, it becomes an aspect of his/her identity; namely, the anorexic-self and thus, the recovery process requires him/her to assume control of their Eigenwelt and Lebenswelt (described further in the model – see section 7.2).

In summary, the medicalization of AN has constructed the experience as an illness that resides within the person (Tomm, 1990); resembling other DSM disorders, the experiencing person is frequently construed as without knowledge, or his or her knowledge is positioned as a

duality such as "'bad' or 'wrong' knowledge" that contributes to the disorder itself (Madigan, 1999, p. 151). Moreover, the experience of AN is akin to an identity crisis, and it assumes a person's identity and sense of self. According to Schneider and Fitzgerald-Pool (2005), as Überwelt refers to "the ideal dimension/worldview includes both traditional beliefs and one's ultimate concern – values and ideals are shown through actions, not by what is professed" (p. 60). Therefore, eating/not eating may become an easy vehicle for transcendence and temporary liberation from the body, an avoidance of the limitations inherent in life (Schneider & Fitzgerald-Pool, 2005).

In this light, Emmett's (2009) psychospiritual approach indicates that emphasis is placed on understanding rather than criticizing/blaming, and "symptoms are continually filtered through a prism linked to the individual's core values" (Emmett, 2009, p. 20). A more holistic approach develops the focus of therapeutic work, enabling individuals to comprehend the meaning and impact of their ED in a far more complete manner (Emmett, 2009). Simultaneously, as the present author's study conveys, a holistic approach can expose women in remission and recovery from AN to the myriad of healing influences offered by Überwelt and other worlds. The four-worlds perspective keeps this disharmony in the forefront, and in doing so, activate a search for meaning, which includes agency and empowerment.

The second question asked about how women in remission and recovery from AN experience the search for meaning. As described in chapter 2 – Theories on Meaning in Life and Meaning-Making Processes (e.g., particularly in section 2.2.1), search for meaning refers to strength and activity of people's efforts to generate or enhance their understanding of the meaning and purpose of their lives. As conveyed in the findings for the current study, a focus on participant's experience of being-in-the world (i.e., Daesin), in all its dimensions can facilitate

possibilities for choice, and increase their ability to make sense of dichotomies for an identity crisis. As conveyed in the experiences and findings of participants, AN seemingly presents as the corporeal/ physical realm (i.e., Umwelt), intertwined and nuanced with the other dimensions in a paradoxical nature. The liberation from the rigidity, within which symptoms entrap them assisted them in becoming open to new possibilities towards themselves (e.g., Eigenwelt, as well as Überwelt), and taking steps to re-connect with others (i.e., Mitwelt) released from both the duality and paradoxical nature of AN. As previously accentuated, AN is truly a paradox that includes the anorexic's thoughts, emotions, and perceived values, including/disguising the four existential worlds in a deceptive way.

Question 3: How do women in recovery and remission from AN experience meaning in life?

Meaning in life (MIL) is a core facet of the positive psychology movement and a fundamental construct of the human condition (Marco et al., 2017). For the purpose of the response to the abovementioned question, this section draws the reader's attention to the definition of MIL that focuses on three facets: (1) coherence (comprehensibility and making sense of one's life); (2) purpose (one's core aims and aspirations for life and direction in life); (3) significance (having a life worth living and a sense of life's inherent value), as previously mentioned in chapter 2 (i.e., subsection 2.1.2 Presence of, and Search for Meaning in Life). Therefore, people who experience MIL are more adequately equipped to effectively deal with life's circumstances (Martela & Steger, 2016). More expressly, they have a purpose in life, a strong sense of autonomy, self-determination. As stated by Geraldine (p.158; superordinate [6. Meaning-Making Process and Sense of Purpose] with subset 6. b. Meaning and Purpose since being diagnosed with Anorexia):

I feel as though everybody is connected. We're sort of all in this human condition together.

> And I would call that spirituality. And…um, and it is my responsibility, I feel it's everybody's responsibility to *help* other people […]

As mentioned earlier in the findings of participants (i.e., Stephanie, Lotus, Stephanie & Geraldine), recovery is not a stagnant or final endpoint, but rather a flexible concept including the fluctuation of advances and setbacks (Garrett, 1998). It is fluid, constantly moving, never finished or an entirely complete journey with an "infinite number of variations" and "its fine details are different for every person" (Garrett, 1998, p. 42). Therefore, it is necessary to reiterate Slade and Longden's (2015) distinction between 'clinical recovery' (i.e., evaluated by the clinician) and 'personal recovery' (i.e., evaluated by the person experiencing the mental health difficulties) (see p. 4). In contrast to clinical recovery, personal recovery centres on the significance of hope, identity, meaning, and personal responsibility (Slade & Longden, 2015). As previously mentioned, the phenomenological core of participants' experience of personal recovery from AN is centered on hope, courage, personal responsibility, freedom, and choice. Therefore, increasing understanding of MIL in personal recovery can help in addressing the gap between clinical recovery ideology and its implementation. As conveyed by the participants, women in recovery and remission from AN experience meaning in life, as a fluid process and continuum; however, this requires increased insight concerning the paradoxical nature of AN and consequential impact paradoxes have on her four-worlds. Meaning in life is akin to participants' experience of the recovery process.

As mentioned in section 5.3 – Validation Process – participants in recovery and/or remission from AN experienced meaning in life by becoming wounded healers (e.g., Lotus, "child and youth care," as well as Rose becoming a "pediatric emergency nurse" and Geraldine's statement "We're sort of all in this human condition together […] it is my responsibility, I feel

it's everybody's responsibility to *help* other people"). As previously mentioned, Carl Jung (1951) believed we have a collective unconscious in which exists the archetype of the wounded healer, whose wounds are both a burden and a driving force in his need to heal the problems of others (Farber, 2017). Irvin Yalom, who considers treatment as an individual, dialectical process, in which the therapist, as a person, participates just as much as the patient, said, "I prefer to think of my patients and myself as fellow travelers, a term that abolishes distinctions between 'them' and 'us' (the healers)" (Yalom 2009, p. 8). This also speaks to the significance of creating a Mitwelt and community of healing, as Nouwen (1996/2009) stated: "a safe togetherness" (p. 23)

As articulated in the theistic approach (see subsection 1.3.6 Spiritual and Existential Factors), several of the core struggles of AN are spiritual in nature (Richards et al., 2007). More specifically, a theistic approach adds to the understanding of EDs, whereby Richards et al. (2007) describe why they regards EDs like AN as a "spiritual problem" (p. 39). There are various spiritual issues and/or dysfunctional beliefs that manifest and persist in women with AN (Richards et al., 2007), which are integrated below in connection with the analysis of the findings.

EDs can provide a perceived sense of identity, meaning, and purpose in life. That is, AN initially becomes the new identity; specifically, the anorexic-self, and so the individual has lost touch with who they were before AN and/or arguably, they no longer want to identify/associate with who they were before AN (e.g., due to trauma, concomitant disorders, strained interpersonal relationships, etc.) This reminds the reader of Van Gennep (1909/2019), as it is imbued with aspects of his stages. For instance, the first stage considered the 'separation phase' becomes symbolic reference to loss and/or leaving the previous state, or loss of a place achieved in life. In other words, it required participants to leave the familiar AN albeit it unpleasant for some

participants due to sexual abuse and concomitant disorders, etc. As highlighted in Table 2, AN was identified as a coping mechanism for participants in the study. The middle stage or 'liminal phase' is the crisis phase, characterized by uncertainty, disruption of order (i.e., a time of testing, learning, and growth). The participants disclosed in their metaphors of superordinate 7, the disruption of AN, as well as the accompanying challenges of remission and/or recovery entailed for them in their experiences. Lastly, the third and final stage of the process or 'return' (i.e., the incorporation phase') entailed participants in constructing a new identity and marking the start of a new period of life without the familiar coping strategies of symptoms of AN. Participants such as Lotus and Stephanie became wounded healers, in order to create some work and accomplish a task such as helping others in their fields of work (e.g., adhering to a source of meaning proposed by Frankl).

As Richards et al. (2007) maintain, nearly all individuals with EDs have "distorted and lost touch with their sense of identity and worth. This identity loss is pervasive to the extent that they lose touch with virtually every aspect of their identity until their identity is their eating disorder (p. 44). This was accentuated by participants in various excerpts, in which they are identified in Table 2 (p. 92). For example, Liesel indicated: "I started getting in my eating disorder"; Lotus acknowledged: "I mean, who was I without anorexia…who was I without being emaciated?"; Rose reflected: "At the time it felt like, it was part of my identity"; Stephanie reflected: "it used to be like, "I am my eating disorder, its's a part of me"; and Geraldine acknowledged and accentuated "I *loved* my eating disorder." Accordingly, their whole sense of identity revolved around their body and experience with AN. After reflecting on the remission and recovery process, participants (i.e., Rose and Stephanie) shifted from describing "my anorexia" to "the illness," thereby creating a distance and *Dasein*.

As mentioned in subsection 2.2.4, the MMM (Park, 2010a) identified how there is a difference between searching for comprehensibility (i.e., make sense of the event within a framework of accepted rules and standards) and searching for significance (i.e., attempts to find significance or value of an event). As shared by the participants, they adhered to the medical community by adhering to a certain BMI and refraining from engaging in ED behaviours. However, it often led to relapse(s) due to their perceived lack of control and meaning, as well as the absence of their previous coping mechanisms and identity (the anorexic). Moreover, the recovery process was an "evolution" and process for participants. Furthermore, participants accentuated how the body (Umwelt) expressed the otherwise inexpressible (e.g., trauma, concomitant disorders, lack of coping and perceived control/identity resultant from AN). This was evidenced through their metaphors, which articulated the paradoxes/differences between their experiences of AN and the recovery process. Whether through starvation, bingeing, and/or purging, the participant was struggling to communicate and relate in the world with others/community (Mitwelt).

As mentioned in subsection 2.2.2, deliberate meaning-making refers to a broad range of efforts to deal with a situation through meaning-related strategies or meaning-focused coping (i.e., differentiated from other coping efforts by its intention of reducing the global-appraised meaning discrepancy that is producing distress). These coping activities and efforts can be directed toward changing either appraised or global meaning (Folkman & Moskowitz, 2007), revising goals and seeking solutions to problems, or activating spiritual beliefs and experiences to help individuals survive their difficult experience (Folkman, 1997; Park, 2010a). While these experiences could be challenging ones, they can also assist an individual in making sense of their stressful experiences, and therefore, find meaning in their suffering (Park, 2010a; Frankl, 2006).

This was the experience for participants, in which they highlighted how they were able to choose to derive meaning from their suffering. While some sought to engage in helping professions as wounded healers (i.e., Lotus and Stephanie), others sought to embrace the "freedom of choice" and seek "direction" instead of the "directionless" path of AN. For some participants, remission and recovery represented the "freedom to choose" how to live their lives without the restrictions and limitations associated with AN: "So recovery was, yeah, I think getting in touch with myself again and just doing things I really enjoyed."

Some participants described lacking personal insight – particularly as they were unaware of the existence of a paradox and its impact on them – into what might have helped them in reaching recovery. Now, in retrospect and after relapses, they reported a stronger sense of who they are outside of the ED and what might be helpful to them in their recovery process (e.g., community, a holistic approach, therapy outside of solely dieticians). Participants also showed a capacity to push through adversity; namely, to have resilience after adversity. This study conveyed that all participants had careers and/or families. These accomplishments are signs of resilience. Even in the face of poor clinical outcomes from treatment (i.e., relapse, fatality) and a host of other negative experiences—including trauma, ruptured or severed relationships with family and/or friends, struggles with mental and physical health, to name a few—participants were moving forward with their lives. One participant reflected it in this manner:

> I guess just…realizing by talking to you how far I've come. Because even two years ago, I would never imagine that I would be sitting here talking today about remission. Yeah. I feel like this is one of the things that I've always wanted to do. I just, I remember my Dad one time told me that I should never let my struggles go to waste. And now, like it's just…it's just right there in my brain and I'm like…maybe…this is…maybe my struggles and the years that I've struggled with anorexia…will help other people in a way. So, I

> just… his words got to me, and I think, I think a lot of us should really not let our struggles go to waste.

As the preceding answers to the research questions 1 and 2 highlight, the medical community and/or clinicians can explore the anorexic's worldview and relationship with the four dimensions of existence. In particular, it will be important to explore the person's inescapable experience of being embodied in a physical world with others (Umwelt); and clarification of her assumptions and beliefs about body size and weight, their meaning and significance for them (Überwelt), and how this is connected to their social and intimate relationships with others (Mitwelt). In addition, an exploration of existential concerns (e.g., death, isolation, identity, freedom, and meaning) can clarify the person's understanding of herself as an individual (Eigenwelt) and pave the way for changing ED behaviour. For example, the implementation of metaphors can assist in remission and recovery from AN by asking the individual: 'What does AN represent or signify to you? What does remission and/or recovery signify to you in words or an image? Clinicians and/or the members of the medical community could also ask: 'How has ED symptoms (e.g., restriction binging/purging) become a comfort, a form of transcendence, an appeasement, a punisher in your life? How does this behaviour relate to your values, goals, aspirations once held or dreamed of?' (Überwelt).

The third research question inquired about how women in remission and recovery from AN experience the meaning in life. As described in chapter 5 – Findings, particularly in section 5.3 Validation Process Discussion of Findings) – becoming wounded healers gave some of the participants meaning in life for understanding their experience of AN. Participants (e.g., Lotus and Stephanie) experienced a deep sense of meaninglessness during the experience of AN. However, the transition into wounded healers and/or meaning in life (e.g., Liesel being pregnant

and thinking of motherhood during the interview process) can assist them in transitioning into the fluidity and continuum of recovery from AN. As conveyed in the findings of participants in their validation process, this fluidity and continuum of the recovery process includes exploring with their worldview and relationship with the four dimensions of existence. With additional time in remission and recovery, they experienced meaning in life, accompanied by existential givens that will be answered in question below.

Question 4: What are the existential givens and significance of recovery and remission for women with AN?

As mentioned in chapter 1 – Anorexia Nervosa/1.3 Etiology of Anorexia Nervosa – particularly in subsection 1.3.6 Spiritual and Existential Factors, research on the existential givens of AN are minimal. In the midst of medical and therapeutic approaches aimed at treating individuals with EDs such as AN, existential therapy has occupied a virtually imperceptible and subtle role (Schneider & Fitzgerald-Pool, 2005). Presently, there are many treatments directed at specific ED beliefs, symptoms, and behaviours, but few of these approaches venture into the core or depths of those difficulties. Among the standard therapies for EDs are cognitive-behavioural therapy (CBT), psychopharmacology, nutritional therapy, and exercise (Kaplan, 2002); however, there is an increasing recognition that although "good short-term results can be reliably produced" from these types of strategies, long-term successes can be "elusive" at best (Wilson & Brownell, 2002, p. 528) and modest or even poor at the worst.

The most important givens of existence according to Yalom (1980) are: the inescapable freedom to choose our lives, the inevitability of death, the existential social isolation, and the meaninglessness of life. According to Yalom's (1980) theory, the confrontation with these givens may evoke existential anxiety that people may want to suppress and avoid. Derived from

conceptual work by Glas (2003), Yalom (1980), and Tillich (1952), Van Bruggen et al. (2017) developed a comprehensive categorization of what they identified as "existential concerns" (the term they use, p.1693) in the following five theoretical domains: (1) Death; (2) Meaninglessness; (3) Guilt; (4) Social Isolation, and (5) Identity. With the aim of assisting the reader, the present author created a table regrouping excerpts of quotations to highlight some of these existential givens of participants in the study (see subsection 2.2.1 Existentialism).

Existential Givens	Quotations
Death	**Lotus** I was killing myself in order to hide who I am. It's just really sad that it got to that point of me thinking of myself so low…I don't constantly feel like I need to die. I don't always feel like I need to disappear and just not exist in this world. **Geraldine:** I…*I felt absolutely hopeless*. And so, I ended up, um, attempting suicide […] I…attempted suicide again.
Isolation	**Lotus:** I was just constantly feeling lonely and empty. And that's the difference now is that I can actually be around people and feel like I'm whole. **Geraldine:** You lose ***everything*** with Ed. You lose ***everything*** […] You have ***no*** connection. You are ***absolutely*** alone. **Stephanie:** I think the only thing I would is kind of the role that, um, other people who have eating disorders, who I've connected with […] I'm not the only person here. Like, I'm not alone in this […] I don't know I God exists, but I do feel like, I'm able to…speak to whatever it is that exists […] I felt like, you know, there's something with me and just like *that*; being able to take away from my feeling of loneliness made *such* a *huge* difference because it can be so isolating.
Freedom	**Liesel:** I think, yeah, like, recovery and meaning and all that it's more like, it was like, the door I had to go through to actually *live* my life, you know? […] freedom. **Geraldine:** I think there was sort of this revelation that I was allowed…to make…I had the freedom of choice […] Recovery feels or parole or (*breath*) whatever that freedom it […] ***Yes*****!** ***Choice!*** There was never choice in my life before. I felt like, I mean, I *think* I thought there was.
Meaninglessness	**Lotus:** So, it was really difficult to find meaning and purpose in life outside of anorexia. **Rose:** There is no meaning attached to it [anorexia].

	Geraldine: Recovery gives meaning or allows meaning and purpose. Um, because it, anorexia eating disorders, maybe mental illness […] there is *no*…. *there is no* meaning.

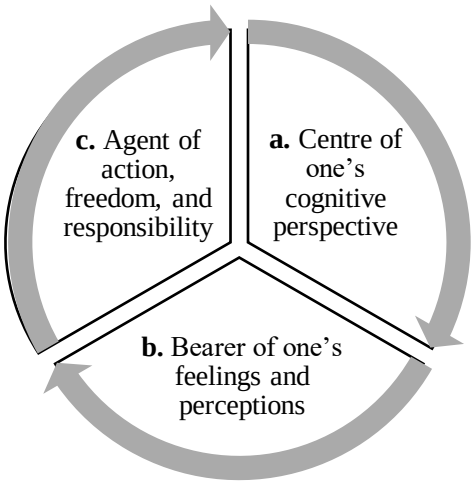
In addition to the previous existential givens, the present author's study reveals a new existential given; namely, the **embodied-self of the anorexic in recovery**. As Osler (2021) indicates, it is important to address the multifaceted bodily experiences of individuals with AN (1) the body-as-object; (2) body-as-subject; and (3) the visceral body (i.e., it is a physical body, but an organic object, one with needs, feelings, and affectivity). As revealed in the findings of the study (visually conveyed in Figure 2 below), clinicians and the medical community have to distinguish the embodied-self of the anorexic in recovery, which involves her as: (a) the bearer of one's feelings and perceptions; (b) the centre of one's cognitive perspective (including experiencing oneself as the author of one's thoughts albeit the anorexic-self; (c) the agent of one's action, freedom, and responsibility. Furthermore, the anorexic is not just a body, but she is not merely a mind and/or behaviours either. Rather, she is a whole person embedded in a fluidity and continuum of recovery from AN. Therefore, the embodied-self of the anorexic in recovery is anchored in an existential given, which is unifying her existential worlds of Eigenwelt, Mitwelt, Umwelt, and Überwelt. She is experiencing herself as the author of not only her body, thoughts, feelings, and behaviours, but also the author of her sense of meaning, purpose, freedom, choice, and responsibility in the recovery process.

As accentuated by the participants, the recovery process and embodied-self of the anorexic in recovery includes a myriad of adjustment, which can include anxiety symptoms (e.g., Stephanie "being able to let go even though you have that anxiety"). However, it is recommended by the present author to acknowledge this, but the adjustment is about more than

simply symptoms, although it can include them. Accordingly, it reaffirms the contribution of Van Gennep's (1909/2019) concept of rites of passage and theory of liminality to the understanding of transformations in the course of a person's life. The term transition itself is directly linked with a shift into a new state, which is often symbolized by the ritual motif of migration, or the symbolic traveling of a road (Van Gennep, 1909/2019). The adjustments participants identified in the study seem to be associated with transitions, whereby the Eigenwelt is transformed in relation to herself, the world, others, and spirituality/values.

Figure 2

Existential Given of the Embodied-Self of Anorexic in Recovery: A Fluid Process and/or Continuum



As mentioned earlier (i.e., subsection 1.3.6 Spiritual and Existential Factors), EDs such as AN often serve as an illusory mechanism for coping with deep voids such as "existential chasm" (Sigg & Armstrong, 2017, p. 145). The article by Sigg and Armstrong (2017) merely reviewed and identified studies, which touched on existential givens in relation to AN (i.e., loneliness; Levine, 2012; Stewart, 2004). Consequently, they did not define existential chasms, but identified some behaviours associated to EDs (e.g., starvation, binging, purging) that apparently

oppose the human experience of connection, fulfillment, and hope. For this reason, it was evident that the current study and research was required concerning the existential givens of AN, especially in providing findings to accompany existing conceptual work on the topic. As the findings conveyed, participants attempted to fill an existential void by incarcerating themselves (e.g., the "jail cell" Geraldine identified) through isolation due to shame and attempts to conceal the behaviours from others (i.e., AN as a "secret," stated by both Lotus and Geraldine).

Through an existential-humanistic perspective, such behaviour can be conceptualized as an attempt to fill a sense of meaninglessness. Therefore, the personal recovery process allowed participants to develop insight into their quests for identity, autonomy, and survival (e.g., trauma, concomitant disorders, suicide attempts, etc.), although they were ultimately self-destructive. Insight into the AN paradox facilitated choice leading to gradual but significant changes. This was evidenced by aspects of the phenomenological core of participants' experience of the remission and recovery from AN: Acceptance, Authenticity, and Paradigm Shift (i.e., Liesel); Hope, Empathy, and Letting Go (i.e., Lotus); Ambiguity, Acceptance, and Insight (i.e., Rose); Trust, Empathy, Perseverance, and Connection (i.e., Stephanie); Resilience, Courage, Empathy, Freedom, and Choice. (i.e., Geraldine). Intrinsic in these phenomenological cores of participants' experience are essential existential tools (e.g., will-to-meaning, and freedom of choice).

For the purpose of the response to the abovementioned question, the present author proposes that the phenomenological core of participants' experience helped them deal with existential givens. Likewise, the phenomenological core of participants helped them to "make meaning" of their experience. Please refer to meanings-made (see page 66). Dasein, being-there, is exposed to the anxieties of, of responsibility for the consequences of past actions, and of existential contingency. An existential perspective of the four-worlds offers a model for

understanding existential givens and anxiety, which is fundamentally different from those which dominate clinical practice, and an application of this perspective has profound implications for ED treatment. For example, if it is the case that fears and ED symptoms are an attempt to contain and manage anxiety, then to treat them as autonomous 'symptoms', which clinicians seek to eradicate without regard to their function (e.g., coping), may be seen as inconsequential. In doing so, the medical community/clinicians are possibly overlooking the opportunity to assist the individual with establishing her fears in a context of meaning (Überwelt). Additionally, it also highlights the importance of developing a community (Mitwelt); namely, it speaks to the significance, as well as relevance of developing Mitwelt (i.e., a healing team). Likewise, they are also foregoing the possibility of aiding her in uncovering the existential anxiety, which lies beneath her fears. When existential givens such as anxiety and/or isolation are deeply understood, far from being problems to be eradicated, they rather are an allies of the treatment for AN; namely, in the endeavour to awaken the anorexic from her illusions and to spur her into living life more authentically.

Several approaches use interpretation (i.e., psychodynamic, attachment-based family therapy) to facilitate the individual's insight into their difficulties and ED problems. However, interpretation suggests an assumption that the practitioner 'knows' the individual (e.g., client/anorexic) better than she knows herself (Lebenswelt, which is introduced/described in section 7.2). In doing so, it does not allow for a sense of community with the treatment team (Mitwelt), as it is likely to accentuate loneliness and might even foster a sense of shame in certain individuals. Consequently, this may confirm individuals' fear that they are incompetent and out of control (e.g., Geraldine, "I'm a terrible person or I'm worthless"), persuading individuals to comply with the clinician's and medical teams expectations. Therefore, the present

author recommends the importance of creating community as a manner to address what causes emotional pain, by directly acknowledging it in the context of a safe and sustaining relationship with the clinician, medical team, and other individuals in treatment for AN. The creation of a community of care, being with, a Mitwelt fostering recovery, but also the development of self (Eigenwelt).

Directive approaches such as rational emotive behaviour therapy (REBT) or CBT assume that there is a measurement of normalcy, and that disordered behaviour indicates dysfunctional and irrational beliefs (Schneider & Fitzgerald-Pool, 2005). As mentioned above, these may confirm the individual's experience of inadequacy, withdrawal, and isolation; thus, loneliness and they may change ED thoughts, feelings, and behaviours without insight. On the other hand, insight, or the motivation to change alone, may not be enough, as conveyed by the findings of participants, including the excerpts and Table 2. As illustrated above in the research questions and answers, an existential and holistic approach/conceptualization may be needed to effect substantive transformation.

As highlighted in the answer to this research question, participants accentuate how existential concerns are entrenched in AN. For example, participants mentioned existential concerns such as death: "It's *very* disproportionate like, you're thinking and everything, it is all-or-nothing thinking. So, *everything* is black and white. *Everything* is life or death" (Liesel, p. 101). Geraldine also echoed this response in her metaphor of AN, in which she put emphasis on the life-threatening nature of the anorexic experience: "It's a *death sentence*. And you're sort of waiting for parole. It really is, *it is* a death sentence. *It is* a prison" (p. 156). Lotus also alluded to the fatality of AN, and existential concerns in terms of identity and death.

In terms of the existential concern of meaninglessness, participants also expressed a sense of meaninglessness with AN (e.g., Rose and subset 6. a. AN self had no meaning or purpose, whereas the recovery self has meaning and purpose). Geraldine also reiterated the meaninglessness of AN with emphasis: "anorexia eating disorders, maybe mental illness, I don't know how far you can expand that, but there is *no*…. *there is no* meaning" (p. 152). As previously mentioned, AN has a paradoxical nature as symptoms (e.g., weight loss, starvation, etc.) seemed to present participants with a sense of meaning and purpose at the beginning when AN has not taken control over them; however, there remained a pervasive sense of the absence of significance, direction, and purpose.

In addition, participants expressed the existential concern of guilt. For example, Geraldine gave strong emphasis on the guilt she experienced with AN, including how her sense of meaning and purpose in recovery has allowed her to dissipate "the guilt, shame [and] anxiety" (p. 152). As previously mentioned, an exploration of existential concerns can clarify the anorexic's understanding of herself as an individual (Eigenwelt) and assist in changing the trajectory of eating behaviours (e.g., eating, not eating, purging). Without a sense of centredness and with a poor sense of 'I' the individual literally loses his/herself (Eigenwelt), consuming and being consumed by ED behaviours and the subsequent identity of the anorexic-self/mind. This cycle becomes increasingly self-destructive, as shame over the ED behaviour leads to more punishment for more failure, an inflexible sense of self, and a closing of possibilities for meaning and purpose. A phenomenological stance of AN that considers existential concerns have yielded compelling descriptions of the lived experience of participants (e.g., women) with AN

Finally, AN symptoms expressed challenges with being-in-the-world and have individual significance (ontic response to ontological givens). The ontological refers to the Being of a

particular being, while the ontic refers to what a particular being (for example, Dasein) can or does do (Heidegger, 1927/2011). For instance, what makes Dasein different from all other particular beings (ontically) is that it takes up the question of its Being (ontological level) (Cerbone, 2009). Accordingly, there is a disturbance of a total, embodied situation of the individual, where mind and body are simultaneously impacted (Piran & Teall, 2012; see subsection 3.1.1). Embodiment is conceptualized as a personal (Eigenwelt), yet intersubjective, experience (Mitwelt): individuals exist through and in a body, with other people who also exist through and in a body. In existential psychotherapy, assigning the label of 'disorder' or 'illness' to eating behaviours limits how others in the community and in interpersonal relationships relate to, as well as understand the individual (Eigenwelt and Mitwelt): labels may obscure the function of AN for the individual. Without a sense of centredness and with a poor sense of 'I' the individual literally loses herself, consuming and being consumed by the ED behaviours and/or food rituals (e.g., over exercising/binging/purging). For example, as accentuated by Liesel, AN had a sense of embodiment: "It just dominated my thoughts, like I couldn't be happy because I was just fixated on all the things that were wrong and what I needed to do to fix them. Like body stuff." Paradoxically, AN robs the person of her body as the latter becomes enslaved to thoughts and associated beliefs. The recovery process allows for an embodied self-identity to emerge.

The medical model with its assumption that theories and techniques are the agents of change and calls for a new, nonmedical model that reflects the power of human and relational factors (e.g., Mitwelt). As a result, the participants of the current study accentuated the importance of shifting from a medical to a holistic understanding of treatment for AN, thus characterizing a "paradigm shift" (i.e., as stated by Liesel) in the continuum and fluidity of the

recovery process. In order to understand this shift in more depth, it is important to take a closer look at the previous and existent paradigm, also known as the medical model (Elkins, 2009):

> In medicine, a doctor diagnoses a patient on the basis of symptoms and administers treatment designed to cure the patient's illness. In psychotherapy, medical model adherents say that a doctor diagnoses a patient on the basis of symptoms and administers treatment designed to cure the patient's illness. However, when they say this, they are superimposing a medical schema on psychotherapy and using medical terms to describe what is essentially an interpersonal process that has almost nothing to do with medicine (p. 67).

This means that clinical and medical treatment for EDs such as AN, as important as it is, has scarce influence on existential well-being and healing. Conversely, most existential well-being and healing does not occur in a medical office as the participants indicated in the current study. Instead, it occurs through supportive connections and interactions with family members, friends, and peers in ED treatment (e.g., Mitwelt), as well as through the search for meaning and purpose (Überwelt). Additionally, in reclaiming one's self-identity and sense of power and control in their own lives (Eigenwelt). The new paradigm shift, in order to reflect this perspective and the evidence that supports it in the current study, ought to place the individual (Eigenwelt), relational elements (Mitwelt), and sense of meaning (Überwelt) at the core of the recovery process, while simply consigning stigmatization and weight restoration to the margins.

If EDs such as AN initially engender a sense of control, as suggested by the participants' experience, then they may play a very functional role in defending against existential anxiety (e.g., loneliness, meaningless, dread, isolation). Indeed, many participants alluded to how they saw their EDs as both challenging (e.g., due to concomitant disorders, relapses, trauma) and

familiar —they knew where they stood in relation to it and could predict their lives through it. This appears to be related to the theme that reflected the paradox of being controlled yet in control—although the eating difficulties and anorexic symptoms take control of the participant's life, that life then becomes much more manageable, predictable, and therefore 'safe'. AN and subsequent cognitions and behaviours, through strictly controlling what participants do with their lives, offer a sense that everything is in order. Accordingly, exploring alternative sources of meaning and stability in life may therefore be an important factor in therapeutic work with people with EDs.

It is now relevant to conceptualize AN in its modern context, particularly as it demonstrates how understandings of self-starvation and food refusal shifted away from religious/spiritual connotations toward medical and psychological interpretations. Nevertheless, it is appropriate to reflect on how the reader can seek to broaden their thinking about AN by learning from the past. As previously mentioned, (please see subsection 1.1.1 Asceticism) fasting had different meanings from the medical one in different historical and cultural periods (e.g., Lasègue and Gull described the first cases of AN from a medical viewpoint in the 1870s), but the most important was the religious meaning (Sukkar et al., 2017). Fasting belonged to ascetic practices, being a means to avoid evil influences and to achieve sacred purposes (e.g., Fassino et al., 2006; Griffin & Berry, 2003).

Let us now consider the lives of two famous religious women, who lived in Europe, around six hundred years ago; Margery Kempe and Saint Catherine of Siena. They were empowered by their roles as religious mystics, and drew strength from suffering, distress and fasting; specifically, food and eating made them quite powerful, particularly in a world dominated by men (Sukkar et al., 2017) In contrast to the mystics, the participants' relationship

with God, as well as family and friends deteriorate, they rely more exclusively on AN and related ED behaviours/symptoms (e.g., binging, purging) as their way of coping with challenges and distress (Richards et al., 2009). For example, this was revealed by Geraldine, who emphasized:

> I…sort of went home and was like, "Do you know what?" Like, "I don't know if religion is *for me*?" And…I was almost immediately excommunicated…from life […] My mother said, "I have one daughter and a son. I don't have two daughters. It's going to be so terrible because when we all die…you're going to be burning in hell […] Like *horrible* statements that I *never* thought would come out of my mother's mouth […] I…didn't know how to handle it. *At all.* Um, I *really* leaned into my eating disorder, really, because I was… "Well, *this* isn't working anymore. I need to do more. I'm not being enough, so if I do eat, I'm going to purge."

Some recurrent spiritual issues or dysfunctional beliefs that manifest in women with AN, which include but are not limited to (1) AN effectively communicates pain and suffering and/or (2) AN facilitates approval and acceptance from others (Richards et al., 2007). However, these thoughts and beliefs are at the expense of the anorexic's Überwelt, Eigenwelt and Mitwelt. Accordingly, when working with the modern anorexic client/patient in today's framework, clinicians may be tempted to leap straight to the diagnostic criteria in *DSM-5*, bypassing the spiritual and existential components intertwined within their experience of AN. Therefore, clinicians and medical communities are encouraged to use their skills in considering and conceptualizing each anorexic fully, within their existential worlds and context, to formulate the conceptualization and arrive at a comprehensive plan.

In summary, the fourth research question asked about the existential givens and significance of recovery and remission for women with AN. As described in chapter 3 –

Meaning in Life and Anorexia Nervosa (e.g., particularly in section 3.1 Existential Themes in Anorexia Nervosa). As previously mentioned (subsection 1.4.4 Existential-Phenomenological), Van Deurzen (1988, 2012) integrated Binswanger and Heidegger to suggest a fourth dimension of worldly being (i.e., Überwelt) that clients can be encouraged to investigate: the physical dimension of nature, environment and bodies (Unwelt); the social dimension of interpersonal relationships and socio-cultural environment (Mitwelt); the personal dimension of self and psychological processes (Eigenwelt); and the spiritual dimension of values and meanings (Überwelt). Within these dimensions, there are particular existential concerns/givens, as well as dichotomies and paradoxes that participants became cognisant about from their recovery process and reflection from the current study. Indeed, the body may serve to express the otherwise inexpressible; however, the individual is struggling to communicate and relate in the world (e.g., whether through starving, over exercising, binging and/or purging). More concisely, the answer to this research question suggests that clinicians' and the medical community adopt a stance of 'un-knowing' towards their clients (e.g., the anorexic): holding in abeyance fixed beliefs, values, and assumptions – including existential ones – such that they can step into their clients' (the anorexic) lived worlds and interpretations.

7. Conclusion

The fundamental premise in this study was to explore how women in remission and/or recovery from AN experience: (1) the presence of meaning; (2) the search for meaning; (3) meaning in life, and; (4) the existential givens and significance of recovery and remission. As proposed by Fox and Leung (2009), the symptoms of AN function as a maladaptive attempt to distract attention away from existential concerns, including existential satiety that is identified and discussed below in section 7.2. Given their conclusion, Fox and Leung (2009) encouraged

researchers to measure, as well as clinicians to introduce techniques that deal with existential issues. In the next section (please see 7.2), the study provides a specific model accompanied by therapeutic implications for clinicians and the medical community, designed to both identify and conceptualize the existential worlds for women in remission and/or recovery from AN.

In this study, a central theme was the conceptualization of *recovery as a fluid process or continuum*. The majority of participants described themselves as "in recovery" (i.e., Liesel, Stephanie, Geraldine), while a small number identified as "recovered" (i.e., Lotus). Therefore, some participants used active and present tense with "in recovery," while one participant identified as part tense and "recovered." Irrespective of how participants identified themselves regarding recovery, participants used a range of terms including "*journey"* and "*it is not linear"* to describe their evolving process of recovery that encapsulated an array of stages of dimension and growth, rather than describing recovery as an end process (e.g., recovery was about more than merely gaining/losing weight or abstaining from ED behaviors). Central to this theme for many participants was that the recovery process was unique to them, their experiences, and their recovery goals, meaning there is no "one-size fits all" definition of recovery due to individual differences in each person's recovery journey. In particular, Rose made several inconsistent statements about recovery, which is indicative to the present author that she is still vulnerable to AN, including how she is still actively engaging in the recovery process. For example, she stated how AN "that's past," yet she stated that she continues to "feel negative" from subsequent experiences in relation to her sense of self and body. Therefore, AN is not past and/or no longer existing, but rather AN and the resultant recovery process resides on a fluid continuum.

Recovery was never described as a final point, but always as an ongoing process in the findings of this study. Within this, however, there were experiences of participants, which emerged and contextualized as the four-existential-worlds. Frequently, there were moments when, consciously or not, a decision was made between life and death, as well as the development of awareness regarding the AN paradox: "I ended up, um, attempting suicide […] I…I…attempted suicide again. I feel like, if I were to go back to that dark place…I, I won't survive […] I am *always* scared…that I'm going to relapse" (e.g., Stephanie). An understanding of recovery and such a definition should accurately capture the lived experiences of persons with EDs to ensure our models of understanding reflect individuals' experiences and meaning of their illness. Thorough examination of participants' narratives of their experiences of ED recovery it arguably provided valuable insight into facets of ED recovery that are missed by routine outcomes assessment. Findings from previous studies exploring patients' perspectives have suggested that recovery goes beyond conventional treatment factors, thus highlighting the disconnection between patient and professionals' recovery goals in treatment (e.g., Duncan, Sebar, & Lee, 2015).

In the study, 'Experience of Remission and Recovery Process' became a superordinate theme. More specifically, it brought together a series of clearly related other subset themes (e.g., see Appendix E, and/or as conveyed in Figure 1; it is the 4th Superordinate [Experience of Remission and Recovery Process], accompanied by the subsumptions [Meaning-Making Process […] as well as Continuum and Fluidity of Recovery]).

Table 4

Subsets: Intricacy and lived experience of recovery, as well as continuum and fluidity

Participant	**Quotations**

Liesel — I think as I was getting recovered, um, I mean, I wasn't like, dangerously restricting my calories. […] Treatment I was just doing because people were making me do it basically. I was not like, at all, like on board with it. I mean, I was, I guess…I wanted to get better in a sense […] Well, a big sense of purpose has come from…learning more about, um, not just like, eating disorders, but diet culture. I mean, from the feminist perspective and that really has had a big impact on my life […] because it literally has shifted the way I think about most things […] it was just like, self-directed, self-motivated. I think the big thing with recovery is just like, first of all, it's like, freedom. Being free from things that were taking up a lot of my time. The *real* meaning that I got from recovery was just actually being free and just being like…just feeling like I could just *live* my *life* and not be restricted by this…thing that was taking over my life. It just feels like, what I like about…life in recovery is just like, every day I'm just living in *my life*.

Lotus — I never thought I would be where I am now to be honest. I thought I would be a rotating patient…in and out, in and out, like I was before. For the first, I would say, 6 months, that I went into remission and recovery, I had a lot of doubts…obviously it was ups and downs as well…it's not linear. I mean, I have them every day pretty much, at least once every day. Um, that's why I say I'm in remission. I'm not sure if I can ever say I'm fully recovered. I realized that I was in remission I think when I was no longer terrified of food. And that I didn't necessarily feel like I needed food to control the events around me or how they made me feel. I decided to start building a life worth living in a way. Like, I went back to school. I was doing things outside of just treatment and recovery. Like, it wasn't just solely…go to therapy, go to appointments. I started doing other things in my life that gave me joy and that's how I knew that I was stepping away from the illness and I was moving towards remission.

Rose — I've noticed some of these women and just other people I've met since, and they, it defines them, they're "a survivor of," or "they're in recovery." Like, I don't really think it really is a part of my life […] It's *still*, like, it's *still*, not a process, but I still have to like, be like, "Ok, doing it." I heard that was the big difference in like, recovery/remission. Recovery was saying like, having the perspective to see, you know, like, "Why am I doing this? What do I hope it will achieve?" I feel like (*pauses*) *before* it's like, I didn't think of myself? And now it's like, I think of like, what *I* personally want, and like, just like, more about me. And like, what meaning means to me and more (*stops*). Like, I don't just do things for other people. I do things for myself that make me happy […] I feel like it's like, what fulfills you (*pauses*) and what, um, what makes you feel really good. Like, I feel like happiness is like, fleeting. It's like, you have moments of happiness, but most of your life is just…like, more contentment or satisfaction or like, what makes you, yeah, what gives you meaning and purpose.

Stephanie — Um, now that I've, like, now that I'm in remission and recovery, and I'm able to kind of see it from, I guess, a more objective perspective, and I'm able to look at my life as a whole outside of anorexia […] I've also felt empowered in that I haven't had any symptoms and any time a thought would come, I'm *very* strict (*laughs*) in saying like, "I will *not* be symptomatic again." That's, um, one of my main priorities is stay…on that path because…you know, you work really hard to get to recovery and remission. And that's how its been for the past year. Anything that – for me – has made me feel like, it might threaten or retrack my recovery or remission, I'm just like, "There is no space for that in my life."[…] I also think that this is something that I struggle with like, even kind of looking to the future, and remaining hopeful is that, "Yes, I'm in recovery, yes I'm in remission and my goal is to continue to be," but I think like, there's always going to be like, I'm always going to have to work at it. It's not something where once you're in recovery, that's it, like, it goes away, and it doesn't come

	back. Like, I think there's always going to be difficult days, where you're going to have to push back, and you know, really work hard to not to fall back into the illness?
Geraldine	I mean, we've all relapsed. If there's somebody who's had an eating disorder and they haven't, I'm so happy for them, but all of my experiences with everybody else that I've met, especially at the unit, like, relapse is just, that's just life. That just happens. It happens without…it's, it's built into it too […] I am *always* scared…that I'm going to relapse. Recovery and remission aren't linear processes in my experience…I think a lot of people even though they, they *say*, "Oh well, it's not linear, it's ok." The disappointment and the…the sadness and the ***guilt***, for sure the *guilt* of you not being able to get your life together, I guess, which is how they see it. Um, that is just…that's a weight. It's terrible. Because I think they, they really do think it is linear. "Well, you're either better or not. Well you're either starving yourself or you're not. You're either purging or you're not." And that's *so* difficult. Life…with an eating disorder is measured sometimes in milliseconds. I, I've tried to recover lot's of times. Um, and I think sometimes are more (*pauses*) every…for many of the times there was always a component missing, I would say. And I don't, I don't really know what it was because I remember, you know, crying over it and being like, "I just want to be better. I don't want to have this burden, I…I want a life! […] I think (*pauses*). I think there was sort of this revelation that I was allowed…to make…I had the freedom of choice.

As demonstrated and validated by participants in the current study, personal recovery centres on the significance of personal responsibility, hope, identity, and meaning (Slade & Longden, 2015); therefore, it conveys a sense of self-perception and self-awareness, as well as a continuum of one's experience. As further stated, and shared by Rose:

> Being aware that it's a thinking pattern and not just a behavioural pattern that can lead to anorexia. For me, that's what I've realized […] I think I still…um, because I…because I caught myself thinking like *that* today about work. I think, I felt before really far removed from anorexia and when I was thinking it…I was like, "Ugh" (*winces*). It's such an awful thing to contemplate. I don't even…just because, if I have those thoughts again it's not…it's not like, a failure. I'm still recovered…it's not, I haven't relapsed, I'm still eating, you know? I'm just…having some negative thoughts and it's not…so it's like, dealing with the same…sort of feelings…

As conveyed and embedded in the preceding excerpt from Rose, there is uncertainty about her recovery process. While she previously felt "really far removed from anorexia," it continues to remain present in her existing thoughts. Accordingly, personal recovery is part of a continuum and not a finite state maintained and/or measured solely by the medical model (i.e., obtaining a certain BMI or eradication of symptoms such as binging, purging, restriction, etc.). Participants perceived AN as a tool for being in control of their life, not that their illness controlled them; specifically, it was paradoxical in nature. Understood in this context, the paradox consumed them, as well as their Dasein during the initial stages of the continuum and fluidity of the remission and recovery process. Therefore, this study confirms that recovery is a complex journey, which required a search for identity and renewal of personal control and power.

Research and literature commonly examine AN from a medical model framework (Dawson et al., 2014). Although this approach is important in the treatment of individuals with this syndrome, it does not adequately consider an individual's unique experience and can have an unintended, deleterious effect (Klyop & Howells, 2019). Studies of recovery from AN have been conducted almost exclusively within a medical model, which seeks causes and evaluates treatment (Bortha, 2015). The medical model presents several challenges: Firstly, these studies have assumed that there must be causes for EDs and that their discovery will solve the problem of recovery. Instead, the present author argued that since the sufferer's own account of causes changes throughout time (e.g., concomitant, trauma), it is the lived experience of these causes which is most relevant to recovery. The participants of the study attested to recovery as a process, which was a continuum and fluidity. The second assumption behind clinical studies is that medical intervention is essential to the recovery process. On the contrary, most recovered participants of the study indicated that events (Umwelt), people (Mitwelt), self-awareness

(Eigenwelt) and meaningful processes (Überwelt) outside of hospitalization and nutritional/dietary aspects were essentially those most relevant to their recovery.

The study's final findings and model offered an in-depth examination of the intricacies involved in the remission and recovery process for women with anorexia nervosa. Furthermore, the study identified the need for a search for meaning and purpose, identified existential contingences, paradoxes/dichotomies, and highlighted current obstacles interfering with individuals' journey towards holistic healing and recovery from anorexia nervosa. From this foundational work, further research is needed to develop and test clinical training tailored to address individuals' existential needs. For future research, a follow-up study is needed to meet with the medical team by asking them how it is to work with individuals with anorexia nervosa, incorporating the findings of the current thesis results. The present author proposes a relational concept of responsibility and identity that extends beyond the stigmatization resultant from eating disorders (i.e., relational that allows the anorexic to have a voice in her treatment with the clinician and medical community).

The medical model is a mold borrowed from medicine that forces the processes and procedures of psychotherapy and eating disorder treatment into a medical-like pattern. For example, medical techniques are an integral part of medicine's regimen of cure. For more than a century, clinical research, training, and practice, in line with a medical model perspective, have assumed that techniques are the agents of cure in treatment (see, e.g., Duncan, 2014). After the completion of this study and review of existing literature (e.g., Fox & Leung, 2009; Marco et al., 2017; Patching & Lawler, 2009) it has become evident that medical techniques (i.e., weight restoration) have relatively little to do with existential treatment and/or healing, whereas common factors, and particularly human factors - like freedom of choice - are the primary agents

of change. Therefore, the medical model, which has shaped the clinical profession for eating disorder treatment, is wrought with insufficiency. As the findings and model of this study conveyed, clinicians and the medical community require a model of treatment that reflects the evidence of how existential and spiritual healing actually occurs from eating disorders such as AN. Accordingly, this is where the new paradigm shift comes in.

The process of treatment and recovery for women affected by AN is neither a fixed nor static pursuit, but rather an enduring quest that includes relapses and remissions (Elran-Barak, 2012). Since the formal introduction of AN in the *DSM*, medical and psychiatric domains have attempted to understand the multifaceted nature of the syndrome in hopes of discovering and developing effective treatment modalities. As previously mentioned, the high prevalence and complex etiology of AN have led to the development of variety of treatment approaches, in addition to nutritional counselling and pharmaceutical therapy (Elran-Barak, 2012; Stein & Latzer, 2012). Despite these collective therapies, many women continue suffering from the syndrome with poor prognosis (Steinhausen, 2002). For this reason, many researchers continue to focus on the etiology of AN and the means of treating it, while others focus on recovery and the means of dealing with behavioral and physiological parameters (Elran-Barak, 2012). Although these are important and relevant areas of focus, they give little, if any, consideration to the existential, spiritual or meanings associated with AN. Furthermore, they provide little opportunity for the women affected by the syndrome an opportunity to share their experiences or give voice to them.

The implications of the study, therefore, will provide insight into the process of remission and recovery from AN. Similarly, it will demonstrate how the presence of, and search for, meaning in life shape and impact the process of healing and recovery. Moreover, it will provide

insight into how existential givens and spirituality may affect this process. The findings of the study can also contribute to the development of clinical treatments that are designed increase the presence of, and search for, meaning in life for women in remission and recovery from AN. That is, it could improve current psychotherapeutic modalities for women with AN by offering interventions focused on finding, and creating meaning, both inside and outside of the syndrome. This in turn can contribute to future studies that seek to design a theoretical framework for understanding this population in greater depth, which is introduced and discussed in the subsequent section with a model and therapeutic implications of the study.

7.2 Final Discussion: Model and Therapeutic Implications

The process by which participants have experienced remission and recovery are those through which individuals continually create and recreate themselves, through narratives and practices; metaphor in language and action, as well as searching and developing a sense of meaning and purpose in life. The "rituals" and/or "compulsions" of the participants during the experience of AN, accompanied by the practices and the changes they brought about were acknowledged in metaphorical language as ''freedom'' (Liesel); "vibrant" (Rose); "building a life worth living" (Lotus); "freedom of choice" (Geraldine), and " [recovery] just feeds who I am as a person and what I'm able to offer […] I'm able to succeed because of my *perseverance* because of my *dedication* and my *passion* like it, things that are more about *me* as a person" (Stephanie). The study is an attestation of their freedom of choice, responsibility, MIL and purpose, as well as their experiences in a continuum and fluidity of the recovery process.

This way of understanding recovery, through a narrative of experiences of the words and metaphors of sufferers, has as much relevance to clinicians and the medical community, as well as research. The phenomenological approach that the study outlined, together with an analysis of

the POM and SFM, as well as MIL of recovery in existential givens, suggests that the following methods are valuable in the treatment of those individuals who suffer from AN. As this study attested, the meanings-made by participants are imbued in the phenomenological cores of participants' personal recovery: Acceptance, Authenticity, and Paradigm Shift (i.e., Liesel); Hope, Empathy, and Letting Go (i.e., Lotus); Ambiguity, Acceptance, and Insight (i.e., Rose); Trust, Empathy, Perseverance, and Connection (i.e., Stephanie); Resilience, Courage, Empathy, Freedom, and Choice. (i.e., Geraldine). Inherent in these phenomenological cores of participants' experience are meanings-made by existential givens (e.g., embodied-self of the anorexic in recovery) and essential existential tools (e.g., will-to-meaning, courage, compassion, and hope) and worlds when confronting the all-encompassing aspects of AN.

Recovery from a mental illness is a uniquely personal experience, which for many people is considered as a process or a journey (Thomas & Rickwood, 2016). According to additional research on mental health (e.g., schizophrenia), four key domains have been identified as salient in the recovery process: finding hope, redefining self-identity, finding meaning in life, and taking responsibility for recovery (Andresen et al., 2003). While research has focused on other areas of mental health and recovery processes, participants stated that their remission and recovery process from AN enabled "freedom of choice" and "a life worth living." Accordingly, this study conveyed the intricacies involved in the remission and recovery process from EDs such as AN; specifically, it furthered knowledge by broadening existential givens accompanying AN (e.g., embodied-self of the anorexic in recovery), rather than solely a clinical or medical illness focused solely upon weight restoration and/or the cessation of symptoms (e.g., binging/purging, restriction).

The model derived from the current study, '**Integrating the Four Worlds, as well as a Fifth World into the Eating Disorder Remission and Recovery Process**,' exemplifies the 'hyphens' of being-in-the-world (*Dasein*) highlighting the existential view of interconnectedness. The model of the study is further explained in the following section.

I. The first dimension, the **Eigenwelt**, is the private, intimate world of the anorexic (client). This is the space of both the intimate relationship that one has with oneself, as well as the relationship one has with significant others. It is the 'I' of one's inner world, with their sense of how they understand and view themselves. This includes one's thoughts, feelings, values, and ideas that add up to one's personal sense of identity. It is the dimension where one's values and beliefs about oneself and their relationship to others come to the fore. Without a sense of centredness and with a poor sense of 'I' the individual literally loses his/herself, being consumed by the food rituals and/or compulsions. The present author recommends that the intake assessment for AN begin by determining, from the individual's perspective (Eigenwelt), what prompted the evaluation and assessment, in order to allow the clinician/medical team members an opportunity to peer into the individual's four-world struggles as he/she begins the arduous journey of self-discovery through self-reflection. The present author also recommends the clinician inquire about what metaphor anorexia signifies and embodies for the anorexic (client). Accordingly, the clinician would be encouraging the retelling and rewriting of personal narratives as stories of overcoming and transformation; not into static perfection, but of actively creating the new, recovering self.

II. The second dimension, the **Mitwelt,** is the aspect of one's everyday relationship to others, which includes viewpoints towards society. It is also the world of one's everyday encounters with other people and community, as well as the way they interact socially with

others. Some key points that emerged from the study are the ways that anorexic's cope with other people: do they only accept people whom they perceive as having the same views as themselves (e.g., online forums and social media websites that encourage ED behaviours), do they want to be in control of their relationships, do they prefer to be submissive and/or people-pleasing? The study also attested to the importance of participants developing a sense of community with other people who grapple with AN or EDs, in order to assist them in their remission and recovery process. These are all aspects of the Mitwelt that the clinician can explore with the anorexic (client) to clarify his or her attitudes towards these various aspects of society at large.

III. The third dimension, the **Umwelt,** is the physical world, with its predetermined physical, biological, and visceral dimension, which includes one's relationship to their body. Accordingly, it will be important to explore the anorexic's inescapable experience of being embodied in a physical world with others (Umwelt); and clarification of the anorexic's assumptions and beliefs about body size and weight, their meaning and significance for them, and how this is connected to their social and intimate relationships with others (Mitwelt), and themselves (Eigenwelt). As the participants conveyed, the body may express the otherwise inexpressible. With this in mind, the clinician can encourage physical practices that deepen bodily awareness and active re-embodiment. More specifically, there are some practices (e.g., yoga, walking, reiki) that are deliberately used to develop the sense of a unified self; of the connection between body, mind, and spirit; but less esoteric forms of exercise like walking, swimming, and walking can take on new meaning when they are employed as techniques of recovery rather than weight loss.

IV. The fourth dimension, the **Überwelt,** or the meaning world, is concerned with an individual's connection with life's meaning and purpose, with spiritual values, as well as

personal perspectives of living and dying. The findings of the current study confirmed the importance of examining the emergence of AN in its modern context, as it revealed how understandings of self-starvation and food refusal shifted away from religious/spiritual connotations toward medical and psychological interpretations. As the participants acknowledged, however, AN "had no meaning," but it gave them a perceived sense of cognitive, emotional, and behavioural structure; however, their perceived sense of meaning with AN "collapsed" due to a "relapse." The present author, therefore, maintains the significance of clinicians including and openly exploring the spiritual lives of anorexics (clients). The definition of spirituality, which participants in the study accentuated is that it concerns connection and reconnection of self with nature, and of self with others. The manner in which participants did this varied (e.g., some attended church and/or read scripture, while others felt spirituality in connection with nature), but they were seeking for some kind of meaning; for a way of feeling that their lives are meaningful and have purpose; to themselves, in society/community, and in the universe: "the Universe itself has put me on this earth for a reason, and so, I owe the Universe, I owe the people around me something" (i.e., Lotus); "I would say for myself spirituality is… believing in something that's bigger you" (i.e., Stephanie).

The Überwelt is the world where individuals define their purpose, explain their existence, and create meaning for themselves against the backdrop of a world without inherent meaning (Yalom, 1980). In work with anorexics, it "means grasping how this person makes sense of the world and what it is she lives for and would be willing to die for" (van Deurzen, 2012, p. 103). What is it that gets us up in the morning? This could be a spirit of exploration, one's engagement and a curiosity, a sense of what one can create for oneself against the backdrop of life's limitations. Encompassing the Überwelt means to consider the paradox, including the

dichotomies of AN. Within the world of meaning and purpose is that of lack of meaning or futility. Each of the worlds is connected to each of the others and relates back to the ontological givens.

V. The fifth dimension, the **Lebenswelt**, or the lifeworld's, learned from the study refers to an underlying concept is the lifeworld of participants (e.g., anorexics), the world of lived experience inhabited by anorexics (individuals) as conscious beings, and incorporating the way in which phenomena (events, objects, emotions) appear to them in their conscious experience or everyday life. Let us begin examining this world of Lebenswelt by reflecting on some of the nuanced philosophy underlining the significant notion of inseparability between human beings and our world (Dahlberg & Dahlberg, 2020). Moreover, let us take note of how this idea was originally described by Husserl in terms of co-constitution, intentionality, and lifeworld (van Manen, 2016). As articulated and described by Dahlberg and Dahlberg (2020):

> Human experience is born from the world, directed to the world, and must be understood with the world as a background. In speaking of co-constitution, Husserl explains that experience neither springs from the subject as a single creator nor does it arise out of an objective world. It results from a subjective involvement in a world that is already meaningful (p. 460).

As embedded within Stephanie's response earlier, she highlighted how AN "consumed [her] life" and she was "obsessed" with the syndrome and consequent symptoms, but she continued to experience a lack of satiety. Paradoxically, she was starving herself with AN, yet she continued to feel a lack of satiety and perhaps existential satiety. Accordingly, she sought to starve herself to lose weight, but she continued to lack a sense of satisfaction and fulfillment unknown to her at the time. Yalom believes that people in therapy fall into despair "as a result of a confrontation

with the brute facts of the human condition" (Yalom, 1998, p. 43). This despair results in what participants conveyed as a fragmented sense of self, as well as their inability to bear existential anxiety and predicaments (e.g., freedom, recognition of meaninglessness, responsibility). The present author maintains that existential satiety describes when individuals cannot find meaning in being alive (e.g., suicide attempts mentioned by participants' and/or severe emaciation), they are unable to act in their lifeworld except in very restricted ways. Their existence and Lebenswelt diminishes – shrinks, so to speak – and everyday routines assume momentous importance as desperate attempts to control the self (Eigenwelt) and its immediate surroundings (Mitwelt and Umwelt) to structure their time and space.

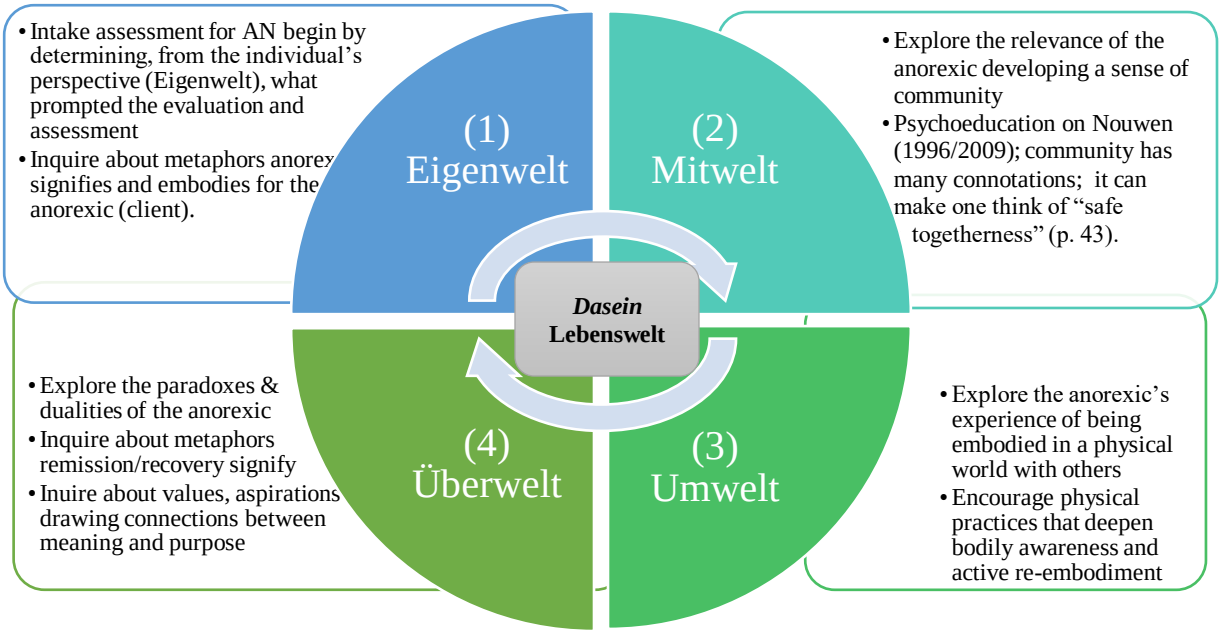
Therefore, the aim of this model is to assist and encourage the anorexic to look within herself (Eigenwelt); to both attend to, and accept, her existential situation; as well as the importance of clinicians and the medical team working with forming a community with the anorexic (Mitwelt). Furthermore, this healing process of recovery begins when the clinician and medical team accompanying the anorexic with her effort to transform a sense of personal dissatisfaction into freedom of choice, as well as the decision to change and then into the act of change. As May (1983) stated, "The human being lives in Umwelt, Mitwelt, and Eigenwelt simultaneously. They are by no means three different worlds but three simultaneous modes of being in the world" (p. 129). May's statements convey the significance of the clinician focusing on the relationship in the here-and-now with the anorexic, which also points to Heidegger's mode of being-in-the-world (Dasein) with the anorexic.

Finally, the resultant model with the five dimensions, 'Integrating the Four Worlds, as well as a Fifth World: Eating Disorder Remission and Recovery Process,' were intentionally discussed separately, in order to identify and conceptualize the concepts. However, they are lived

and experienced as parts of the whole person and their relationship to the world at large. The fourfold world, accompanied by the fifth – fivefold world – makes it possible for clinicians and the medical community to explore how anorexics (clients) exist on each dimension. Van Deurzen (1988; 2012) writes: "there is no point in working on other dimensions as long as people have not learned to come to terms with a basic sense of being able to manage their own physical existence (Umwelt) autonomously" (p. 108). However, the present author challenges this statement, as the 4 dimensions are inter-related, and at least with anorexics the study and reader have seen how this inter-relatedness has a substantial impact on their recovery process. The exploration of the Lebenswelt world is also a powerful means for anorexics (clients) to delve into and challenge their value systems. Furthermore, listening to an individual and understanding their relative position on these five dimensions can reveal where possible disparities and discrepancies exist. Some anorexics, for example, may be more preoccupied with one dimension to the exclusion of another. Although it is not necessary to have equilibrium, if one of the five worlds dominates, exploration of the other four can open up whole new vistas of viewing one's experience of living. The five worlds, and how one expresses them, mirror their worldview and hence are another lens for understanding one's Dasein (being-in-the-world).

Figure 3

Fivefold World for Eating Disorder Remission and Recovery Process



From this model, it is recommended that the clinician community explore the anorexic's inescapable experience of being embodied in a physical world with others (Umwelt); and seek clarification of his/her assumptions and beliefs about body size and weight, as well as their meaning and significance for them; moreover, how this is connected to their social and intimate relationships with others (Mitwelt). Therefore, it is also recommended that clinicians accompany the anorexic, as the way out of what causes emotional pain/existential angst is to face it directly in the context of a safe and sustaining relationship and milieu with the clinician, medical team and community (Mitwelt). In addition, an exploration of existential givens (e.g., can clarify the anorexic's understanding of himself/herself as an individual (Eigenwelt) and initiate the means for adjusting restriction/purging behaviours. For example, clinicians can ask the anorexic: 'How do these thoughts, behaviours, and feelings relate to values, goals, aspirations once held or

dreamed of?' (Überwelt). Clinicians can also assist the anorexic in identifying and exploring the metaphors (i.e., images and/or analogies) associated with the experience of AN versus the recovery process to arrive at an alternative understanding of them (e.g., AN as "an enemy" whereas it was once considered "a friend" or entity). With this model, a focus that validates the anorexic's experience of being-in-the world, in all its dimensions, facilitates his/her possibilities for choice, and increases their ability to make sense of paradoxes and dichotomies in an uncertain world. Through this model and process, the anorexic will be able to engage with his/her present existence in a more meaningful and purposeful way.

7.3 Study Limitations and Implications

The limitations of this study correspond to that of any qualitative study: (a) a limited number of participants and low level of generalizability; (b) use of self-report, the question of accuracy and participants' memory of their life history and experiences; (c) the inability to say anything about cause and effect; and (d) the possibility of inadequacies due to possible researcher bias in the interpretation of data (Creswell, 2013). Additionally, it could be perceived as a limitation that participants are required to be medically recognized as in remission and/or recovery, particularly since attention continues to be placed on weight restoration as the dominant criteria. As such, the participants may continue to grapple with the psychological, emotional, existential, and spiritual, as well as emotional sequelae of remission and recovery from AN. However, the in-depth focus and the rich narrative accounts of participants are expected to yield a deeper exploration and understanding of the phenomenon in question, which will constitute a strength for further future investigation. Likewise, participant self-selection bias will also be a limitation. At the same time, however, this will provide a richer understanding of the phenomenon studied and contribute to a more thorough understanding of the impact of the

presence or, search for, meaning in life, as well as the existential significance for women in remission and recovery from AN. This in turn will strengthen the validity of the results.

It is also important to note that another potential limitation of the study concerns the constructs of the presence of, and search for, meaning in life; namely, these are complex constructs to measure in an objective manner. Specifically, the MIL construct has been criticized for lacking conceptual boundaries; that it, is has been defined in a variety of ways with "no consensus definition for the construct" (Hicks & King, 2009, p. 638). Most meaning research has used a variety of measures in an attempt to capture the depth of the construct (e.g., Purpose in Life Test, PIL; Crumbaugh & Maholick, 1964; Sense of Coherence Scale; Antonovsky, 1987; Meaning in Life Questionnaire, MLQ, Steger et al., 2006). Nonetheless, these measures arguably do not provide in-depth or rich data about what constitutes these processes, especially for women in remission and recovery from AN. Given that the existing studies on this topic are preliminary and quantitative in nature, the study sought to address this gap.

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Appendix A

Participant Demographic Information Questionnaire

Participant Code: _____

Age: _____

First Language: _____

Language being used most often: _____

What is your sex? (Sex: the physical and biological characteristics that identify you as male or female, for example)

1. Female
2. Male
3. Intersex

What is your gender? (Gender: largely social construct that associates certain behaviors, roles, expectations, and values with being male, female, or…)

1. Woman
2. Man
3. My gender is not listed above (Please specify: _____)

Which of these commonly used terms would you use to describe your sexual orientation?

1. Heterosexual
2. Gay
3. Lesbian
4. Bisexual
5. Transsexual
6. Queer
7. My sexual orientation is not listed above (Please specify: _____)

Your current relationship status is:

1. Married
2. Cohabiting
3. Divorced
4. Separated
5. Single, never married
6. My relationship status is not listed here (Please specify: _____)

Your level of education is:

1. High school
2. Community college

3. University (undergraduate)
4. University (graduate; M.A.)
5. University (Graduate; Ph.D.)
6. My level of education is not listed above (Please specify: _____)

Country of Origin: _____

Which of the following best describes your ethnic background? Please check as all that apply:

1. Indigenous (Inuit/First Nations/Metis)
2. White/European
3. Black/African/Caribbean
4. Southeast Asian (Chinese, Japanese, Korean, Vietnamese, Cambodian, Filipino, etc.)
5. South Asian (East Indian, Sri Lankan, etc.)
6. West Asian (Iranian, Afghani, etc.)
7. Arab (Saudi Arabian, Palestinian, Iraqi, etc.)
8. Latin American (Costa Rican, Guatemalan, Brazilian, Columbian, etc.)
9. Other (Please specify: _____)

Are you part of an organized religion?

1. No
2. Yes. Please specify:
    a. Catholic
    b. Jewish
    c. Protestant
    d. Anglican
    e. Muslim
    f. Buddhist
    g. Hindu
    h. Sikh
    i. Other (Please specify: _____)

Do you define yourself as a spiritual person?

1. No
2. Yes. Please specify. (Please check all that apply):
    a. I associate spirituality to an experience of sacredness
    b. I associate spirituality to a relationship with God, the Transcendent, an Entity greater than myself
    c. I associate spirituality to my religious beliefs
    d. I associate spirituality to my fundamental values
    e. I associate spirituality to nature
    f. I associate spirituality to music
    g. Other (Please specify: _____)

How important are your religious and/or spiritual beliefs in your daily life?

1. Very important
2. Somewhat important
3. Not very important
4. Not at all important

Age of Onset of Anorexia: _____

Treatment Received (if any):

_____

_____

_____

_____

_____

In remission/recovery for how many months: _____

Who determined that you were in recovery/remission? (Check all that apply):

1. Myself
2. My physician
3. My psychiatrist
4. My psychologist
5. Other (Please specify): _____)

Thank you for your collaboration!

Appendix B

Semi-Structured Interview Questions and Schedule

Interview One: Focused Life History

We would like to express gratitude to all participants for accepting our invitation to participate in this study. Within the next 90-minutes, we will ask you some questions about your life history and experience with anorexia and remission/recovery, as well as meaning in life. In this first interview, we will strive to put your experience into context by asking you to share, as much as possible, about yourself considering these topics up to the present time.

A. Anorexia

1) What was life like before you experienced anorexia? (Prompt: Can you tell me what was happening for you that lead up to your experience with anorexia?)

2) What was your experience of being diagnosed with anorexia? (Prompt: What did it mean for you to receive a diagnosis of anorexia? How did you make sense of it?)

3) Can you tell me what was happening for you at the time of receiving your diagnosis?
    a. What was happening in your family?
    b. What was happening in school?
    c. What was happening with your friends?
    d. What was happening at work?

B. Remission/Recovery

4) How would you describe your initial experience with remission/recovery * up until now? (Prompt: What has this process been like for you?)

5) How did you determine yourself to be in remission/recovery * from anorexia? What was this process like for you? (Prompt: Did you determine it with the professional opinion of a psychologist, psychiatrist, or physician? If no, please explain…).

6) Can you tell me what was happening for you at the time of determining yourself in remission/recovery * form anorexia?
    a. What was happening in your family?
    b. What was happening in school?
    c. What was happening with your friends?
    d. What was happening at work?

Note: * *Insert what the participant identifies with currently.*

C. Presence of Meaning

7) Do you have a sense of what makes your life meaningful?
    a. If so, please explain
    b. If no, how do explain that?

8) What gives you a sense of purpose in your life now? What, if anything, challenges your sense of purpose in life?

D. Search for Meaning

9) Would you say that you are looking for something to make your life feel meaningful?
    a. If so, please explain.
    b. If no, how do you make sense of that?

10) What would you consider as the greatest challenge in making your life feel meaningful? (Prompt: What would you describe as the greatest struggles? Please provide examples)

E. Meaning in Life

11) What areas* give meaning or importance to your life? (Prompt: What gives your life meaning? Regardless of how satisfied or unsatisfied you might be with them now).

12) What, if anything, challenges those areas* that give meaning or importance to your life?

13) Is there anything you would like to add that perhaps I did not ask you, but you consider important to mention?

Interview Two: Details of the Experience

Within the next 90-minutes, we will ask you some questions that focus on the concrete details of your present lived experience with anorexia and remission/recovery, as well as meaning in life. In this second interview, we will strive to reconstruct the details of your experiences in these areas. We invite you to respond in as much detail as possible.

2. Anorexia

1) How would you describe a typical day with anorexia? (Prompt: What was it like to experience anorexia from the moment you woke up until you went to sleep?)

2) When has anorexia had the greatest impact on your life? What specific moment, event or experience comes to mind? (Prompt: Can you provide some concrete examples?)

3. Remission/Recovery

3) How would you describe your relationship with remission/recovery? * Is this different than your relationship with anorexia?
    a. If so, how?
    b. If no, how do you explain that?

4) How would you describe a typical day in remission/recovery * from anorexia? (Prompt: What was it like to experience remission/recovery* from the moment you woke up until you went to sleep?)

5) When has remission/recovery* had the greatest impact on your life? What specific moment, event or experience comes to mind? (Prompt: Can you provide some concrete examples?)

4. Presence of Meaning

6) Have you noticed any changes in what gives you a sense of purpose since you were first diagnosed with anorexia and now? (Prompt: What are these changes? To what do you attribute these changes?)

7) Would these sources that give you a sense of purpose be different if you did not experience remission/recovery*?
    a. If so, how?
    b. If no, how do explain that?

5. Search for Meaning

8) During your experience with anorexia, were there any specific events, moments, or situations** that you consider as the most meaningful for remission/recovery? (Prompt: What specific examples come to mind?)

9) In what ways, if at all, did those experiences** impact your experience of remission/recovery? (Prompt: Can you give some examples?)

*Note: ** Insert participant's words for their experience*

6. Meaning in Life

10) How has recovery/remission *, if at all, impacted your sense of what gives meaning or importance to your life? How do you make sense of it?

11) You may recall that in the demographic questionnaire, there is the following question: "Do you define yourself as a spiritual person?" Your answer was X. Please tell me more about what spirituality means to you.
    a. If you identified as "not spiritual," can you please elaborate?

12) What was the role of spirituality, if any, in your remission/recovery * process?

13) Is there anything you would like to add that perhaps I did not ask you, but you consider important to mention?

Interview Three: Reflection of Meaning of the Experience

Within the next 90-minutes, we will ask you some questions about the meaning of your experience with anorexia and remission/recovery, as well as meaning in life. In this third and final interview, we will strive to look at how the situations in your life interacted to bring you to your present understanding of anorexia, remission/recovery, and meaning in life. We invite you to respond in as much detail as possible.

A. Anorexia

1) Given what you have said about your life before experiencing anorexia, and given what you have said about your life now, how do you understand anorexia's role in your life?

2) What does it mean for you as a person that you have experienced anorexia? Is this positive, negative, or both and why? Please explain…

3) Would your life be different if you did not experience anorexia?
    a. If so, how?
    b. If no, how do you explain that?

B. Remission/Recovery

4) Can you tell me a bit about who you are now, and if this has changed since experiencing remission/recovery? (Prompt: I am wondering how your experience of remission/recovery* invites you to see yourself as a person now?)

5) How has this process affected you? (Prompt: How did this impact the way you see yourself?)

6) Are there words or metaphors that come to mind when you think of remission and/or recovery? (Prompt: If you try to describe remission/recovery in just a sentence or just a few words, what would you say?)

C. Presence of Meaning

7) How has experiencing remission/recovery* impacted, if at all, the way you view yourself? The world? How you fit into the world? (Prompt: Can you give some examples?)

8) Given what you have reconstructed in these interviews, what are some ways that remission/recovery has impacted your sense of purpose in life?

D. Search for Meaning

9) What has been the role of remission/recovery* on the how you seek purpose for your life? (Prompt: Were there any changes in your ability to seek purpose for your life that you believe could not be possible without remission or recovery?)

E. Meaning in Life

10) How would you describe yourself to yourself now in terms of what you stand for and what matters to you?

11) Since our previous interviews, I am wondering if you can please tell me more about what spirituality means to you.
    a. If you identified as "not spiritual," can you please elaborate?

12) What was the role of spirituality, if any, on your experience with anorexia and your remission/recovery * process?

13) Is there anything you would like to add that perhaps I did not ask you, but you consider important to mention?

Appendix C

Consent Form

Title of the study: The Presence of, and Search for, Meaning in Life Among Women in Remission and Recovery from Anorexia Nervosa

Name of researcher: Caitlin Sigg, MA, RP(Q), PhD (Cand.)

Name of supervisor: Judith Malette, Ph.D., C. Psych.

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Caitlin Sigg under the supervision of Dr. Judith Malette.

Purpose:

The purpose of this study is to explore how women in remission and recovery from AN experience: (1) the presence of meaning; (2) the search for meaning; (3) meaning in life, and; (4) the existential significance of recovery and remission.

Participation:

My participation will consist essentially of answering a series of open-ended questions through three separate individual interviews with the researcher. The respective interview questions will be guided by the study's objectives. The duration of the interview will vary from one individual to another, but the session may last no longer than 90-minutes. The researcher will use a safe and secure location to conduct interviews without jeopardizing my right for privacy and confidentiality. A few months after the interviews, I will be asked for a follow-up interview over the phone to validate and clarify concerns that rose during the first set of interviews. All interviews will be audio recorded to help the researcher accurately capture insights in my own words. Given the sensitive, personal, and confidential nature of our discussions, I will be guaranteed anonymity and confidentiality. A detailed explanation of how the researcher will maintain the confidentiality of data with respect to any identifiable information and information shared during discussions will be discussed in-depth on the section titled confidentiality and anonymity.

Risks:

My participation in this study will entail exploring my experience with anorexia, remission and recovery, as well as their meanings in detail. Sharing detailed information on this sensitive subject matter can be difficult for some individuals. I have received assurance from the

researcher that every effort will be made to minimize these risks. For example, a list of available resources will be provided should I experience any difficult reactions during or immediately after the interview and require support.

Benefits:

My participation in this study will personally benefit me, the society and scientific community as a whole by: (1) offering women in remission and recovery from anorexia a platform to share their experiences; (2) challenging the medical construct and narrative about remission and recovery; (3) contributing to the advancement of our understanding of anorexia, remission and recovery, while also offering an in-depth examination of the impact of the presence of, and search for, meaning in life in the process of healing from the syndrome; (4) exploring the existential significance of remission and recovery for women with anorexia, including the implications it has for advancing treatment, and; (5) increasing our understanding of the role of spirituality throughout the process of remission and recovery from anorexia.

Confidentiality and anonymity: I have received assurance from the researcher that the information I share will remain strictly confidential. I understand that the contents will be used only for the purpose of this research study and that my confidentiality will be protected. All identifiable information collected will be kept private. Any identifiable information will have a number on it instead of your name. Only the researcher will know what your number is.

Anonymity:

Information submitted will be published, as a report, confidentiality and anonymity will be maintained through the removal of identifiers as described on the section above.

Conservation of data:

The data collected (both hard copy and electronic data) will be stored in a password-protected file on the researcher's computer, as well as a secure cabinet in her office. Only the researcher will have the key to access the secure cabinet. A duplicate copy of the research files will be created to safeguard it and enable recovery in case of a loss, corruption or infection by malware. Non-personal research data may be used for future research. I am assured that the confidentiality of my personal data will be upheld through the removal of identifiers.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal (including tapes) will be destroyed and omitted from the final paper.

Acceptance: I, _____, agree to participate in the above research study conducted by Caitlin Sigg of the Human Science Department, School of Counselling, Psychotherapy and Spirituality, Saint Paul University, which research is under the supervision of Dr. Judith Malette.

Using current data in future research studies:

We would like to inform you that data collected from the present study might be used anonymously to support future research.

____Yes, I consent for my personal information to be used in future research studies.

____No, I do not consent for my personal information to be used in future research studies.

Secondary use of data:

The current thesis aims at knowing more about the presence of, and search for, meaning in life among women in remission and recovery from anorexia. Information or materials collected from this study may be used in the future to knowledge and understanding about these themes, as well as to possible treatment modalities.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research and Ethics, Saint Paul University, 223 Main Street, Ottawa, ON K1S 1C4
Tel.: (613) 236-1393

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Appendix D

Email, Phone or In-Person Script Template

Hello,

My name is Caitlin Sigg. I am a PhD student in Counselling and Spirituality with the Faculty of Human Sciences at Saint Paul University. I am writing to invite you to participate in my research study about the presence of, and search for, meaning in life among women in remission and recovery from anorexia nervosa. Your participation in this study will contribute to furthering our understanding of anorexia, as well as remission and recovery, which in turn can have an impact on the treatment and strategies used. This research is being done as part of my PhD project and my supervisor's name is Dr. Judith Malette.

To participate you need to have received a diagnosis of anorexia, ranging between 18 and 35 years of age, and medically identified as being in remission and recovery.

I will like to emphasize that your participation is completely voluntary. If you decide to participate in this study, the researcher will be conducting interviews in a safe and confidential space at the Saint Paul University Counselling and Psychotherapy Centre. Your identification will be protected through a coding system and only the researcher will have access to this information. There will be 3 separate interviews that will take no longer than 90-minutes each. Follow up interviews will be conducted over the phone to clarify certain information. Your participation is completely voluntary.

The research has been reviewed and approved by the Saint Paul University Research Ethics Board.If you are interested in more information about the study or would like to participate, please reply to this email or contact me.

UNIVERSITÉ SAINT-PAUL UNIVERSITY

PARTICIPANTS NEEDED FOR RESEARCH IN:

The Presence of, and Search for, Meaning in Life among Women in Remission and Recovery from Anorexia Nervosa

We are looking for:

- Women who have received a diagnosis of anorexia, ranging between 18 and 35 years of age, who are medically identified as being in remission and recovery

This research study seeks to explore and understand the meaning of life for women in remission and recovery from anorexia, as well as the significance of this process. The results of this study will be used to further our understanding of anorexia, as well as remission and recovery, which in turn can have an impact on the treatment and strategies used.

Your participation will require you to engage in 3 one-on-one interviews that will last no more than 90-minutes. Your participation is voluntary and will remain confidential.

If you are interested in participating in this study or for more information, please contact:

Caitlin Sigg (PhD Candidate)
613-236-1393

Dr. Judith Malette
613-236-1393

This research study has been reviewed and approved by the Saint Paul University Research Ethics Board.

Appendix E

These tables were shared and reviewed with two participants, as well as an external co-validator as a way of validating the findings of the analysis.

Legend:

1) **Diagnosis of Anorexia**
2) **Experience of Anorexia Nervosa**
3) **Anorexia Treatment Process**
4) **Experience of Remission and Recovery Process**
5) **Metaphors for Anorexia, Remission and/or Recovery Process**
6) **Spirituality**
7) **Meaning-Making Process and Sense of Purpose**

Superordinate's and Subsets Across Participants for 3 Interviews

1. Diagnosis of Anorexia → Participant 1 (POM01ML)

- 1.a. Onset
- 1. a. 1. Impact of Anorexia and Diagnosis
- 1. a. 2. Maintenance Factors
- 1.b. concomitant disorder (physiological)
- 1.c. external impacting factors
- 1.d. ambivalence about anorexia due to colitis

1.a Onset of Anorexia → **Participant 2 (POM02YM)**

- 1.b. Diagnosis and Initial Experience of Anorexia
- 1.c. Events at the time of diagnosis of Anorexia
- 1.d. Impact of Diagnosis

1. a. Onset of AN → **Participant 3 (POM03LT)**

- 1. b. dx of AN
- 1. c. First encounter with ED\AN

1. Onset of Anorexia → **Participant 4 (POM04BR)**

1. Onset of Anorexia → **Participant 5 (POM05BS)**

- 1.a. Diagnosis and Initial Experience of Anorexia
- 1.a.1. Initially, she did not think anything was wrong with her.
- 1.a.2. In denial, even though she felt extremely unhappy and depressed.
- 1.a.3. Years of starving herself on this quest for perfectionism.
- 2.a. Approximately 25- or 26-year-old when she initially sought support for healthy eating in a group
- 2.b. Label of anorexia or eating disorder was misunderstood
- 2.c. Considered anorexic behaviours and symptoms as a superpower in the past

2. Experience with Anorexia Nervosa: → **Participant 1 (POM01ML)**

- 2. Anorexia as a…
- 2. a. Coping mechanism
- 2. b. An entity
- 2. c. Typical day with Anorexia
- 2. Characteristics of AN:
- 2. a. Cognitions
- 2. b. Affect
- 2.c. Existential concerns
- 2. d. Relationship with her body
- 2. e. Coping mechanism
- 2. f. View of anorexia and subsequent experience of it
  - 2. f. 1. Evolvement
  - 2. f. 2. Languishing

2. Experience with Anorexia Nervosa: → **Participant 2 (POM02YM)**

- 2. a. Coping mechanism
- 2. b. Entity
- 2. c Eating disorder Behaviours and Daily Activities of Anorexia
- 2. d Experience and Effects of Anorexic-Self
- 2. e. Paradox of Anorexic-Self and Ongoing Recovery-Self

2. Anorexia and identity → **Participant 3 (POM03LT)**

- typical day with anorexia
- 2. b. feeling uncomfortable in her own skin
- 2. c. becomes enslaved to AN
- 2. d. AN was part of her personal identity
- 2. e. typical day with anorexia
- 2. f. feeling uncomfortable in her own skin
- 2. g. becomes enslaved to AN
- 2. h. AN was part of her personal identity
- 2. i. AN ambivalence of learning experience
- 2. j. concealing experience and label of AN

2. Cognitive and Affective impact of Anorexia: → **Participant 4 (POM04MBR)**

- 2. a. Anorexia as a coping mechanism
- 2.a.1. typical day with anorexia
- 2. b. Anorexia as an entity
- 2.b.1. Source of external sense of agency
- 2. Reasoning behind the Development and Maintenance of Anorexia:
- 2. c. Body shaming and comparison
- 2. Anorexia as a Coping Mechanism
- 2. a. Method of fostering a sense of control

2. a. Interpersonal Relationships after Diagnosis → **Participant 5 (POM05BS)**

- 2. b Interpersonal relationship with anorexia and "Ed"
- 2. c. Typical Day with Anorexia
- 2. c. 1. Good Days and Continuum of growth and experiences during a typical day with the Anorexic Self

- Emotions
- Cognitions
- 2. c. 2. Bad Days and Continuum of challenging experiences during a typical day with the Anorexic Self
- Emotions
- Cognitions
- Physical Sensations
- 2. d. Impact and resultant influence of Anorexia in her Life
- 2. d. 1. Growth
- 2. d. 2. Challenges
- 2. d. 3. Self-awareness
- 2.d. e. Contemplated suicide

3. Anorexia Treatment Process → Participant 1 (POM01ML)

- 3. a. Beginning
- 3. b. Development of Eating Disorders and Difficulties with Current Treatment for Anorexia
- 3. c. Strategies and treatment that helped sustain Ongoing Remission-Self and Active Recovery-Self
- 3. d. Her dissatisfaction with the medical team.
- 3. e. ongoing Dialogue b/w cognition and affect of anorexia (prior to treatment)
- 3. f. Living conditions

3. AN Treatment Process **→ Participant 2 (POM02YM)**

- 3. a. Development of Eating Disorders and Difficulties with Current Treatment for Anorexia
- 3. b. Strategies and treatment that helped sustain ongoing Remission-Self and Active Recovery-Self

3. Learning from Anorexia **→ Participant 3 (POM03LT)**

- 3. a. positive aspects learned from AN
- 3. b. negative aspects learned from AN

3. Anorexia Treatment Process **→ Participant 4 (POM04BR)**

- 3.a. Ambivalence and inconsistency in treatment from AN
- 3.b. Treatment as strange/idiosyncratic
- 3.c. Treatment as invoking a sense of powerlessness
- 3.d. Feeling lost and overlooked during treatment
- 3. e. Treatment and professionals' flexible, attentive, and knowledgeable in information outside of AN (e.g., mainly focused on body, weight gain and restoration).
- 3. e. 1. Her need to be in contact with people
- 3. e. 2. The need for human connection
- 3. e. 3. Connection and trust with others and increased sense of self

3. Anorexia Treatment Process **→ Participant 5 (POM05BS)**

- 3. a. Attended a support group and spoke to a physician and was referred to an eating disorder unit and attended it but was in denial.
- 3. b. Met with a doctor, who referred her to a dietician, who spoke about her behaviours, in which the dietician claimed it was not normal
- 3. c. Since it was on campus, she did commit to the treatment and support
- 3. c. 1. Decided to attend the unit to see if it was real due to being very underweight

- 3. c. 2. Since it was on campus, she did commit to the treatment and support
- 3. c. 3. She received medications for depression
- 3. c. 4. Did not want to let treatment team down, but felt absolutely hopeless and attempted suicide
- 3. d. Lacked trust in treatment planning
- 3. e. Asked and arranged for a meeting with her treatment team
- 3. e. 1. Needed to do treatment or felt she would not survive.
- 3. e. 2. Came to realization that she had freedom of choice

4. Experience of Remission and Recovery Process → Participant 1 (POM01ML)

- 4. a. self in remission
- 4. b. continuum
- 4. b. 1. Cognitions
- 4. b. 2. Behaviours
- 4. b. 3. Existential
- 4. b. 4. Affect
- 4. b. 5. Attaining a sense of internal control and agency in ongoing recovery process
- 4. b. 6. Self-awareness
- 4. c. Link with recovery
- 4. d. Onset of recovery
- 4. e. Significant aspects of healing and recovery
- 4. e. 1. Self-awareness
- 4. e. 2. Real recovery involves having realizations and being completely internally self-motivated
- 4. e. 3. Recovery involves a personal decision and wanting it for yourself
- 4. g. Coping with concomitant disorder and impact on remission and recovery process (dialogue b/w colitis and AN)
- 4. h. Phrases and words for remission and recovery process
- 4. i. Recovery process and impact on shaping values

4. Experience of remission and recovery process → **Participant 2 (POM02YM)**

- 4. a. Ongoing Remission
- 4. b. Self and Recovery-Self (transforming)
- 4. c. Confirmation of Recovery
- 4. d. Initial Onset of Remission in Treatment
- 4. d. 1. Day in remission
- 4. d. 2. Day in recovery
- 4. e. Understanding of Initiating and Maintaining Recovery
- 4. f. Grieving process involved in remission and recovery from anorexia
- 4. g. Metaphor of Remission and Understanding Insights obtained from Active Remission-Self

4. Experience of remission and recovery process → **Participant 3 (POM03LT)**

- 4. a. recognition of remission and recovery process
- 4. b. remission and recovery mindset vs the AN cognitive characteristic
- 4. c. impact of stress since remission and recovery from AN
- 4. d. recovery-self
- 4. d. 1. a shift of sense of self since AN
- 4. d. 2. challenging to reflect back on the AN self
- 4. d. 3. shift from the AN self to the self in remission and recovery

- 4. e. remission and recovery shifted her perspective and sense of meaning and purpose in life
- 4. e. 1. recovery enabled her to return to setting and establishing goals
- 4. e. 2. recovery had the greatest impact on her life when she was able to donate organ
- 4. e. 3. significant aspects of enhancing recovery
- 4. f. typical day in recovery from AN
- 4. g. nurturing and sustaining recovery
- 4. h. recovery as an ongoing process
- 4. i shame-based perception of AN
- 4. j. implications of relapse

4. Experience with Remission and Recovery Process → **Participant 4 (POM04BR)**

- 4. a. Challenges
- 4. b. Growth
- 4. b. 1. Vulnerability in Remission and Recovery
- 4. c. 2. Personal values and qualities seen in remission and recovery are not contingent upon Anorexia
- 4. d. Dynamics that assisted in Remission and Recovery
- 4. e. Maintenance of remission and recovery
- 4. f. Remission and Recovery: An Enduring Process
- 4. f. 1. Particular fear associated with remission and recovery
- 4. f. 2. Positive dimensions/growth
- 4. f. 3. Remission and recovery transforming the self

4. Experience of remission and recovery process → **Participant 5 (POM05BS)**

- 4. a. Grieving the loss of anorexia during remission and recovery
- 4. b How Remission and Recovery has changed her sense of Self and Identity
- 4. b. 1. Growth
- 4. b. 2. Challenges
- 4. b. 3. Active Remission-Self
- 4. b. 4. Behaviour for Initiating the Active Remission-Self
- 4. b. 5. Determined Recovery-Self
- 4. b. 1. Active Recovery-Self compared to Anorexic-Self
- 4. b. 2. Imprisonment of Anorexia
- 4. b. 3. Liberation of Recovery
- 4. b. 4. Challenges of Active Recovery-Mind
- 4. b. 5. Seeking Meaning and Understanding of Anorexia's Purpose
- 4. c. Typical Day in Remission and Recovery from Anorexia
- 4. c. 1. Challenges
- 4. c. 2. Growth
- 4. c. 3. Grieving the loss of Anorexia
- 4. c. 4. Emergence of Self in Remission
- 4. d. Continuum and Fluidity of Recovery
- 4. d. 1. Ambiguity and Flexibility of Recovery Process

5. Metaphors for Anorexia, Remission and/or Recovery Process → **Participant 1 (POM01ML)**

- 5. a. Being derailed during the experience of AN.
- 5. b. Being present in yourself, the world, and situation
- 5. c. Words for remission and recovery consist of acceptance and neutrality

5. Metaphors for Anorexia, Remission and/or Recovery Process → Participant 2 (POM02YM)

- 5. Metaphor of Remission and Insights attained from Active Remission-Self
- 5. a. Metaphor of foggy glasses with Anorexic-Self and clearer vision with Ongoing Recovery-Self.
- 5. b. Metaphor of recovery journey being a puzzle.

5. Meaning-Making with Metaphor of Recovery and Anorexia → **Participant 3 (POM03LT)**

- 5. a. lights being turned on again.
- 5. b. Anorexia is a dark passenger

5. Metaphors for Anorexia, Remission and/or Recovery Process → **Participant 4 (POM04BR)**

- 5. a. Metaphor of Anorexia presented as a friend at first; but shifted to a poison upon entering recovery.
- 5. b. Increased insight shifts AN to the enemy, as she enters recovery.
- 5. c. Metaphor of recovery is opening a door to life, imbued with empathy by reaching back to help others through that door.

5. Metaphors for Anorexia, Remission and/or Recovery Process → **Participant 5 (POM05BS)**

- 5. 1. a. Active Recovery-Self compared to Anorexic-Self
- 5 .2. b. Metaphors of Anorexia and Recovery
  - 5. b. 1. Imprisonment of Anorexia
  - 5. b. 2. Liberation of Recovery

6. Spirituality → Participant 1 (POM01ML)

- 7. a. Seeking meaning in life
- 7. b. Seeking understanding in life
- 7. c. Strength and connection with the transcendence
- 7. d. Questioning around religiosity
- 7. e. Mindfulness
- 7. f. Meaning-making and recovery process
- 7. g. Understanding and significance in her life and recovery process

6. Spirituality → **Participant 2 (POM02YM)**

- 7. a. Connection, Nature, and Hope
- 7. b. Role during AN
- 7. c. Role during remission an recovery process

6. Spirituality → **Participant 3 (POM03LT)**

- 7. a. role during AN
- 7. b. role during recovery process
- 7. c. Spirituality represents openness, colour, compassion, and understanding
- 7. d. Meditation accompanied by reading Biblical passages provided her with a sense of connection, validation, normalization, and compassion.

6. Spirituality → **Participant 4 (POM04BR)**

- 7. a. Spirituality and Faith
- 7. b. Meaning and Significance of Spirituality in remission and recovery
- 7. c. Initial challenges and fears with spirituality in remission and recovery

- 7.d. Spirituality represents connection with something outside of oneself, providing a sense of comfort and trust.
- 7.e. Spirituality signifies coherence, continuity, synchronicity, and permanence.

6. Spirituality → **Participant 5 (POM05BS)**
- 7. a. Experience of Religion
- 7. b. Questioning religion and faith
- 7. c. Spiritual Beliefs and Values

7. Meaning-Making Process and Sense of Purpose → Participant 1 (POM01ML)
- 6. a. Anorexia gave a perceived sense of purpose in life
- 6. b. Anorexia as an identity Crisis
- 6. c. Developed from Remission and recovery
- 6. d. Former sense of meaning and purpose from anorexia

7. Meaning-Making Process and Sense of Purpose → **Participant 2 (POM02YM)**
- 6. a. Remission and meaning—making
- 6. b. Challenges to sense of meaning outside of Anorexia
- 6. c. Impact of Sense of meaning and purpose with Anorexia
- 6. d. Impact of Sense of meaning and purpose
- 6. e. Remission and Meaning-making process
- 6. f. Remission process instills and provides hope

7. Meaning-making process → **Participant 3 (POM03LT)**
- 6. a. AN self had no meaning or purpose, whereas the recovery self has meaning and purpose
- 6. b. recovery, dimension: growth
- 6. c. Meaning-making with metaphor of recovery and AN
- 6. d. Meaning-making: how it relates to life prior during and after AN
- 6. e. shifts and changes since recovery from AN
- 6. f. impact of AN on sense of purpose and meaning

7. Emergence of Meaning and Purpose in Life → **Participant 4 (POM04BR)**
- 6. a. The need for human connection
- 6. b. Motivation and/or Inspiration
- 6. c. Greatest Barriers to Meaning
- 6. d. Sense of Meaning and Purpose from Remission and Recovery
- 6. e. Former sense of meaning and purpose developed from AN
- 6. f. Influence from remission and recovery

7. Meaning-making process and experience → **Participant 5 (POM05BS)**
- 6. a. What Makes Life Meaningful
- 6. b. Meaning and Purpose since being diagnosed with Anorexia
- 6. c. Impact of Remission and Recovery on Sense of Purpose

Appendix F

Table of Emergent Themes for Each Participant

These tables were shared and reviewed with participants as a way of member checking by getting their feedback on the accuracy of the identified superordinates and emergent themes.

Liesel – POM01ML (Interview 1)
- Before onset and diagnosis of anorexia, she does not remember having issues with eating disorder thinking and/or behaviours - She was previously and still is a perfectionistic person and overachiever - Ulcerative colitis diagnosis and serious digestive symptoms - Continued to experience eating disorder symptoms and behaviours of anorexia after diagnosis of ulcerative colitis - Anorexia went unnoticed by others due to symptoms of colitis - Malnourished due to colitis, but used weight loss and restriction as coping mechanisms - Family, friends, and boyfriend commented on her weight loss. - She continued to focus on her eating disorder behaviours, relating it to colitis with others - Experience with ulcerative colitis and anorexia are blended together - Eating disorder is like a coping mechanism for seeking control - Family identified the eating disorder behaviour and tendency, as well as anorexia diagnosis - Physicians do not receive enough eating disorder treatment training or have the awareness. - Referred and admitted into day Program for eating disorder treatment. - Hospital program was predominantly focused on food with dieticians. - She did not find it helpful or beneficial for her treatment, remission, or recovery - Dissatisfied with hospital eating disorder treatment program. - Family, friends, and partner pleased she was seeking hospital treatment for anorexia. - She used ulcerative colitis as a mechanism and strategy for maintaining eating disorder behaviours like food restriction. - Continuum of remission came at an ambivalent time due to managing colitis and changing eating behaviours - Engaged in eating disorder behaviours like restriction and overexercise - Eating disorder behaviours shifted, but it continued to take up her mind - Exercise compulsion began to take up a lot of her time, and others like family commented on her obsession with it. - Onset of recovery started with no longer dangerously restricting her caloric intake. - A significant shift began for her recovery process during vacation. - Increased self-awareness that eating disorder thoughts and behaviours were no longer health motivated - She began listening to her body and trusting herself by engaging in increased food consumption. - Her mother asked some deep and meaningful questions she remembered during vacation - Reflected on sister's sobriety from addiction and felt inspired. - Real recovery involves having realizations and being completely internally self-motivated - Recovery involves a personal decision and wanting it for yourself

- Attended a program was ABA (Anorexia, Bulimia Anonymous).
- Experienced some benefits from the program, but also some challenges as it focused on cognitive aspects of the eating disorder
- She finally felt she was being honest and initiate insights to maintain her recovery process.
- She educated herself about feminist topics and the societal pressures women experience
- Recovery process involved total acceptance
- Asking questions and challenging statement was helpful for her recovery process.
- She felt overwhelmed and discouraged by ulcerative colitis, so after acceptance it improved
- Recovery process from anorexia also involved acceptance.
- Does not identify as a spiritual person, but maybe some of it was spiritual
- Life was just getting a lot better in all parts of it once she stopped having the obsession
- Recovery was mostly a positive experience
- Relationships make her life meaningful, as well as reading to increase her knowledge and understanding, as well as situating herself in a broader sense
- Although not very spiritual, she was raised Catholic and a spiritual context
- Many times, she has felt like there was a Higher Power
- Meaning in life is related to what gives a sense of purpose
- Intellectual pursuits, family, relationships, and pregnancy give her a sense of purpose in life now.
- Relationships, family, and pregnancy pose some challenges to making life meaningful
- She continues to have negative thoughts, but also has ways to challenge them
- Sense of meaning in recovery has been learning and understanding the broader context of her experience with anorexia
- Understanding and having that knowledge of what has worked has been a source of meaning for her.
- Now in recovery process, she can handle more challenges and became more resilient
- She now sees the bigger picture in the remission and recovery process.
- Frustrated by the lack of resources for eating disorder
- She is happy the eating disorder is in her past, and hopeful that she gave enough information

Liesel – POM01ML (Interview 2)

- From the moment she woke up, anorexia was a constant preoccupation.
- Very unsustainable, repetitive patterns and behaviours that were very rigid and restrictive.
- She would let herself have coffee and diet drinks because they were filling without many calories
- Many rules around weighing herself that included never missing a day, as well as checking to see if she lost and/or gain weight.
- Constant obsessions concerning weight, mirror checking, and appearance which consumed a lot of her time
- Obsession thoughts would be the first thing on her mind when she woke up and throughout the day
- Preoccupation dominated her thoughts.
- Anorexia had the worst and biggest impact on her when it got to be so overwhelming
- Working on undergrad, but she did not have many ambitions beyond that at the time.

- She felt uncertain and discontent in what she was doing with her life in the moment and future.
- Eating disorder was her focus
- She started graduate studies and towards the end of the semester she could no longer do it
- Parents intervened and told her to defer until she felt better.
- Work environment was quite boring, so she had a lot of time to herself
- Time to herself allowed her to focus and obsess on eating disorder all day.

a) Behavior: So sick at the time that no matter her job or situation, she was determined to maintain eating disorder behaviours. The minute she woke up she checked to see if she lost weight.

b) Cognition: Another co-worker had an eating disorder, so there was mutual reinforcement.

- Main focus was preoccupation, obsessions, and rituals (i.e., eating only specific things)
- A grey and dull time with nothing exciting because obsession and rituals dominated her thoughts
- Fixated on all the things that were wrong and what she needed to do to fix them like perceived physical flaws
- Broke up with her boyfriend with no hard feelings, but she was settling because she was focused and preoccupied with other things (cognitions are taking over the affective dimension of her experience)
- She began treatment in the Ottawa hospital and received a note from them.
- The biggest impact of anorexia was when she had to do the day program and drop out of school, which she did not feel bad about
- At the time of treatment, she was aware that she had a problem, but would try to hide eating disorder behaviours
- Coping mechanism of humour
- She was devoted to obsessive behaviours, which were more important than her studies, so was never truly invested or able to enjoy them.
- After getting better, school was no longer an option
- Still working at her job and living at home rent-free
- Part of her recovery has been becoming a less all-or-nothing person
- Did treatment for others because she felt she had to do it; however, shift in wanting to do treatment for herself many years later.
- Did treatment and was semi-better
- However, she continued to have one obsession or another compulsion
- Felt annoyed by the concerns of others and their monitoring of her because a lot of eating disorder behaviours were very secretive
- Did not have awareness that she was not in control of the eating disorder or that it was a mental illness
- Did not want to stop eating disorder behaviours and patterns
- She knew it was not normal, but she did not care at the time.
- Anorexia was not making her happy, but it was truly a compulsion
- Brain was probably not functioning properly due to malnourishment, as she was not eating to fuel her brain
- It was self-training and self-discipline to not act upon eating disorder thoughts

- Thoughts and resultant behaviours that enter the mind now seem irrational.
- She always has a rule for herself to wait another day and sleep on the eating disorder thoughts before acting on them.
- She was trying all kinds of medicine and dealing with colitis at the same time.
- The colitis did not feature as prominently as her obsessions with the eating disorder.
- The eating disorder was her real obsession.
- Colitis controlled her life in many ways due to limitations, but she did not really focus on that.
- Presently, she is in remission from colitis
- Colitis is not dominant, but she knows her energy levels and flare-ups.
- She is better at managing her colitis and has such a level of acceptance.
- She felt very directionless without anorexia
- School was not working out at the time, as she lacked enjoyment, passion, and self-awareness at the time.
- Felt directionless since undergrad, and just doing things she felt she was supposed to do
- Boss at the government suggested she do the master's program, so she did and went through the motion.
- She needed something to focus on since she felt she had nothing else to focus on, so she just focused on anorexia.
- The eating disorder was a distraction and something to focus on
- She had always been a perfectionist, so she does not think the eating disorder caused her to be directionless
- She needed something to focus on since she felt she had nothing else to focus on, so she just focused on anorexia in the absence of knowing what she wanted to do.
- She felt like she was in the wrong life, and felt lost as a result
- Relationship with recovery is very different than with anorexia
- Others are unaware of diet culture conversations, but she is now more aware of it
- Recovery process has played a role in increasing self-awareness
- She does not follow any kind of diet, but does have three meals a day for her recovery
- Recovery process did not impose rules on herself.
- Self-judgment and expectations, as well as self-criticism is a constant for her
- She has been told multiple times that she is very critical of herself (e.g., her mother has said it)
- She does not fixate as much on appearance, but she still feels uncomfortable
- Thinking is now towards more indifference, whereas with anorexia and the sickness she would fixate.
- She strives towards neutrality
- She is still self-critical, but strict with herself in the sense of awareness about certain behaviours
- She asks herself why she is going something and what it is about (e.g., if it is about controlling her body, weight, shape, or size she does not do it).
- Anorexia or other mental health issues are similar to addictions
- Continues to have eating disorder thoughts but does not act upon them.
- She considers herself someone, who just powers through it and had this mindset with recovery

- Downplays experience with anorexia, which is very common in recovery
- To get out of eating disorder thinking and behaviour, it requires so much energy invested in recovery
- Same amount of energy needs to be put into recovery, which was out into addiction or one's disorder
- At a certain point in time, the mindset changes in recovery
- To get better one has to put their energy into recovery that they did for their eating disorder
- At the beginning of the recovery process, she was not putting her energy into it (e.g., Anorexia was still dominating at the onset of recovery).
- Must do something to replace eating disorder type of thinking and behaviour
- Start of recovery had minimal guidance
- Recovery also requires making long-term changes in one's thinking and perspective of things
- Recovery process involves honesty instead of denial
- She feels free from those conversations that are diet culture centered.
- She is annoyed that she feels forced to listen to those conversations

a) Attaining a sense of internal control and agency in ongoing recovery process

- In remission, she strived to have three meals a day, and she no longer has rigid rules round food
- When in treatment at the beginning, three meals a day was a requirement with the dietician
- She feels she no longer got a choice in treatment, and she had to relinquish control.
- Now in the recovery process she has full control
- She is now more aware of her thoughts and behaviours
- She asks herself how she wants to live (e.g., she does not want to have a life restricted by diet).
- Important part of recovery process was more general self-awareness
- Started to challenge her thoughts like should statements and the rules related to anorexia
- Recovery has allowed her to focus on different aspects
- She no longer must focus on what she did previously with anorexia (e.g., she would not be able to focus if she still had rules around exercise and food consumption).
- Recovery gives her more mental energy to devote to other things (e.g., she did not have time to devote to other activities outside of the eating disorder
- She has more freedom in a day now
- Both positives and negatives with recovery process awareness, in which her mindset it is too bad others are not more aware
- She is not angry, but disappointed others are unaware of the recovery process
- Without self-awareness she does not think she would have been able to recover
- Recovery has given her more awareness
- Recovery process was self-directed and self-motivated for her
- Awareness was not formal through therapy or treatment at the program (e.g., if others educated themselves, it could be beneficial).
- Awareness from recovery gives her a sense of meaning, as she can reframe her thinking
- Both negative and positive aspects to it.
- Positive in the sense that she is a healthier person and able to connect to others better

- Negative aspects to recovery process in the sense that it separates' her from others due to their lack of understanding
- Acceptance about how things are in the moment or day, and not dwelling so much
- Since becoming pregnant she is a lot less critical of herself
- She is a lot less critical of herself, but she does not know why.
- Prior to pregnancy, she scrutinized herself.
- A lot of promotion around body positivity and acceptance, but she does not think that is a solution.
- Neutrality is important for recovery
- She is more sensitive because of the experience with an eating disorder
- She is more aligned like a healthier person with disordered eating or thinking
- She does not believe there are many people, who doesn't have body image issues or obsessions
- She is more aware of obsessions, but it does not affect her.
- Recovery process involves being more present in life
- Being present in the moment and what she is doing; although it is not perfect, there is a lack of mental distraction from anorexia
- Previously she had rigid rules on herself around being perfect of appearing a certain way.
- Rigidity was very unhelpful for her and prevented her from having real relationships and experiences
- Physical appearance is no longer her focus, but rather her actual activity is her focus\Sense of purpose has come from learning more about other topics not just limited to eating disorders (e.g., Learning about feminist perspective has been impactful for her in increasing knowledge and awareness).
- Recovery is like freedom
- She is free to focus on her life, and what interests her
- She is free from the rules of anorexia, and can just live her life
- Recovery gave her a sense of meaning and purpose from the freedom it provided her in life.
- She wants to give other people that freedom, who are in remission and recovery from eating disorders
- The real meaning, she received from recovery is the freedom to live her life and no longer being restricted by anorexia.
- Relationships give her a real sense of meaning
- Acceptance is an important part of her meaning in life
- Living her life in the present moment are important for meaning
- Acceptance and presence, and being aware
- Ability to reframe things, which is part of getting healthier mentally and emotionally
- Recovery process was not about diminishing or minimizing her experiences, but having a more realistic view of her life
- That helps her a lot with colitis as well, which is something chronic she will have to manage
- Changing mindset and perspective, as well as acceptance of her situation
- An important part of recovery is being in the present, as well as wanting to be comfortable with herself and reflecting on her life.
- She has not had a lot of spirituality in her recovery
- Recovery process has been more on connection and authenticity with herself

- She is not familiar with the term remission and recovery, which seem to be very medical terms to her
- In her experience, people in recovery from eating disorders experience relapse
- An eating disorder is a lifetime thing, so it is hard to believe in remission
- Recovery is an active process
- She thinks she is kind of recovered because of a result of a lot of active eating disorder behaviours she continues to do
- She knows that she does not want to engage in eating disorder thoughts or behaviours
- With pregnancy there are more judgmental statements
- She is unsure about if she sees herself as a spiritual person
- She does not think we know enough to say if God or another realm exists
- She was raised Catholic, so it is not that she did not believe in God, but she did not question it.
- She is open to a different kind of reality or truth
- She is open, but questioning the existence of God
- Spirituality was a stumbling block during her recovery process because of the way it is framed
- Treatment framed religion into the process, which was challenging
- For those without a strong belief in God, it does not resonate with the
- For her, recovery include focusing on the world and how it functions with nature
- The language around God and religion, as well as framing around that did not help her
- She is open to the possibilities (e.g., in the absence of certainty or answers, she is focused on living her life).
- She does have moments, in which she does have a feeling of there being something greater than herself

Liesel – POM01ML (Interview 3)

a) Anorexia as an identity Crisis

- Anorexia was the manifestations of many aspects building up in her life, like risk factors of perfectionism
- Reflecting on her life now, it makes sense the manifestation of anorexia
- There were a lot of risk factors such as being perfectionistic and a higher achiever
- Anorexia was a wakeup call for her to make changes in her life, which took time for her to move away from it.
- She had to let go of perfectionistic tendencies
- As she reflects back, she sees so many positive to letting go aspects of anorexia
- Colitis has not gone away, but she has learned to manage it
- The eating disorder she is unsure if it will ever fully go away.
- Recovery is a very gradual process
- She does not have compulsions around restriction, but she still experiences eating disorder thoughts
- She still has some thinking patterns and compulsions around exercise
- Although she does not always have to deal with eating disorder thoughts, she must be on guard for it to support herself
- She knows many people, who have struggled with recovery and relapse for decades

- Eating disorders are a mental illness, so she questions whether one gets rid of it.
- As someone who has experienced anorexia, she does not see it as a positive or negative
- Sees anorexia as both positive and negative

a) Evolvement

- She has a lot of resilience now, as she is able to cope more with stress
- She has experienced adversity, so a level of resiliency and acceptance as well
- Anorexia brought a lot of positives into her life such as connection with other people
- She has experienced people being very accommodating, helpful, and caring about her situation with anorexia and recovery (e.g., there was much more exposure to kind people).
- As someone with anorexia, it had some positive impacts on her life (e.g., allowing her to see and receive compassion from other people)
- In relation to anorexia, she is a lot more compassionate, softer, and empathetic for those struggling with eating disorders

b) Languishing

- Life would be better if she had not experienced anorexia, as she would have been more productive and focused
- Anorexia somewhat derailed her for a while, as she would have finished school earlier, as well as had healthier relationships
- It is not the same with colitis, but it has also been very difficult for her family.
- Colitis was completely beyond her family's control, but easier to understand the physical illness
- An eating disorder was harder to understand
- Experience with anorexia and all the time and energy she devoted to it was shameful in a way.
- Anorexia derailed her and she felt that she was drifting
- She was unable to devote time, focus or energy to a path because of anorexia.
- Timeframe was not only affected, but also her personal disposition
- Her weakness of perfectionism and being self-critical has harmed her, but it has also contributed to other things like being a good student.
- She sees both sides of positive and negative aspects from anorexia.
- It is hard to image her life without having experienced anorexia
- It is difficult to say if her life would be better if she had not experienced anorexia
- People encounter almost an identity crisis at the beginning of recovery.
- She questioned who she would be without anorexia and kind of had an identity crisis
- The big step in the recovery process was being able to let that go

a) Phrases and words for remission and recovery process

- She is more present now
- She was putting so much energy and focus into other aspects of her life now and less into the eating disorder thinking or behaviours

b) Recovery process and impact on shaping values

- Recovery process requires you getting to know and figure your identity out
- It is more of a process of letting go and seeing what is still there
- Recovery process was initially effortful but was a gradual process that occurred with time.
- Recovery process was more a feeling of relaxing
- Recovery process involved stopping the whole striving, effort, and trying

- Eating disorders are an unhealthy part of a person and who they are
- Being able to be present in yourself, the world, and situation
- Acceptance
- Body positivity
- Acceptance is a big one
- Remove yourself from negative thinking
- You're in your life, and in the present moment
- You are just being with people and living your life.
- Stepping outside of self-objectification
- Recovery process is hard and not easy, but necessary for one's sanity
- People intellectually might understand, but she thinks emotionally and experientially one needs to understand recovery
- Anorexia takes hours of energy and focus, which is a waste of time.
- Recovery has to resonate with you to actually make changes
- Others with anorexia are powerless
- For her, it was being confronted by the consequences of anorexia
- She thinks it will be hard for others trying to treat individuals with eating disorders
- Treating eating disorders is a hard endeavour because providers cannot make those with an eating disorder see reality
- Recovery has to be internal
- There are many misperceptions with eating disorders.
- Recovery means you're getting better, and it is a paradigm shift
- Self-compassion is also helpful for recovery

a) Developed from Remission and recovery

- She thinks she is a feminist killjoy, and loves being once because she identifies with it.
- Feminist approach can provide peace of mind, a sense of happiness and pleasure, but also exhaustion having to challenge others in society
- Feminist convictions are important for her, and an internal process
- Feminist approach and convictions requires an awareness of internal conflict she has about them.
- Notion of responsibility for feminist view and convictions
- Strives towards being honest, and others thank her for the honesty
- Authenticity and honesty are important to her, and she cannot relate to others when they lack them
- Recovery has taught her the importance of acceptance, which has helped with her sense of purpose
- Recovery has demonstrated the purpose of not being obsessed with trying to achieve things.
- Being present in her life is enough of a purpose
- Recovery has involved being accepting about the uncertainty of her purpose
- Acceptance towards the ambiguity
- Maturity involves accepting ambiguity and not needing to know everything
- Recovery has conveyed the importance of trying to be flexible in life
- She feels more resilient since the recovery process from anorexia.
- She had a lot of faith in herself while writing her thesis
- She had faith in herself despite feeling frustrated at times

- She has a sense of agency since experiencing the recovery process from anorexia
- Her life has been filled with challenges, so it has impacted and increased her sense of resilience
- Recovery has allowed her to focus on devoted her time to internal focus
- Recovery has given her so much freedom and mental space for other aspects
- Recovery has shifted her sense of focus
- She now knows happiness has nothing to do with her physical appearance
- Now she is at her highest weight and extremely happier (e.g., she cannot even measure her happiness)

b) Former sense of meaning and purpose from anorexia

- With the eating disorder she was never fully satisfied
- Purpose was focused on controlling her body, weight, shape, and size.
- Purpose was mostly unrealistic with the eating disorder
- With anorexia, you do not see how sad and pointless it is
- She was more miserable with her body when it met societal standards
- She was not happy with her body at the time when she had anorexia
- The lowest weight gives someone a miserable existence
- One might not believe it because they have not experienced what it is to let anorexia go
- Negative thoughts and self-criticism require challenging them and poses reflective question
- Shame never motivated her, and it never motivates anyone to change
- Shame does not motivate people to change or do positive activities
- Spirituality is about being present and perceiving reality in the moment
- Spirituality is defined as connection, feeling or belief in something greater than yourself.
- She does have a sense of some larger principles that guide the world and universe due to her understanding of religion
- She was raised Catholic and has read the Bible many times
- She never felt restricted by spirituality in the recovery process
- Acceptance is an important part, and not having to fight or struggle with everything
- Authenticity, self-awareness, genuineness, and honesty is a kind of spiritual practice for her.
- Self-assertion and acceptance about her thoughts and feelings in disagreements is important to her now
- Acknowledging feelings involves acceptance and honesty
- Anorexia is very disproportionate due to cognitive distortions like all-or-nothing, and black and white thinking
- Recovery involves admitting wrongdoings and being in alignment with self-needs and goals.
- Anorexia has self-hatred, but you do not think anything is wrong with it or know it at the time
- There are no boundaries, perspective, or sense of reality with anorexia
- Considers herself a spiritual person

Lotus – POM02YM (Interview 1)

- Anxiety prior to the onset of anorexia due to feeling lack of internal and external control from feeling unsafe.
- Internalized lack of control and determined she could control food.

- Struggled with eating disorder behaviours for 5 years before being officially diagnosed.
- Did not understand what an eating disorder meant or grasp initial diagnosis of anorexia.
- Hated initial diagnosis, and was secretive about behaviours and symptoms
- Felt control would be taken away from her after secret was exposed.
- Hospitalization felt like imprisonment, and she hated being in the hospital and having coping skills and devices – whether unhealthy or not – taken away from her.
- Felt lack of control and wanted to be alone on her own.
- Anorexia felt like her best friend at the time and provided a sense of false security.
- After receiving diagnosis family was in a state of chaos, and parents were emotional, and she was unable to connect.
- Felt awful that her secret was exposed
- Although not close to her family, knowledge of diagnosis to others felt like a weak spot and upbringing was lonely.
- Experienced physical, emotional and psychological abuse.
- Disconnected from her mother, as she feels unliked by her and did not receive love or affection from her as a child.
- Always alone, so anorexia provided a perceived sense of fulfillment.
- Anorexia kind of filled that sense of internal emptiness.
- Bullied during youth from peers due to albinism (e.g., called cruel names), and unsupported by teachers and lost trust in adults as a result.
- Isolated and did not have friends, so she kept to herself.
- Remission and recovery are not linear at first, but with time seemed more natural.
- Continues to have frequent eating disorder thoughts, so she does not know if she can ever say she is fully recovered.
- Thinks she can always relapse and engage in eating disorder behaviours (e.g., restriction, purging).
- Realized in remission when she no longer needed food for internal or external control and no longer scared it.
- Maintenance of remission and recovery is a hard process, and she had initial doubts.
- Took a long time to realize that she does not have external control but does how internal control by how she reacts to things.
- Becoming emaciated to distract others from albinism.
- Although she has had no behavioural symptoms, she continues to struggle with eating disorder thoughts in recovery.
- In remission she decided to start building a life worth living.
- Stepping away from the illness and moving towards remission by doing activities in life that gave her joy.
- Building a life worth living
- Relapsed many times over the past decade.
- Mother was more kind during recovery, which created confusion after the abuse experienced with anorexia.
- Stronger since remission and recovery; no longer easily triggered or sensitive to things, so she can cope more positively situations without relying on eating disorder symptoms
- Attended college during remission and had a positive experience.
- Confirmation of being good at something other than anorexia makes her feel more alive.

- Eating disorder no longer provides a sense of worth or control.
- Replaced the symptoms of the illness (anorexia) with something positive – passion for school.
- Studies conveyed how extremely compassionate, empathetic, and passionate she is outside of anorexia.
- Eating disorder community can be negative and toxic; therefore, she had to sever ties.
- During recovery, realized she could have friends and experiences with different things and other people.
- Helping people makes life meaningful, and experiences joy when around and supporting people she cares about.
- Support she received as a youth in treatment saved her life.
- She wanted to be there for others as well and as a result.
- Always felt compelled to help other people even as a young child.
- Disability of visual impairment challenges sense of meaning now, which is helping others.
- Feeling criticized by others for visual impairment was awful
- Supervisor for school placement in child and youth work felt uncomfortable with her doing work due to her visual impairment, in which she was devastated by the comments.
- Nature gives her a sense of purpose
- Didn't really look at the world when grappling with eating disorder, as all she could focus on was food.
- World did not have colour to her in the depths of the eating disorder
- Seeing and noticing the world signified remission
- Losing her father would challenge sense of purpose.
- Nature is also important for her father, so they spend a lot of time together in nature.
- Education is something to make her life feel meaningful.
- Knowledge and learning contribute to life feeling and having more meaning.
- Education is a purpose and a steppingstone to getting what she wants in life.
- Education involved in choosing remission and recovery was connected to wanting to do something with her life.
- Felt compelled to do something meaningful on earth.
- Childhood trauma, particularly sexual abuse made her feel there was no meaning.
- Disconnected her from the world for a long time.
- Albinism also challenges her sense of meaning, as she experiences judgment and disengagement from others for the disability
- In light of judgment for visual impairment, she has other heightened areas and skills.
- Doubted herself for a long time due to others doubting her, and perceived the whole world doubted her.
- Increased self-awareness in trusting her own abilities.
- Worked hard at self-compassion and self-love in therapy.
- Shifted into self-love and self-care during remission.
- Self-criticism shifted and challenging cognitive distortions.
- Family and her father are very important.
- The hurt in his eyes from the eating disorder motivated remission and recovery.
- Losing father would challenge meaning and importance in her life.
- Father understands her and is consistent, as well as a source of support

- He saw her potential and skills, seeing her as a person beyond anorexia.
- Father understood the eating disorder did not define her; specifically, he understands that she did not choose to have an eating disorder and it was not her fault.
- Father is confident in her abilities, and he really motivates her
- Going back to school and seeing the positive aspects of things.
- An emotional connection and trust with him, as he is both maternal, paternal and her best friend.

Lotus – POM02YM (Interview 2)

- Anorexia involved consistent obsessions and rituals
- Weighing herself multiple times a day and over, starting the moment she woke up as well as over exercising
- Routine rituals to get through the day (e.g., less food restrictions compared to diet drinks and coffee) – feeling of control.
- Started binging and purging in addition to anorexia rituals /behaviours
- Anorexia, eating disorder thoughts and behaviours are irrational.
- Despite hospitalization that sought to minimize symptoms, she found other ways to restrict, binge, purge, and over exercise.
- Symptoms and behaviours were endless, so she was unable to stop.
- Anorexia was a love-hate relationship, whereas remission is a confusing one.
- Confusing aspects of remission include different behaviours and lack of self-trust.
- Remission is state of trying to figure things out in a way, which is a lot more peaceful.
- Not concerned or fixated on eating disorder thoughts
- Remission had the greatest impact in relation to school and realized full remission when the passion for studies was much more noticeable
- Remission has increased sense of compassion and understanding not only for others, but also towards the self and she is no longer blocked by the eating disorder.
- Increased awareness of self-needs.
- Others who struggle with eating disorders in the depths of it, it is not purposeful (e.g., they grapple with isolation, and concern of the self and not others).
- Changes in sense of purposes since remission and recovery.
- Now she feels she has a purpose outside of anorexia
- Emptiness with anorexia but feeling consumed by it at the same time.
- Anorexic-Self constantly felt lonely and empty.
- Ongoing Recovery-Self feels whole and connected to others, as well as more comfortable being alone.
- Days where Ongoing Recovery-Self still feels like Anorexic-Self, but in waves.
- Ongoing Recovery-Self does not engage in symptoms from feelings of loneliness or emptiness but is reminded of the Anorexic-Self.
- Anorexic-Self created a distance from treatment supports, and resultant disconnection.
- Remission initiated connection and no longer pushing supports away.
- Recovery occurs when one is challenged in the ‘real world.’
- Remission is being triggered and facing them, as well as challenging them, which leads to recovery.
- Confronting challenge is very difficult due to underlying issues of eating disorder

- Society in general is scared and uncomfortable with difference due to uncertainty of what to say or do.
- Continues to struggle with the fact she is disabled and visually impaired.
- Does not want others to see her that way; therefore, she consciously has to separate the eating disorder from her disability
- Back to being healthier since recovery with Ongoing Recovery-Self is more energetic and able to communicate with people
- Back to being healthier since recovery
- Spirituality means deeper connection
- Lost spirituality with Anorexic-Self, but regained it with Ongoing Recovery-Self
- Felt more comfortable in nature and alone, so part of self-care is to connect to Earth
- Spiritualty and nature allow her to feel grounded and that she has a purpose.
- Lost connection to spirituality and nature when experiencing anorexia.
- Ongoing Recovery-Self wondered what would happen at the onset of remission
- Art was helpful in identifying and expressing thoughts and feelings for Ongoing Recovery-Self
- Ongoing Recovery-Self initially questioned the remission and recovery process.
- Questioned the recovery process at the beginning, including if recovery was meant for her, so she reminded herself that she could always return to Anorexic-Self
- Continues to question recovery process, and is therefore still experimenting with recovery
- Ongoing Recovery-Self is open to new things and likes to change (e.g., more participation with others like family and friends)
- At the beginning of remission and recovery, recalls going to restaurant.
- Attending school and making new friends.
- Ongoing Remission-Self provided permission
- Remission and Ongoing Remission-Self gives her hope
- Remission ignites hope, as well as happiness of survival.
- Wakes up with hope for the day, plans for the next day and an ability to fulfill them.
- Treatment is often focused on eating food and being medically stabilized, so a lack of therapy in treatment, as food is just a symptom of an underlying issue.
- Treatment often overlooked the causes of development for an eating disorder, which leads to high relapse number
- Treatment at the hospital did help by giving her some skills and a healthier state physically, but it was individual therapy that really helped.
- Able to use the DBT and CBT skills from the hospital to cope with distress
- Trauma therapy provided a light bulb moment when she was able to deal with it in sessions
- Recovery is possible to a certain extent; she had a shift in realizing that recovery is possible after realizing through discussions how far she has come
- Does not want her struggles to go to waste and wants to help others if possible, so she chose the mental health profession because she understands from experience and wants to help others

Lotus – POM02YM (Interview 3)

- Anorexia controlled her life, played a role as a coping mechanism and she felt less alone
- Eating disorder was so consuming, to the point she could not control herself

- Presently, when feeling loneliness some days starts thinking about the eating disorder.
- Anorexic-Self filled up that time and emptiness.
- Ongoing Recovery-Self feels awful now when feeling a sense of emptiness.
- Anorexic-Self was not friends with herself, so eating disorder presented as one.
- She hated herself, so she thinks the eating disorder was there for her.
- Experience of Anorexia was positive, as she learned more about herself.
- Feel stronger after experiencing and overcoming an eating disorder.
- Increased self-awareness and insight, as well as it taught her that she is patient.
- Passionate about helping others, and fostered empathy.
- Ongoing Recovery-Self has been introduced and opened up to a whole new world.
- Anorexic-Self shaped her into the person she is now, and led her to a career she is passionate about
- For a long time, anorexia was her identity.
- Ongoing Recovery-Self had to distance herself from the Anorexic-Self.
- Required letting go and self-discovery, whereas the process of letting go is still ongoing
- Ongoing Recovery-Self is unsure of who she is without Anorexic-Self, so she is still exploring remission and recovery
- Experience of remission invites her to see herself as a strong person.
- Able to cope and challenge triggers since remission.
- Things would have led to relapse in the past, but since remission she has grown a lot stronger.
- Feels like a waste of time if she were to let go of the past two years of remission and recovery work.
- There is a distance now between Anorexic-Self and Ongoing Recovery-Self.
- Ongoing Recovery-Self sees herself as more worthy of remission, and respect from others; therefore, creating more boundaries, self-care, self-awareness, and assertiveness.
- Anorexic-Self was punishing herself in a way (e.g., She didn't care about herself or love herself when she struggled with anorexia)
- Longer pause to deeply reflect on responses.
- Metaphor of foggy glasses with Anorexic-Self and clearer vision with Ongoing Recovery-Self.
- The more distance from symptoms, the clearer she can see herself and identity.
- No matter how hard it is or how lonely and awful one feels, remission is worth it.
- Remission takes time, but people are there, who love and care about you.
- For some, remission happens in a light bulb moment, but it can and does take time for others.
- Remission was a process, which took treatment, time, and therapy to shed some of that layer of self-hatred and pain.
- Metaphor of recovery journey being a puzzle.
- Remission involved finding those puzzle pieces and putting them together to get closer to the full picture.
- It is different for everyone but finding and putting the puzzle pieces together is scary.
- Impact of an eating disorder allowed her to realize she does not need to fit into the world.
- Being unique and different is cool, as well as being her Ongoing Recovery-Self is cool.
- Societal pressures of body-image are still present and triggering for others in the eating disorder community; but she no longer lets that impact Ongoing Recovery-Self

- Ongoing Recovery-Self considers rejection of others as their loss.
- Huge mental change and shift in the brain since Ongoing Recovery-Self.
- Relates to self-love and self-acceptance, while remission has given her more hope.
- Anorexia and remission itself could be her purpose.
- Using experience with anorexia and remission to help others.
    - Empathy
    - Self-disclosure
    - Gratitude
- Grateful for experience with anorexia and remission
- Gratitude has been important and positive in keeping her inspired and motivated.
- Spirituality allows her to see the good in life and the positive, which also protects her against slipping back into depression.
- Remission has enabled her to seek purpose through her education and goal of helping others.
- Replaced the Anorexic-Self with something more important to her and the Ongoing Recovery-Self.
- Respect for others and self-respect is very important to her, while self-care is also important and socialization.
- A deep thing, which is unrelated to religion without judgment or assumptions.
- Nature is particularly important and being surrounded by it.
- Being present with and for others as they are in the moment.
- Spirituality is a deep thing, which involves letting the life flow and move around her.
- Still felt there was a purpose on Earth despite grappling with anorexia, which led her into remission.

Rose – POM03LT (Interview 1)

- Isolation and subjugation of her own needs
- Coping with change and ambiguity
- External sense of agency
- The importance of pleasing a 'loved one' even if this means lying to oneself
- Reacting to change by forgetting about oneself
- Deceiving oneself and not giving herself a voice
- Pleasing a loved one (partner):
    - dieting and exercising
    - had never dieted before
    - losing weight
- Dieting as mechanism for inner agency and control
- Not eating as a way to regain control over her life
    - but it was the only thing I had control over for sure, at the time…
- Disbelief, surprise, and difficulty to accept diagnosis
- Diagnosis as incongruent and syndrome as incongruent with self
- Preconception of Anorexia
    - Young girls who have problems (corresponds to the disbelief)
- Anorexia as undesirable diagnosis

- One associated to immaturity, which does not correspond to how she experiences herself: "Oh, it's not me"
- Starts to doubt she may have AN
  - Googling information
  - A competition with myself
- Depression and anxiety as a way of coping with changes
- AN as passive suicidal ideation
- Denial of symptoms
- Need for validation by pleasing others: a need for others to confirm her own existence
- Onset ascribed to coping with loss/ difficult feelings
- Depression and change, as well as lost sense of self
- Eating disorder as mysterious, as well as a situation to be controlled (as opposed to cancer)
- Discomfort with ED and AN diagnosis
- Being AN and being unique, as well as accentuating late onset
- Uniqueness of late onset of the anorexic experience, and helpfulness
  - Refers to Anorexics as "these people" …
  - Being different from younger anorexics: "everything was different
- AN as providing connection with others (her brother), as well as unrealistic expectations of the self (both participant and brother)
- Continuum of perceived severity of anorexic symptoms
- Anorexia as a physically starving self, as well as a 'special' self and going beyond the earthy need of eating
- Anorexia as a form of passive suicide

a) Influence of food prior to AN

- The importance of food in her family:
  - Her father's love of food; her mother being an amazing cook
  - Everyone in the family being thin
  - "Felt a bit pudgy" late teen, early 20, but did not act on it
- Food as celebrated and providing familial connection
- Disbelief and sense of incongruence, as well as feelings of weakness and immaturity
- Deceiving oneself by not acknowledging needs, accompanied by feelings of helplessness and unhappiness
- Being surprised that family members and her psychologist's perception of her is different from her own
- Lack of insight into who she is/the self, so anorexia and external validation
- Traits of Anorexia:
  - Perfectionism
  - Dichotomous thinking ("all-or-nothing thinking)

a) Anorexia as an entity or feature that accompanied her

- Anorexia as a state of being and as a way of thinking
- Not knowing oneself (before dx) (which would explain her surprise of being dx with AN and being told she is a people please

b) Anorexia as an experiential means to find herself

- Not giving oneself a voice
  - Not being able to say "no"

- Anorexia and a sense of regression in life, so it becomes the focus
- Filling a void of meaninglessness with AN as modality and a way of being
- Identified using food to help cope with stress, but not in a restrictive or symptomatic way.
- Came to realize she was in recovery by pie chart exercise and worksheets.
- She was no longer experiencing eating disorder thoughts anymore.
- After recovery and remission, she created a distance from her experience with AN and did not want to discuss it with others.
- Recovery and remission process involved disinterest and distance with AN
- Fearful that experience with AN would define her and accompany her even after remission and recovery.
- Eating disorder behaviours and tendencies are removed from her in remission and recovery.

a) Remission and recovery initial experiences

- Filling a void of meaninglessness with AN as modality and a way of being
- Remission and altruistic organ donation
- Remission and regaining a sense of ownership over one's body
- Group therapy helpful in reframing negative thoughts related to AN and weight gain in recovery.
- Group therapy helpful in providing skills, insight, and perspective in remission and recovery from AN.
- After remission and recovery, she lost interest in AN and/or discussing it.
- After recognition behaviours and thoughts were indicative of AN, she did some reading and did not want to be like that.

a) Remission and recovery mindset versus the Anorexic cognitive characteristics

- No longer internalizing potential eating disorder thoughts or labels.
- Protecting herself from the frame of mind of negative self-image that led to the onset and development of AN
- Comments about food during recovery distressing and aggravating
- Anorexic mindset fixated on using the scale to check weight to ensure weight loss.
- She no longer weighs herself, doesn't own a scale, and is unsure of average weights of people.
- Looks at scales for functionality and practicality now in remission and recovery

b) Impact of stress since remission and recovery from Anorexia

- Experiences stress, but it does not challenge her sense of purpose.
- More engaged and focused on self-care, self-growth, and personal needs.
- Stress triggers fixation on other areas in life and no longer eating disorder tendencies
- Stress leads to loss of appetite and not intentional self-starvation due to anorexia.
- Intentional decision of letting things go and doing it
- Taking self-responsibility to take responsibility for aspects of her life that are within her control
- Remission and recovery involved self-responsibility, as well as identifying goals and strategies of how to achieve them.
- Sense of purpose involves connection to others like family and friends, including helping behaviours (altruism).
- Now has an overarching sense of purpose, in which she feels more connection
- Does not force connection or strive, but rather lets it naturally grow.

- Identifies as fairly spiritual and letting go of perceived religious expectations.
- Sense of genuine connection leads to striving for purpose and meaning.
- Sense of purpose involves connection to others like family and friends, including helping behaviours (altruism).
- Now has an overarching sense of purpose, in which she feels more connection.
- She did not have a sense of meaning or purpose with anorexia.
- Life became very bleak, gray, and colourless when she experienced anorexia.
- Came to realization of self-knowledge and self-trust
- She feels she has meaning in a broader sense
- Making peace with decisions and life in the present moment.
- Remission and recovery have given her meaning the way she has it now.
- In remission and recovery, she now cares about things in her life, so she does not want to lose what she cares about or what gives her meaning
- No longer fixated on people pleasing, increased happiness
- Identifies increased meaning with personal satisfaction, enjoyment, and happiness.
- Describes meaning and purpose in life with personal enjoyment, satisfaction, and happiness
- Realization of different opinions and self-knowledge and authenticity is freeing.
- Truly freeing and liberating to have choices for meaning and purpose

a) Identification of what brings her meaning and goals have led to increased awareness of meaning in life since recovery and remission

- Staying in the present moment increased meaning in life, as well as contentment and comfort.
- Identifying goals, objectives, and ambitions leads to contentment, as well as increased meaning and sense of purpose in life.
- Every day hold meaning, as well as her own larger goals.
- Part of Anorexia included wanting to disappear, but now in remission and recovery she feels completely different; for example, she thinks and feels in terms of enjoyment, fulfilment and meaning.
- Markers in life are different since remission and recovery
- Decision for organ donation was a personal decision and she donated an organ because she wanted to do it.

Rose – POM03LT (Interview 2)

- Combination of depression and anxiety
- Fixated on eating disorder thoughts and behaviours.
- Attempted to find activities for distraction, and forced herself to eat
- Symptoms were restriction, over exercising, and fixation on body image.

a) Feeling uncomfortable in her own skin

- A stay at a friend's cottage, lost a great deal of weight, led to increased sadness, negative self-talk.
- Before diagnosis she felt trapped in her own body and incredibly uncomfortable in her skin, which was an awful feeling (repeated x 2)
- Anorexia as awful, it was just awful.
- Self-critical with negative self-perceptions

b) Becomes enslaved to anorexia

- The anorexic self was engaged in an internal war.
- Fighting herself from within and feeling like a shell.
- Depression was experienced for a long time in the midst of anorexia.

c) Anorexia was part of her personal identity

- As anorexia progressed, she functioned less and less.
- Anorexia was another part of her, and it was part of her identity
- The recovered self identifies with the anorexic self in the past, so she no longer sees it as an ongoing struggle.
- Read a book "the Golden Cage," which she found very helpful since it was relatable (perfectionistic and obsessive tendencies)
- She identified with a description of anorexia that made sense to her.
- Focused on not entering negative path of anorexia.
- Missing meals was very stressful.
- Regression into symptoms (e.g., restriction) made her perceive she ruined the day.
- She can now create a distanced from the anorexic self.

a) Challenging to reflect back on the Anorexic-Self

- Unaware of when she was suffering from it the most when she had anorexia.
- Anorexia became a low point in her life (e.g., there was no enjoyment and just feelings of sadness and dread); therefore, the period remains a blur of unpleasantness.
- Being more self-aware and comfortable
- Hope and meaning flourishing and emerging, waking up in the morning and looking forward to the day.
- Feeling vibrant in recovery
- No longer consumed by food in a punitive sense, but rather the kind of food she wanted to try and the activities she wanted to do.
- The recovery-self is vibrant and reconnect with herself and others.
- She was a person outside of anorexia, and there was a personal self and not merely an anorexia self

a) Anorexic-self contrasted with the Recovery-self

- The anorexic self was characterized by feeling dead inside and hopelessness, as it was obliterating herself.
- The anorexic-self felt selfish and self-involved, but the recovery-self is more compassionate.
- The anorexic-self missed so much, due to the illness; therefore, the recovery-self wanted to make up for lost time.

a) Recovery enabled her to return to Setting and Establishing Goals.

- Recovery involved being acquainted and connected to herself again.
- Recovery had the Greatest Impact on her Life when she was able to donate an Organ
- She had to disclose her medical history with an eating disorder and was still able to go forward with the organ donation process.
- In preparing to donate, she was eating healthy, and recalling how she would not have been able to do that beforehand with anorexia.
- Our bodies are much stronger than we think, and these are the benefits of recovery.
- Significant aspects of enhancing recovery
- Perspective and balance since recovery
- Part of recovery involved finding balance

- Group therapy and participants, with different experiences and circumstances still allowed her to feel understood and affirmed.
- Influential in supporting remission and recovery, which instilled and provided a sense of hope for remission and recovery.
- Seeing other participants striving for recovery assisted her in seeing and addressing challenges or stressors differently.
- Group therapy and insights obtained instilled hope, which gave her perspective and hope.
- Whole life felt consumed by anorexia (e.g., emotionally, physically, and psychologically).
- She did not have a sense of purpose with anorexia, as she was "mired in it"; to be involved in a difficult situation, especially for a long period of time.
- She did not want to be there when she had anorexia, which suppressed any sense of meaning or purpose.
- She has goals that she wants to achieve instead of the anorexic-self goal of being sick the recovery-self goal is to overcome it.
- There was no purpose with anorexia, as there is nothing to achieve because it is fatal.
- Experiencing indicators of meaningfulness differently since remission and recovery
- What gives a sense of meaning has shifted since remission and recovery
- Shift in meaning since remission and recovery.
- Shifted from "I should" as anorexia necessitated to more freedom and flexibility with recovery to have meaning.
- Anorexia took away meaning, whereas recovery permits striving and a sense of arrival.
- Found meaning in her struggle with anorexia and being able to empathize with other group members.
- Recovery and remission were an internal process, in which recovery self was marked by exploration.
- Improved perspective since remission and recovery from anorexia
- Relapsed and found it frightening, but used strategies learned in group therapy.
- Uses the past tense to describe that she went through an eating disorder
- Relapsed and found it frightening, but used strategies learned in group therapy.
- Used cognitive reframing to assist her all-or-nothing thinking.
- Positive reframing that it was just a bump in the road.
- Referred to coping strategies learned in treatment.
- Cognitive distortions with anorexia consumed her past, present, and future.
- Recovery gave space to create a framework for meaning.
- In recovery, no longer thinking about food, worrying what others thought or consumed by negative self-talk.
- Recovery gave space and time to reflect on what she would like to do with her time and experiences.
- Finally had space to engaging in meaning thinking and activities, as no longer engaging in eating disorder thoughts or behaviours

a) Changes and progress since recovery

- Remembers experience with anorexia and the hardships but honours how recovery has shaped her moving forward.
- Recovery gave time and space to look back on different experiences – negative and positive – and shape meaning from it.

- Recovery has allowed her to connect the dots and shape meaning from the experience with anorexia.
- Identified and honoured her own wants and needs.

b) Recovery with increased self-awareness and insight

- Doing activities, she enjoys that is what gives her a sense of meaning and purpose
- Identified and honoured her own wants and needs.
- No longer self-sacrificing or people pleasing.
- Anorexia was not allowing herself to give herself what she needed.
- Realizes that connection with anorexia, in which you deny yourself of what you need (e.g., food)
- Restricted not only food she needed, but also people and relationships.
- Anorexia and those patterns were self-destructive.
- Recognizes in recovery presence of a lot of willpower.
- Uses determination and willpower constructively in recovery instead of using self-destruction like she did with anorexia.
- Anorexia was a form of suicide due to self-starvation and potential organ failure.
- Identified as religious and Catholic growing up
- Positive experiences during her childhood
- Identifies religion as inducing guilt (e.g., classic Catholic guilt).
- She still identifies as religious, but has shifted her practices
- Engages in Bible study with a friend and believes in God
- No longer a desire to go to structured religious place of worship or mass
- Defines religion as value-based by being considerate and thoughtful.
- Making her own decisions about how to enhance her faith.
- Does not see God having a part in human suffering, which gives her a sense of meaning.
- Importance of being open and nonjudgmental and focus on doing one's part.
- Spirituality represents openness, colour, compassion and understanding.

a) Bible passages were significant for her recovery

- Does like to read Scripture and reflect on weekly reflections and how to carry them out for the ongoing recovery-self
- Biblical passages from Psalms and Proverbs were particularly helpful.

Rose – POM03LT (Interview 3)

- Anorexia is something that is past and no longer a part of the self or her identity.
- Anorexia no longer takes space in her mind, so detached from the anorexic-self.
- Ongoing-recovery self no longer gives anorexia space in the mind.
- Differentiation of *having* anorexia and *dealing* with an eating disorder

a) Anorexia: Ambivalence of learning experience

- Still might experience and feel negatively about certain aspects of her body and self-image.
- Anorexia as an experience and learning experience.

b) Concealing experience and label of Anorexia

- Anorexia was part of the identity when was during it, so anorexic-self when she was actively engaged in the disorder.
- Protecting herself from having to explain to others, as well as protecting herself from shame
- Ongoing-recovery self is protective by suppressing history with anorexia.

a) Positive aspects of learned from experience with AN

- Adds more depth, understanding, and empathy for others and increased self-awareness.
- Less self-awareness or insight without experiencing anorexia.
- Increased self-exploration.
- Self-awareness and self-understanding from anorexia

b) Negative aspects of experience with AN

- Separation from anorexia and the self due to embarrassment due to negative feelings attached to the disorder/disease.
- Embarrassment, shame, and negative feelings
- How deeply entrenched self-criticism
- Extent of negative body-image and negative sense of self
- Anorexia is equivalent to a total lack of self-worth.
- Ongoing recovery-self led to increased acceptance to address the negativity

a) Shift of sense of self since anorexia

- Although stress and sadness are still present at times in life, no longer go back to the place of anorexia or the anorexic-self.
- Ongoing-recovery self is still active and present.
- Thoughts and feelings towards experience with anorexia shift

b) Re-emergence of anorexia since remission and recovery

- Anorexia is interconnected with other mental health issues such as depression and anxiety.
- Thinking about experience with anorexia increased feelings of negativity (e.g., questioning internal strength, coping strategies, and resilience).
- Since recovery, she feels very different about herself including much more self-awareness, and ability to identify goals.
- Recovery allows her to see herself as a whole person.
- Recovery-self is a whole person, whereas Anorexic-self was fragmented
- No longer a fragment of the self, since she sees her whole self now
- Life is not so narrow since recovery, as she has room to experience other things.
- Recovery-self is more engaged.
- Recovery is the lights being turned on again, whereas Anorexia is a dark passenger.
- Super optimistic views of recovery, negative self-talk is still present, but not regarding eating disorder symptoms
- Recovery has given the world shades of gray

a) Meaning-making: how it relates to life prior, during and after anorexia

- Relapse does not mean failure.
- Recovery was an evolution,
- Core of sense of meaning and purpose is also an evolution.
- Sense of purpose evolves and gets deeper as she progresses throughout life.
- Meaning and purpose in life is present but was dormant with anorexia.
- Was unable to express it with anorexia because she felt limited

b) Shifts and changes since recovery from anorexia

- Recovery reminds her that relapse is possible, but also leading a healthy life without anorexia.
- No longer sees experience with anorexia as a failing, as there is more acceptance of ambiguity

- Although frustrated that she has experienced anorexia, there is more acceptance and no longer a desire for perfectionism.
- Depression, anxiety, and anorexia feel intertwined and interconnected
- Recovery provided newfound purpose and it enabled returning to life, goal, and everything.
- Recovery-self she does have a sense of purpose.

c) Impact of anorexia on sense of purpose and meaning

- Felt very lost and no purpose with anorexia.
- Being sick with anorexia, she was unaware of what to do with her life.
- Anorexia evolved into no self-worth and depression.
- Anorexia stripped her of all-purpose.
- Sustaining recovery takes a lot of reflection.
- Reframing and realizing that a slip is not a relapse back into anorexia.
- Relapsing into anorexia can happen but have a different experience or impact.
- Relapse does not mean failure.

a) Recovery is an ongoing process

- Ongoing-recovery self acknowledges that recovery is not a finite state.
- Continues to cognitive reframe and structure.
- Increased self-awareness since seeing her vulnerabilities.
- Can derive meaning from it rather than associating it with identity.
- To reconstruct anorexia is identical to feeling like a failure and no self-worth.
- Although recovery is considered an accomplishment, it does not feel that way to her due to fear and negative feelings attached to experience of anorexia
- Still has negative shame attached to experience of having anorexia.
- Recovery process has been an evolution and not as static as once thought (e.g., Recovery is an ongoing process).

a) Shame-based perception of anorexia

- Growth and change have happened, but does not feel recovery is something to be proud of
- Anorexia is a different state, as well as anorexic-self.
- Perception of anorexia is more shame-based; therefore, not considered an accomplishment
- Emergence of eating disorder thought/cognitive distortion, but able to reframe it.
- Recovery is positive.
- Remission and recovery have assisted in articulating goals better; for example, she became more self-aware of her personality
- Experience with anorexia has increase compassion and empathy for others.
- Changed perceptions of things and self-perception.
- Since experience with anorexia, she is more reciprocal.

a) Implications of Relapse

- Stress is a potential vulnerability for her to go down that path of relapse.
- Extreme stress could lead to using anorexia or restriction as a coping mechanism.
- Fearful of complete relapse and not merely a lapse or slip

a) Role during Anorexia

- Awful feeling and disconnection
- Religious and spiritual life was desolate when experiencing anorexia
- God felt far and removed from her when experiencing anorexia.
- Unable to focus, read or concentrate with anorexia.

- Restriction from anorexia led to restricting spirituality and religiosity at the time.

b) Role during Recovery Process

- Spirituality since recovery has broadened.
- Recovery there are so many more possibilities to explore.
- No longer the same limitations on the self as was present with anorexia.
- Spirituality allowed prayer life to thrive.
- Recovery enabled her to feel more expansive in religion and spirituality.

Stephanie – POM04BR (Interview 1)

- Uncertainty and ambiguity around onset of anorexia
- Normalizing and mitigating initial eating habits
- Adolescence
- 14 years old symptoms emerged; 17 years old
- Reacting to change and transition.
- medical issues (e.g., medication that led to increased weight, so reasons for weight loss) and resultant social challenges
- Interpersonal challenges/difficulties such as bullying and sexual abuse
- Coping with change and ambiguity through anorexia
- Difficulty with acceptance

a) Coping mechanism

- AN as coping mechanism
- Addressing needs, sense of agency, and identity.
- Symptoms of restriction to regain control and a sense of inner agency in her life.
- Subjugation of her needs, as well as sense of loss of control and the self
- Decreased self-awareness
- Symptoms of AN to invoke a sense of internal and external agency/control.
- Identifying what is occurring ("what's going on internally") "internally" and she has "addressed it," eating disorder thoughts dissipate ("go away").
- Recognition that AN was used to cope for so long it becomes the "first inclination" when something challenging or "difficult" is manifesting.
- Regaining a sense of control outside of AN

b) An Entity

- Anorexia nervosa as my identity
- Preconceived notions of anorexia (Dancers/ballerinas; pressure towards the body and sense of self)
- Attempting to normalize focus on body and weight in dancing).
- Being seen outside of AN as a person
- Need to identify and "figure out."
    - Eating disorder thoughts are indicative of "something more going on" and a lack of self-awareness or addressing self-needs ("I'm not giving enough attention").
    - AN is "a separate person" or entity.
    - Before remission and recovery, she used to identify as, "I am my eating disorder, and it's a part of me."
    - Remission and recovery have enabled her to see it as a "separate person" or entity.

- Recognition that AN is separate from her as a person. Eating disorder thoughts are separate than who she is as a person.
- Initial experience with anorexia as peculiar ("strange").
- Difficulty to accept and comprehend initial diagnosis.
- Denial and confusion about diagnosis and what it means.
- Developed symptoms of bulimia nervosa.
- Difficulty to accept and comprehend initial diagnosis.
- Denial and confusion about diagnosis and what it means.
- Anxiety and resultant feelings of lack of control, as well as depression.
- Treatment as strange/idiosyncratic
- Inadequacy, self-deprecation, and self-criticism ("Not good enough"; "self-hate")
- Life was consumed by AN

a) Maintenance Factors

- Anxiety due to lack of control and symptoms of restriction
- AN consumed fear of life, as well as external and internal sense of agency
- Anorexia and herself could not warrant the care and attention required, so begins more compensating behaviours such as purging and more
- Restriction as mechanism for inner agency and control
- Diagnosis and treatment as invoking a sense of powerlessness.
- Protecting remission and recovery to ensure well-being and happiness
- Conscious decision to protect remission and recovery by setting boundaries

a) Challenges

- Ambivalence and incongruity in recovery/treatment from AN
- Feeling lost and overlooked, as well as did not understand the issues ("problem") resultant from having AN
- Familiar with the suffering resulting from AN., exhausting, difficult and challenging.
- Challenge ("attack") thoughts that are symptomatic.
- Unaware of potential relapse due to using AN for coping and not labelling herself.
- Recognition and Appreciation of the Internal Self versus the External Self (AN)
    - Perfectionism "feeds" standards of "good enough," which is the "easiest way to measure herself" during remission and recovery without symptoms.
    - Remission and recovery require "finding and making new paths" for coping and addressing cognitive dissonance.
    - Self-trust for feelings and interpersonal relationships to assist in reducing perfectionism without AN.

b) Growth

- Aspects of life emerge that AN previously minimized/controlled, initially in particular.
- Treatment and professionals flexible, attentive, and knowledgeable in information outside of AN (e.g., mainly focused on body, weight gain and restoration).
- Cessation of symptoms and/or acting upon the urgers to engage in symptoms.
- Seeing herself outside of AN thoughts and symptoms; therefore, forming a sense of self.
- Trust and faith in professional helps with the emergence of remission and recovery
- Acceptance of the Self outside of AN lead to increased trust and decreased shame
    - Conscious decision to protect remission and recovery by setting boundaries
    - Protecting remission and recovery to ensure well-being and happiness

- Seeing internal strengths instead of external appearance is significant in remission and recovery.
- Remission/recovery fosters self-reflection and self-awareness: It forces you to acknowledge […] what is on my mind right now? What am I feeling? What are my struggles? What do I need […] to talk about?
- Permission "just to be" to challenge perfectionism without the presence of AN or depression (e.g., "It's not all about this perfectionism").

a) The need for human connection

- Her need to be in contact with people
- Interpersonal relationships (connecting with others)
- Connection and trust with others and increased sense of self

b) Motivation and/or Inspiration

- Beautiful aspects of life emerge, leading to excitement.
- Helping Profession, research, knowledge, and impactful work
- Relationships provide a sense of meaning and purpose, as well as connection
  - such as her dog and the "comfort and joy" he brings.
  - therapeutic relationship
  - decreases feelings of loneliness and promotes remission and recovery from AN

c) Greatest Barriers to Meaning

- Perceived sense of failure and rupture to self-confidence and self—esteem
- Sexual Assault
- Coping with Challenges to Meaning and Purpose in Life
  - Balancing thoughts, focus, and concentration
  - Positive affirmations of the self
  - Recognizing her value and worth outside of others criticism
  - Feeling Empowered
  - Lack of meaning due to "a little hole, emptiness," and lack of romantic relationship.
  - Greatest challenge in making life meaningful is convincing herself that she is "good enough" and "doing enough," which suggests feelings of inadequacy.
  - Self-confidence, perfectionism, and not "meaningful enough."
  - Objective criteria/Subjective criteria as impacting sense of meaning

Stephanie – POM04BR (Interview 2)

- Feeling not in control (subsumed themes)
- Side effects of medication such as weight gain
- Attempt to gain control by self-asserting with neurologist.
- Powerless after speaking with Neurologist
- Diagnosis of epilepsy was difficult.
- Hears/receives diagnosis but does not understand what it means.
  - Felt isolated and feelings of hopelessness
  - Becomes "super assertive" to neurologist.
  - She claimed she did not have epilepsy anymore and therefore demanded that her neurologist take her off her medication.

- Received a diagnosis and resultant medications. With further explanations from the medical professionals.
- "Felt almost traumatized as a result."
- She could not believe the diagnoses and implications.

a) Typical day with Anorexia

- Specific restrictive behaviours and patterns (e.g., physical activity, workout and limiting food intake).
- Now that she is "recovered", she recognizes the "huge deficiency" in her previous caloric intake and exercise with Anorexia.
  - "I would always calculate meticulously."
- Excessive exercise and weight moderation through the scale.
- Anorexia consumed and influenced her life.
- Thought and perception of "Never enough" leading to "extreme" eating disorder thoughts and behaviours.
- Perception of self-worth deteriorated, leading to more eating disorder symptoms and behaviours.
- Anorexia led to depression and being so consumed by the eating disorder.
- Anorexia had such a significant "huge" impact on her sense of self-worth or perceived worth.
- Eating disorders behaviours presented and perceived as needed and normalized.

a) Anorexia as a coping mechanism

- AN provided a sense of control, worth, confidence ("I'm good at something")
- AN provided avoidance of other presenting issues (e.g., PTSD)
- Eating disorder provide a sense of focus, as AN provided distraction

b) Anorexia as an entity

- That is how she felt at the time that successes were connected to eating disorder symptoms or Anorexia.
- It did not matter what she did, but rather only, if Anorexia thought she was worthy or good enough.
  - AN led to self-sacrifice
- Remission and recovery provide a sense of peace.
- Feeling stronger and more resiliency since remission and recovery
- Anorexia, in contrast, fostered feelings of vulnerability and powerlessness.
- Starts day calmly.
- Listens to body for food, enjoying and appreciating it.
- Eating disorder behaviours from Anorexia replaced with other focus on the body to provide a sense of fulfilment.
- Remission and recovery have led to significant changes and increased self-awareness and appreciation in life.
- Enhanced values and connections in life, as well as an appreciation.
- Anorexia identified and differentiated as an illness.
- Anorexia or anorexic symptoms replicated as self-focus ("focusing on myself")
- Anorexia seemed to justify self-care and self-focus initially.

a) Body shaming and comparison

- Weight gain (from medication) led to feelings of disappointment and failure.

- Comparing oneself to others, and resultant body shaming
- Self-worth based on the size of her body.

b) Metaphor of Anorexia

- Anorexia presented as a friend at first; but shifted to a poison upon entering recovery.
- Increased insight shifts Anorexia to the enemy, as she enters recovery.

- Remission and recovery with so many great moments
- Shift in perception of self-worth
- Sense of accomplishment in life
- Increased insight ("I'm intelligent"). No associations to physical appearance in remission and recovery.
- Attributes and strengths are just inherent and not related to AN
- Rewarding and not related to Anorexia
  - "I like who I am, I *love* who I am."

a) Personal values and qualities seen in remission and recovery are not contingent upon Anorexia

- Anorexia gets too much credit.
- Developed an understanding that successes were outside of Anorexia.
- Anorexia had found a way to manipulate that understanding and realization.

b) Finding meaning or purpose outside of Anorexia

- It was difficult to find meaning and purpose in life outside of Anorexia
- Now in remission and recovery she can find meaning and purpose outside of AN; She presently thinks she can see herself now.
- Recovery and remission enabled her to define what meaning and purpose can look like and signify in the present moment and an engaged manner.
- Increased energy towards work and activities that give meaning and purpose.

- Helping behaviours and recognitions of accomplishments (remission and recovery).
- Compassion and acknowledgment from others about the difficulty associated with Anorexia.
- Behaviours and support of others assisted in continuing with remission and recovery.
- Honesty and explicitly from others in encouraging and supporting non-eating disorder behaviours or symptoms.
- Need for self-compassion and compassion from others in remission and recovery.
- Catalyst for recovery was comprised of support and openness from others.

a) Maintenance of remission and recovery

- Maintenance of remission and recovery entails assertiveness and setting boundaries.
- Opposite action and challenging ED thinking to help maintain remission and recovery.

- Spirituality provides a sense of connection to the self and universe, as well as a sense of comfort.
- Identifies spirituality and faith as involving unconditional love and therefore great comfort.
- Spirituality as positivity in messages and energy, as well as supportive stance; Spirituality provided external love and compassion.
- Image of God shifts from punitive to loving and merciful, so personal relationship with God as open, loving, and nonjudgmental.
- Faith facilitates forgiveness from God, as well as self-forgiveness.

- Personal relationship with God through prayer, conversations, and resultant personal reflection.
- Spirituality facilitates and extends from external to internal self-love and self-compassion in remission and recovery.

Stephanie – POM04BR (Interview 3)

- Ownership over one's life and body.
- Lack of control due to difficult life events led to feelings of hopelessness sadness, and despair
- Anorexia suppressed vulnerability with others.
- Anorexia was a mechanism to hide and avoid emotions.
  - **a) Method of fostering a sense of control**
    - Anorexia as previous experience for coping mechanism
    - Although life without Anorexia would be different, it could have been replaced by a different negative strategy.
    - Anorexia consumed her sense of self and life
    - Continues to struggle with perfectionism, which she associates with AN; However, she struggles much less with it.
- Defines remission and recovery as not only the absence of symptoms, but not acting on those thoughts and behaviours.
- However, she continues to have anorexic thoughts, remaining doubtful thinking it will ever fully dissipate.
- Therefore, she sees remission and recovery as an enduring process of not acting on the eating disorder thoughts that might emerge.
- Positive aspects of remission and recovery from Anorexia is that, although it was initially exceedingly difficult at the beginning, the experience and result are worth it.
- Self-needs and self-care are the main positive coping strategies during remission and recovery.
  - **a) Particular fear associated with remission and recovery**
    - Fears associated with relapse.
    - Results in feelings of fear and hopeless about the future.
    - Acknowledges that relapse from Anorexia is possible, including how there might always be challenges.
    - Continue to work on protecting her remission and recovery from challenges.
    - Since being in remission and recovery for only a year, continues to present feelings of hopelessness and fear of relapse.
  - **b) Positive dimensions/growth**
    - Led to a more objective and neutral perspective of experience with AN.
    - However, presently realizes it was a negative coping mechanism.
    - Assisted her in coping during difficult times, wherein she did not have the necessary or correct tools to cope otherwise.
    - Remission and recovery have positive dimensions: specifically, led to more rationale and a balanced mind.
    - In addition, it has led to increased happiness, openness, self-compassion, and interpersonal connections.

- Significant changes from remission and recovery are positive changes in interpersonal relationships.
- Focus has shifted from appearance and body to being present with others in relationships.
- Remission and recovery nurtures the self and person, including characteristics, personalist, values, and morals.
- She is also able to succeed in remission and recovery due to inherent aspects of the self such as perseverance, dedication, and passion.

c) Remission and recovery transforming the self

- Appreciates how others see her as a person and her accomplishments outside of Anorexia symptoms or thoughts.
- It does not reside in her weight or physical appearance, but her as a person and self.
- Trusting others and self-trust, as well as openness is significant for her now.
- Recovery and remission entail the self-expression and identification of the foundation of emotions.
- Remission and recovery have led to an increased internal sense of self-worth
- Remission and recovery have enriched her life by providing time and energy to focus on what gives her a sense of purpose.
- Sense of purpose comes from self-fulfillment such as working in a helping and caring role, being a student, researcher, interpersonal relationships.
- Well-connected and meaningful relationships are particularly important to her sense of purpose and meaning.
- An emphasis now on providing a sense of community, partnership, compassion, kindness, and empathy.

a) Former sense of meaning and purpose developed from AN

- Anorexia provided a different sense of meaning and purpose, related to the symptoms and behaviours of it.
- Previously, she associated being symptomatic with meaning and purpose, as well as worthiness.
- She associated any personal success she had with Anorexia and symptoms.

b) Influence from remission and recovery

- Goals and future-oriented approach fostered and enriched by remission and recovery.
- Remission and recovery have renewed her sense of meaning and purpose.
- Personal values, but also lived experience fosters a sense of the significance of kindness, compassion, and community.
- Using her lived experience with AN, to assist in increasing knowledge of remission and recovery for others.
- Spirituality represents connection with something outside of oneself, providing a sense of comfort and trust.
- Spirituality signifies coherence, continuity, synchronicity, and permanence.
- Spirituality was not initially present during the onset and development of AN.
- Initially, in remission and recovery there was a lot of uncertainty and a sense of loss of control.
- Increased trust and development of spirituality provided a sense of comfort during remission and recovery.

- Spirituality played a role in remission and recovery by assisting her in placing trust in that process.

a) Initial challenges and fears with spirituality in remission and recovery

- Initially difficult to trust in something Greater than the Self.
- Spirituality initially required what she felt was letting go of control.
- Letting go of the need for control, as well as fear of vulnerability during remission and recovery.
- Trusting in professionals that give orders presents fear of vulnerability and lack of control.
- Remission and recovery entailed vulnerability, as well as letting go of control and trusting others.
- Vulnerability from remission and recovery has become incredibly significant, meaningful, and a strength.
- Vulnerability from this process has allowed her to connect with others, which is something she inherently values.
- She now sees how her perceived flaws or imperfections through the empathy of therapist conveyed the strength in vulnerability.
- Vulnerability from remission and recovery allowed her to view the self as whole. It also enabled an experience of connection, acceptance, and validation.
- Vulnerability has a role in remission and recovery, but in a positive, helpful, and powerful manner.

Geraldine – POM05BS (Interview 1)

- Uncertain if the beginning of anorexia was a massive trigger or event
- Unintentional comparisons between her and her sister
- Lack of praise and validation and not regarded as the beautiful one.
- Memories of actively restricting by age 15 or 16
- Felt like she had to find her own identity
- Very concerned with her body, physical appearance, and clothing
- Wanted to be the smart and intelligent one, sought validation through intelligence
- Fixation on school and education stems from perfectionism
- Perfectionism as a way to compensate

a) Diagnosis and Initial Experience of Anorexia

- Initially, she did not think anything was wrong with her.
- In denial, even though she felt extremely unhappy and depressed.
- Thought she had so much self-control and so much restraint.
- Years of starving herself on this quest for perfectionism.
- Approximately 25 or 26 years' old when she initially sought support for healthy eating in a group
- Label of anorexia or eating disorder was misunderstood
- Attended a support group and spoke to a physician, and was referred to an eating disorder unit and attended it, but was in denial
- Met with a dietician, who spoke about her behaviours, in which the dietician claimed it was not normal

- Since it was on campus, she did commit to the treatment and support

b) Events at the time of diagnosis of Anorexia

- Attended a support group and spoke to a physician
- Referred to an eating disorder unit and in denial
- Decided to attend the unit to see if it was real due to being very underweight
- Since it was on campus, she did commit to the treatment and support
- She received medications for depression

c) Impact of Diagnosis

- Came to the realization after a week, month or so that she could not do it anymore – she could not eat.
- Did not want to let treatment team down, but felt hopeless
- Felt she no longer followed rules in life, wherein Anorexia was her best friend
- Perceived she needed anorexia, in order to be successful
- Attempted suicide

- Family is very religious
- Raised Roman Catholic with holidays entered around it
- Attended Sunday school and a Catholic school.
- Stopped attending church on Sundays during university

a) Questioning religion and faith

- Unsure about the existence of God when asked by another person in university.
- Mother expressed disappointment and disowned her for questioning her faith
- Leaned into eating disorder more to cope with the hurtful statements from her mother
- Felt not enough and started purging food and bulimia tendencies in addition to anorexia
- Eating disorder was the only way to be perfect
- Questioned her beliefs and was villainized by her mother
- Told something bad needs to happen to bring her back to faith
- Attempted suicide and her parents were contacted
- Felt punished because of questioning her faith and beliefs
- Parents impacted her lack of motivation for recovery
- Familial focus remained on religion while she was hospitalized

- No one in her life knew she had an eating disorder
- Good at concealing this hidden secret
- Felt she had no identity, but the identity others wanted for her
- Lacked trust in treatment planning
- So much that felt like it was not her decision, and everything felt out of control
- She had no identify, but the identity she perceived others wanted for her
- Had no one in her life that knew she had an eating disorder
- Good at trying to be functional and managing others' expectations
- Having a hidden, secret and superpower that was all hers
- Very alone and isolated by choice, which was sad, in order to maintain eating disorder (Ed)

a) Interpersonal relationship with anorexia and Ed

- Anorexia as a best friend named Ed
- Ed was always there for her without fail, and Ed was her everything

- Giving up the relationship with Ed for recovery was a huge demand to her
- Not only was Ed her best friend, but also her partner.
- Continues to have eating disorder thoughts
- Ed continues to reside in her mind and present

b) Grieving the loss of anorexia during remission and recovery

- Remission and recovery have been a mourning process
- Loved the feeling of control she thought she had over her life
- The ability to be as close to perfect as possible she thoughts in her mind.
- Continues to strive to the standard of perfection
- Mixed emotions about the presence and/or return of Ed
- Relapse seems to be a part of the recovery process
- Recovery should not be back and white/all or nothing
- Remission and recovery are not a linear process
- Terrible weight of guilt, sadness, and disappointment comes from relapse.
- Lack of understanding about the difficulty of remission, recovery, and relapse.
- A separation is needed between the eating disorder and the self; namely, hospitalization was no life to live

a) Active Remission-Self

- Had to get to an Active Remission-Self, in order for every single part of her to heal
- Decision felt like it just emerged and happened.
- Thankful and grateful that the decision to enter remission did.
- Became ready to create her own identity and decided to create her own identity.
- Asked and arranged for a meeting with her treatment team
- Needed to do treatment or felt she would not survive.
- Came to realization that she had freedom of choice
- Tired of being critical of self and feeling like she was a terrible person all the time.

b) Behaviour for initiating the Active Remission-Self

- Challenging herself to purchase and wear fitted clothing.
- Awareness of negative female stereotypes
- More of a dictatorship before with Anorexic-Self compared to now with Active Recovery-Self
- Insights learned from therapy about Active Recovery-Self
- Started to have a dialogue with the Anorexic-Self to initiate Active Recovery-Self
- Questions her dialogue between the Anorexic-Self and associated beliefs
- Challenges/combats thoughts she experiences from the Anorexic-Self belief system, which has given her a lot of freedom

c) Determined Recovery-Self

- No longer needed support from the unit, and able to do eating and food preparation on her own
- Weight restored, so stopped scheduling appointments with dietician
- Made the decision to do recovery on her own after receiving treatment
- Gratitude for being able to acknowledge any eating disorder behaviour slips
- Took all the advice, knowledge, and skills from treatment and used them.
- Done with the secrets of anorexia, which is so liberating
- Became more vulnerable and open sharing experience with an eating disorder

- No longer as shamed-based experience with anorexia or associates herself with having an eating disorder
- Redefining for her by developing her own personal identity outside of anorexia

- To be happy and no longer isolating herself
- There is meaning now, whereas it was previously a blind following
  - She had no meaning when she was ill with anorexia
  - She was void of meaning before with anorexia
  - Strove for perfectionism to get validation before with the anorexic-self
  - Meaning was very short sided in that way
  - There was no meaning in anorexia; therefore, bigger goal in life that do not include anorexia
  - Emotions were limited before with anorexia
- Recovery is much more than weight restoration
- Finding meaning is the great way to treat people from anorexia
- In recovery, she can identify with others
- There was no meaning in anorexia; therefore, bigger goal in life that do not include anorexia
- She is now receiving validation about herself she never did before
- She is validated as a good person and friendly, which is so wonderful
- Loves where she is presently in life, and is so happy; therefore, she would protect her recovery with everything that she has

Geraldine – POM05BS (Interview 2)

- Horrible in a typical day.
- Good days and bad days
- Eating disorder thoughts were the worst part and all consuming
- Needed to change the narrative., and decided this has to end for recovery to begin
- Poured her heart and soul into the decision to recover
- She was trying to do better for herself and cope with many emotions like anger and sadness.
- Somehow you make the commitment

a) Good Days and Continuum of growth and experiences during a typical day with the Anorexic Self

- Being able to get up and out of bed\
- Have a shower, get dressed and ready for school and/or work
- Possibly having a cup of tea of coffee

i. Emotions

- Could feel normal and not guilty about certain food
- Did not have to justify additional to coffee
- Those days were wonderful.

ii. Cognitions

- Waking up without having critical thoughts and feeling rejuvenated
- You wake up and feel functional without those negative thoughts

b) Bad Days and Continuum of challenging experiences during a typical day with the Anorexic Self

- How long could she restrict or starve herself

iii. Emotions

- Others seeing body was humiliating and embarrassing
- Worried about what other people would think if she gained weight.
- Worried they would presume she had little control over herself
- Very disappointed in herself, felt so terrible, and badly about needing to complete it in two-years.

iv. Cognitions

- Negative and perseverating thoughts would be unbearable sometimes
- So many negative thoughts associated with the day
- Trying not to eat all day and being self-critical if she did eat.
- Horrible thoughts.
- The thoughts were terrible and horrible.
- Really isolated to avoid others seeing her and what she ate
- The thoughts were terrible and horrible.

v. Physical Sensations

- Body would be demanding food, and she knew was hungry, but was not allowed to eat
- Couldn't sleep some days because she was starving
- She would try to sleep all day for challenging times
- When she felt she could not fix the issues, she would sleep all day to disappear.
- Really, really starving herself.

- She never ate them and liked to see the food rot
- Did this once a month, and experience guilt thereafter
- She saw her death when looking in the mirror
- She saw her skeleton and what she would look like in a casket
- Had blinders on before with anorexia
- Life was devoted to being skinny and people loving her when she had anorexia
- Moment of change was looking herself in the mirror and realizing her self-worth
- She broke up with an abusive partner and Ed, and Could not do having anorexia anymore

a) Contemplated suicide

- Wanted to disappear and questioned suicide as a viable option.
- Contemplated suicide for many months.
- Wrote out potential steps to ensure that it could be successful.
- So absurd and bizarre, but there was comfort on the very bad days when Ed was out of control.
- Created a guide or contingency plan
- Contemplating suicide was all about seeking relief.

- Similarities is that she thinks about them both often
- Thinks about being in recovery and practicing recovery
- When negative thoughts surface, she counters them with positive
- Cognitive reframing and restricting
- Actively engaged in remission and recovery process
- Wonderful being able to wake up without negative thoughts or self-hatred
- Rally tried to get into recovery while on the outpatient unit in the hospital
- Woke up to attend meals and breakfast
- Outpatient treatment was very difficult.

- Since being in active recover-self,
- She feels more freedom
- Waking up at home for breakfast is fabulous
- So much freedom being in her own space at home and doing her own activities

a) Challenges

- Cannot cook batches of food because it scares her
- Worried that some of those eating disorder behaviours will emerge and she will be unaware
- Scared it will lead to relapse and the return of anorexia
- Interesting to think about how this behaviour still dictates her daily activities
- Continues to think about Ed all the time

b) Growth

- Putting food into containers scares her
- She does not want to get back into the habit of throwing food out
- Trying to maintain safety and remission/active recovery-self
- Active in trying not to engage in eating disorder behaviours, which is so much better
- Flexibility in recovery outside of outpatient treatment is so wonderful.
- All of this freedom and the whole day to decide what she would like to do.
- Strong enough to break-up from an abusive person, strong enough to recovery
- I am going to be recovered she shared with treatment team

c) Grieving the loss of Anorexia

- Loved her eating disorder
- Misses her eating disorder
- When she had it, it was supportive
- Eating disorder felt like a person and validated her
- There are still moments in recovery that she grieves the loss of anorexia
- Anorexia was a huge part of her life, and hard to let that go
- She will always remember the relationship she had with her eating disorder

d) Emergence of Self in Remission

- Self-kindness is overwhelming, and most days are really good
- Breaking those behaviours, and breaking up with Ed to remind yourself of self-love and not self-hatred
- The moment she chose recovery was big
- She just decided and made an active choice for recovery
- So proud of herself for making that decision to break-up with an abusive person and to honour her recovery process from anorexia.
- Does not want to be complacent in her recovery
- Recovery was the first time in her life that she knew she needed to change

- No longer feels the need to be perfect
- Although she still enjoys perfectionism and others approval, she no longer feels compelled by it
- Everything was concerned with how everyone saw her
- Need to fill her own cup now
- Asked herself what she does to bring herself joy like exploring her own boundaries
- She wants people to know about her now

- There was no space before, but now she sees many possibilities
- No longer living by "Ed's" rules or feeling limited
- Would never have experienced purpose or living without recovery
- Recovery has allowed her to open her eyes, seeing life with meaning and purposed outside of Ed or anorexia
- Most meaningful moment in recovery was when she broke up with an abusive partner
- Now experiences empowerment and inner strength since ending that relationship and choosing recovery

Geraldine – POM05BS (Interview 3)

- Made her the person she is now.
- A lot more understanding
- Empathy has increased
- Importance and impact of words on others
- Defined her life in so many way
- Hard to conceptualize life without it
- Many positives from having anorexia, as she always wanted to help people in a similar situation
- Relationship with anorexia was complete commitment
- Understanding of how to function in recovery is very limited
- Rare to meet another person who is in recovery from an eating disorder
- Everything is very cloudy, especially for someone who had an eating disorder dominate their life
- Could be way of mind trying to heal from the past
- Memories are not as strong
- Healthy to not remember experience with anorexia, how terrible, and the thick of the eating disorder
- Lost so much time in the thought patterns, self-anger, and inability to self-forgive
- Still impacted by experience with anorexia
- Anorexic-mind versus the Recovered-mind is an uphill climb
- Physically in recovery, but mentally she is not as recovered as she thought
- Still sensitivity to triggers she did not know existed
- Partner did not think she was putting effort into a goal, which was difficult for her
- 20 years of anorexic-mind/anorexia and perfection
- Now in recovery-mind, she tried to explain the anorexic-mindset to her partner
- Goal in recovery is not to push herself past her boundaries or limits
- Boundaries and assertion in recovery-mind and process is freedom
- Now, choosing not to engage in perfectionism with recovery-mind for part of her mental health
- Chooses because she knows that she needed not to do certain activities or behaviours for her active recovery-mind
- More compassionate now towards how she asks other questions
- Life would be so different if she did not experience anorexia, she would be more judgmental in life
- Before anorexia, she was quite judgmental

- Thankful that she forced herself through recovery (e.g., to derive meaning from her experiences
- Anorexia is horrible; Anorexia twists your mind, heart, and soul.
- Tries to find every positive that she could from experience with anorexia
- Asking herself what it is trying to teach her.
- Able to help others communicate better in treatment and because of it.
- I am thankful for my eating disorder because it has made me who I am.
- Anorexia is death sentence, where you are waiting for parole
- Recovery is parole and freedom
- Anorexia incarcerates or imprisons the mind, body, and heart
- Anorexia is a prison, which locks the person in there for a long time with a lack of awareness
- Anorexia is really a death sentence and a prison
- Experience of anorexia was for praise, validation, and looking perfect for people
- She still has trouble in receiving compliments
- Does not know how to receive compliments, but she is going to work on it
- Going to receive them and be thankful
- Picture the compliments slowly decaying or hitting the bricks, so they eventually crumble
- Going to let the compliments tear those bricks down
- Awareness of difficulties accepting compliments and how it reinforces brick wall.
- Job is to say “thank you” to compliments
- Things eventually become habitual over time
- Since remission/recovery feels like she is allowed to be here
- Anorexia would say she was not worthy to even sit on a couch or be in the room
- Remission and recovery say, she is allowed to sit down and enjoy her life
- Allowed to be who she wants to be.
- She can create a world that she wants to live in
- Remission and recovery allow her to own things
- Ed or Anorexia did not allow her to be a part of others’ lives
- Anorexia or Ed said, “You’re not good enough.”
- Ability or knowledge that she can engage in activities and do something outside of anorexia in remission and recovery gives meaning
- Being able to develop meaning and connection; is new, overwhelming, and wonderful.
- Before the eating disorder and she were synonymous
- Now, they are not, and she no longer pictures herself when she hears anorexia.
- Remission and recovery have allowed her to depersonalize anorexia, sees herself as a person now
- Family and friends focused largely on the health of her body, and not her sense of self
- Focus from others was often on caloric or food consumption and not her personhood, which reinforced that ghost
- There needs to be some sort of dialogue to remind them she is still a person
- It is very hurtful because no one believes her
- Assumptions made that she does not take anorexia or the illness seriously
- Those types of conversations are horrible and almost crippling.
- Feels like she cannot be authentic with others
- She has not figured out how to be authentic in the recovery process

- She is overcompensating in remission and recovery
- Remission and recovery are bringing the word of freedom to mind
- Image or symbol of being in prison can be extended to all mental illness
- Prison is with an eating disorder
- You are on death row because it feels so far away with recovery
- Recovery is like being in an open field
- Recovery is worth it is the best description
- Comfort in knowing your knowing your surround in the prison of anorexia
- Since experiencing remission and recovery, allowed to be in the world.
- Recovery is not a static state or solid
- It is always changing
- Does not know if she has hit remission, as she is unsure how to function
- Seems to be an ebb and flow of recovery
- In this moment, believes she in in the in-between area of remission and recovery
- Some days, she feels more recovered
- Recovery is very difficult
- Unsure about triggers
- Recovery is and has been about learning
- Recovery is not only about eating, but also about challenging eating disorder thoughts and behaviours
- The triggers and emotional components contribute to slipping into eating disorder thoughts and behaviours
- Treatment does not assist someone in preparing themselves for recovery
- Recovery is more ambiguous
- Unsure of how to prepare for the uncertainty of what might rattle or shake her.
- Sometimes life is wonderful, but it is frightening at the same time because of the uncertainty of whether it is going to be good or bad.
- Unsure of how to prepare herself as a recovered person for uncertain situations like her brother's wedding
- Knows how she would do it with anorexia and anorexic-mind
- Tries her best to not be hard on herself
- Has given herself allowances
- Self-care is difficult and tough
- Recovery process has allowed her to have a sense of purpose
- Allowed to exist and want things for herself
- Just that allowance is worthy recovery
- Jail cell in the mind of anorexic-mind of Ed finds this shameful and confronting
- Recovery is nice and like a grandmother
- Recovery is a cute little old lady
- Recovery as a grandmother is protective of her granddaughter
- Recovery is the voice of her grandmother
- Ed of Anorexia is was sticky and illusive
- Ed was almost like a long-distance relationship
- Since remission and recovery, she is excited to find purpose in things

- To try different thing and figured out how she is allowed to take up pace and function in society
- She has goals now
- The idea of being able to find purpose was not even a concept she had before
- She can be a person now.
- She has the opportunity to have purpose now
- The opportunity to have purpose is worth everything, and she feels empowered
- She feels she has her own power over her own decisions now
- The guilt she would feel was overwhelming with anorexia
- Still gets shame, guilt, and embarrassment, as well as anxiety, but she still can do things in recovery
- Guilt, shame, and anxiety is residuals of previous life.
- She is allowed to exist and that is enough
- She is really able to push her boundaries
- Recovery is worth it
- Recovery gives meaning and allows for meaning and purpose
- Recovery does not mean living by a predetermined set of rules like it did with anorexia
- Now she is free to choose who and what she wants to be
- She is creating a person now
- She is worth something and has meaning now
- Worldview now is that it is endless.
- Endless opportunities, possibilities that she can do and be what she chooses to be
- She is her own warden now in recover, and now she realizes it
- Process of interview has been really wonderful due to self-awareness and insights emerging
- It makes her a better and stronger person because she understands herself more
- Increased self-awareness
- She now feels inspired from self-reflection
- Feels there is something bigger than her
- There is a bigger purpose
- There is a reason, meaning, and purpose for her experiences
- Feels as though everyone is connected through human condition together
- Her responsibility and everyone's to help others
- Learning to be a much gentler, kinder, and more positive person
- Connecting with others through small acts of kindness instead of being consumed by the eating disorder
- Remission/recovery allows for a stronger connection and positive one
- Spirituality and remission/recovery has helped her know she can connect
- With Ed she could not have happiness or connection
- Could be why she attempted suicide a few times with Ed and no connection
- Anorexia created a barren and desolate space with no connection
- Remission and recovery remind her that it is wonderful to experience emotions even sadness
- Emotions for her because of spirituality and connectedness are amplified in remission/recovery
- Learning how to identify and process emotions is huge
- Grateful she can see different parts of herself now