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Rethinking Recovery:

Posttraumatic Growth Through Eating Disorder Recovery

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Abstract

The eating disorder (ED) treatment and research communities are plagued by hopelessness due to poor prognoses and treatment outcomes. However, a growing movement—the Recovery Movement—seeks to re-conceptualize ED recovery, empower patients, and inspire hope. One possible contribution to this movement is application of a Posttraumatic Growth (PTG) framework, which has been used to examine transformative, psychological growth resulting from overcoming adversity. PTG has only recently been explored in recovery from mental illness and has not yet been applied to ED recovery. The present study sought to pioneer the application of PTG to ED recovery using qualitative interviews with female ED survivors ($N=10$). Qualitative analysis revealed three superordinate themes describing the experience of PTG through ED recovery: *New Relationship to the Self*, *New View of Life*, and *Interpersonal Growth*. This overall thematic structure aligns with and extends traditional conceptions of PTG and offers hope for the promise of recovery. Further investigations of growth using recovered voices could strengthen treatment and research while clarifying the definition of ED recovery, empowering survivors, and inspiring patients.

Keywords: Posttraumatic Growth, Eating Disorder Recovery, Recovery Movement.

Rethinking Recovery:

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It is both an intuitive and well-documented phenomenon that experiencing trauma can have negative physical and psychological consequences. In the early 1990s, however, researchers began to formally study what can perhaps be considered conventional wisdom: that which doesn't kill you makes you stronger (Joseph & Butler, 2010; Tedeschi & Calhoun, 1996). Almost all of the research into transformative, psychological growth following extreme adversity—termed Posttraumatic Growth (PTG)—has focused on survivors of physical trauma, natural disasters, or life-threatening physical illnesses; far less has explored growth following recovery from mental illness. To date, there have been no formal research investigations of PTG through recovery from Eating Disorders (EDs), a class of mental illness with relatively bleak prognoses (Fichter, Quadflieg, & Hedlund, 2006). The present study sought to begin to fill this gap while also integrating important findings from a closely related body of research—Recovery Movement research—that has emerged over the past decade and that seeks a new conceptualization of recovery from mental illness (Ridgeway, 2001). Given their shared theoretical foundations and goals, linking PTG and Recovery Movement research through exploring ED recovery may have significant implications for PTG, Recovery Movement, and ED research. More specifically, it would broaden PTG research through its investigation in a new population, expand the work of the Recovery Movement by building the evidence base for growth through mental illness recovery, and bring hope to the ED community.

Posttraumatic Growth: An Overview

Understanding the mechanisms of growth through adversity has been an essential part of the study of PTG. Tedeschi and Calhoun (1996), PTG's pioneer researchers, explained that when

individuals are faced with extreme challenges, their constructions of themselves and the world are severely challenged. The authors used an earthquake metaphor to explain the phenomena of trauma and growth:

“A psychologically seismic event can severely shake, threaten, or reduce to rubble many of the schematic structures that have guided understanding, decision making, and meaningfulness... [O]ne’s safety is challenged, and one’s identity and future are challenged... Such threats to the assumptive world are accompanied by significant levels of psychological distress.” (Tedeschi & Calhoun, 2004, p. 5)

In the aftermath of trauma, individuals are left to “rebuild” their worlds. Because PTG is not a universal phenomenon, there are some individuals whose worlds never return to the functional level sustained before the trauma. Others are able to rebuild their worlds so that they match their pre-trauma construction. Finally, there are some individuals who achieve PTG and are able to reconstruct their worlds in such a way that they are better able to withstand future shaking (Tedeschi and Calhoun, 1996; 2004). The psychological growth that characterizes PTG encompasses reevaluation of priorities, feelings of self-reliance and strength, development of new interests, establishment of a new life path, and deepened relationships (Tedeschi & Calhoun, 1996; 2004).

Research has identified several factors that can assist in the rebuilding process and ultimately support growth, drawing upon a combination of individual characteristics and access to resources. More specifically, women tend to report higher rates of growth than men (Linley & Joseph, 2004), as do individuals with higher education (Linley & Joseph, 2004) and higher scores of extraversion and openness to experience (Tedeschi & Calhoun, 2004). Essential contributors to growth include development of problem-focused coping skills and a strong social

support system (Linley & Joseph, 2004; Tedeschi & Calhoun, 2004). Social support is particularly important in achieving PTG because it allows individuals to engage in supported disclosure, aiding in the development of a life narrative and search for meaning (Tedeschi & Calhoun, 1996). With these resources, individuals engage in *cognitive processing*, a deliberate, ongoing reflection and form of constructive rumination that occurs after a trauma and helps an individual to reconstruct life schema and move forward having grown through the process (Tedeschi and Calhoun, 2004). Overall, research indicates that PTG is a dynamic construct following a non-linear course involving periods of progression and regression (Tedeschi and Calhoun, 2004).

Given the dynamic and fluid nature of PTG as a theoretical construct, most measurement tools assess growth across multiple domains. The most commonly used measure, the Posttraumatic Growth Inventory (PTGI) is a 21-item assessment that measures growth in five broad categories: *the experience of an increased appreciation for life; closer, more meaningful relationships; a sense of increased personal strength; the identification of new possibilities for one's future; and a deeper sense of spirituality* (Tedeschi & Calhoun, 1996). Research teams around the world have used the PTGI to assess growth in a variety of populations including survivors of natural disasters, abuse, military combat, bereavement, and medical/health-related traumas like cancer and HIV (Bostock et al., 2009; Linley & Joseph, 2004; McMillen, Howard, Nower, & Chung, 2001; Zoellner & Maercker, 2006). Systematic reviews have indicated that PTG is frequently reported by 30-70% of trauma survivors (Joseph & Butler, 2010). When directly compared with survivors of other traumas, people who had lost loved ones reported the lowest growth rates (3-41% of people surveyed) and breast cancer survivors had the highest rates of PTG (98% of people surveyed; Linley & Joseph, 2004).

The breadth of specific populations studied in PTG research was influenced by early researchers' inclusive definition of "trauma" as an experience that challenges individuals' identities and beliefs about the world and future (Tedeschi & Calhoun, 2004; Zoellner & Maercker, 2006). This is in contrast to the narrower, American Psychological Association (APA, 2004) definition of "trauma" as something that presents a threat of death or serious injury. The broader, PTG definition highlights the subjective experience of adversity, suggesting that it may not be the objective severity of the trauma itself that predicts growth, and rather the way the experience is internalized (Linley & Joseph, 2004). Even with PTG's broad definition of trauma, until recently there was relatively little investigation of the direct application of the PTG framework to those who have successfully recovered from mental illness, despite the very real and profound level of adversity they face.

However, with the growing body of research documenting the challenging and defining nature of mental illness, one of the more recent populations to which PTG is now being applied is survivors of mental illness (Dunkley et al., 2007; Mapplebeck, 2010; McMillen et al., 2001). These recent investigations have examined people who have recovered from substance use disorders (McMillen et al., 2001), depression (Mapplebeck, 2010), and psychosis (Dunkley et al., 2007). Each of these studies had several significant limitations: the participants in the study by McMillen et al. (2001) were still in treatment, and therefore could arguably be unable to provide an accurate depiction of overall, sustained PTG; Mapplebeck's (2010) PTG and depression study did not control for severity of symptoms, formal diagnosis, or whether individuals were currently in recovery, clouding the ability to interpret results. Future research controlling for these variables would facilitate a more accurate depiction of the nature and course of growth from mental illness recovery, which was one of the goals of the present study.

Further, the formal application of PTG to the unexplored terrain of EDs—a class of mental illness with especially bleak prognoses and associated high levels of adversity—would appear to hold particular promise, both for deepening and expanding the understanding and explication of PTG *and* for enhancing the understanding and treatment of EDs and other mental disorders. Findings from the mental health Recovery Movement suggest that conceptualizing mental illness recovery based solely on the absence of symptoms may restrict treatment goals, contribute to hopelessness, and narrow the scope of treatment (Rapp & Goscha, 2006; Ridgway, 2001; Saleebey, 2005). Applying a PTG framework and documenting the possibility for transformative, psychological growth to occur through recovery therefore could make a significant contribution to Recovery Movement research. To fully understand the implications of the dearth of research applying PTG to the recovery from mental illness, one must examine the literature and findings emerging from the Mental Health Recovery Movement.

The Mental Health Recovery Movement

Over the past decade, a new conceptualization of recovery from mental illness has emerged, in many ways paralleling the paradigm shift in the conceptualization of trauma represented by formally studying PTG. The catalysts for this new conceptualization have been a large and growing number of former patients, caregivers, researchers, and treatment providers who have launched what has been called the Mental Health Recovery Movement. Since 2003, this movement has been supported by a US government initiative for a recovery-oriented shift in mental health delivery systems (President's New Freedom Commission on Mental Health, 2003).

The Recovery Movement and the research that it has generated are motivated by a desire to explore and document the very real, positive outcomes that recovery from mental illness can entail, and to thereby counteract the negative messages of hopelessness that pervade mental

health research and treatment. Research suggests that maintaining hope during both mental health treatment and through the process of overcoming subsequent struggles is essential in achieving lasting recovery (Dunkley et al., 2007; Ridgway, 2001). Research also highlights the potential impact of others' negative attitudes in perpetuating mental illnesses (Button & Warren, 2001; Colton & Pistrang, 2004; Offord et al., 2006). For example, in one qualitative analysis, ED sufferers indicated that they had received negative messages about prognosis from others, including treatment providers, who suggested that a part of them would always remain entrenched in their disorder (Malson et al., 2011). Other studies have similarly indicated that negative staff attitudes contribute to internalization of an ED identity and sense of hopelessness (Button & Warren, 2001; Colton & Pistrang, 2004; Linville, Brown, Sturm, & McDougal, 2012; Offord et al., 2006). It is these individuals with close, personal experiences with EDs and other mental illnesses who are seeking to change the negative messages and inspire hope for those who still struggle.

Underpinning the Recovery Movement is a very important shift in the definition of mental illness recovery away from one driven by a medical model (wherein recovery is defined as the absence of symptoms; Davidson & Strauss, 1992) to one that is more holistic. The need for this shift is particularly evident in ED research in which there has been a significant and meaningful discrepancy between the definitions of recovery provided by professionals and people who have (or once had) an ED. For example, according to one study, although both sufferers and clinicians agreed upon the importance of addressing the behavioral and symptom-related components of the disorder (i.e., *weight controlling behaviors*), sufferers placed a greater emphasis on psychological and emotional issues as a fundamental part of recovery (i.e., *psychological-emotional-social criteria*) than did clinicians (Emanuelli, Waller, Jones-Chester,

& Ostuzzi, 2012). Research suggests that those who have recovered from EDs define the *meaning* of recovery as achieving self-acceptance, coping with problems without the use of ED symptoms, an ability to recognize and regulate emotions healthily, a stable mood, less anxiety, positive social relationships, fulfilling one's potential, and obtaining a sense of life purpose (Pettersen & Rosenvinge, 2002). Similarly, a qualitative study of hospitalized ED-patients reported that recovery is dynamic, encompassing emotional wellbeing, elements of thriving, and engagement in life and the environment rather than solely being defined by weight-status or the remission of symptoms (Malson et al., 2011). These findings align with the Recovery Movement's definition of psychological recovery as encompassing establishment of a new identity, accessing hope, and finding fulfillment and meaning in life (Andresen et al., 2003).

Not surprisingly, Recovery Movement investigations with survivors of mental illness also suggest that struggles associated various mental disorders are similar to the trauma and adversity that is typically studied in PTG research. For instance, a participant in a qualitative study on EDs reported, "It [the ED] took over everything completely and I had nothing left" (Button & Warren, 2001, p. 81). Another participant described the crisis point leading her to seek treatment as, "a question between life and death" (Pettersen & Rosenvinge, 2002, p. 66). Similarly, a woman in recovery from severe schizophrenia described her diagnosis as "the shattering of her world, hopes and dreams" (Ridgway, 2001, p. 337), which offers a direct link to Tedeschi and Calhoun's (2004) earthquake analogy of trauma in PTG. These parallels suggest that the traumatic nature of struggles with mental illness mirrors the traumatic nature of struggles with physical illness or other events that have been empirically linked to PTG. This supports future investigation of PTG through mental illness recovery.

The only existing qualitative investigation of the recovery experiences of individuals who

have overcome EDs suggests that those who have recovered may not only experience reductions in symptoms and improved functioning, but also actual growth (Björk & Ahlström, 2008). In their investigation, authors reported that their participants expressed that the ED represented a trauma that brought about growth and personal development that may otherwise never have been achieved. Furthermore, other general Recovery Movement research has provided descriptions of growth subsequent to recovery from mental illness that overlap with the domains of growth assessed by the PTGI. For instance, one study reported that growth through mental illness recovery was found in social engagement, a sense of meaning, and reengagement in life through identifying new beginnings (Roe & Chopra, 2003), directly relating to the PTGI categories of growth of *more meaningful relationships, increased appreciation for life, and new possibilities for one's future* (Tedeschi & Calhoun, 1996). In sum, while PTG researchers and Recovery Movement researchers have used different labels to describe the same phenomenon: overcoming adversity (including the experience of severe mental illness) is an opportunity for growth.

Using the Voices of Those Who Have Recovered

One way to investigate the experience of recovery from EDs and other mental illnesses and to directly combat the pervasive, powerful, negative messages about prognosis is to use the voices and stories of individuals who have overcome their disorders. Indeed, using the stories of recovered individuals to shape the new understanding of recovery has significantly affected many who have been directly affected by mental illness, including those who are afflicted, caregivers, practitioners and researchers (Ridgway, 2001).

Research suggests numerous benefits to sharing mental health recovery stories including reducing stigma, offering inspiration, and creating meaning (LeCroy & Holschuh, 2012). Studies suggest that hearing from people who have recovered engenders a sense of hope for the future,

motivation to change, and encouragement to seek professional help among those who suffer from mental illness (Linville et al., 2012; Pettersen & Rosenvinge, 2002; Offord et al., 2006). There has also been a documented benefit of hearing recovery stories for staff who interact with chronically ill patients with schizophrenia, stating that these stories provide “a ‘counter-plot’ that challenges and overturns the master decline narrative” (p. 342), offering hope and positively influencing interactions (Ridgeway, 2001). Moreover, recovered individuals who are involved in research benefit by having the chance to make meaning from their struggles (LeCroy & Holschuh, 2012). In this way, the reciprocal growth that occurs in the direct contact between those who suffer and those who have overcome suffering has been described as hope that is “contagious” (Deegan, 1994, p. 59).

The Present Study

The present study used in-depth, qualitative interviews with ten ED survivors to investigate the application of a PTG framework to recovery from EDs. Beyond seeking to strengthen the framework on which to build future research in this areas, this study further aimed to inform the treatment and research communities about the hope for full recovery, while empowering survivors whose personal narratives have the potential to motivate and inspire those who are still struggling.

The research methodology in the present study sought to make improvements on extant ED recovery research by addressing several consistent limitations. For instance, very few studies have used a population of women exclusively in recovery from an ED to explore the subjective experience of recovery (Björk & Ahlström, 2008). Additionally, no studies have been conducted with samples recruited exclusively from within the US in which alternative theoretical models are used to conceptualize and treat EDs, potentially impacting the experience of recovery. Past

studies have also used mixed samples without differentiation between those who are in recovery and those who are still struggling, which limits the conclusions that can be drawn from findings given that research has shown the conceptualization of recovery to change over time (Noordenbos & Seubring, 2006). The present study also included a quantitative assessment of ED symptoms as a way to confirm that all participants met objective criteria for recovery. Although research has indicated that a self-defined recovery status may be more important than a symptom-based recovery checklist (Björk & Ahlström, 2008), asking participants to complete a quantitative assessment of ED behaviors and thoughts would enable a comparison between their subjective experiences of recovery to a more medically-driven definition. Moreover, past research suggests there may be a disconnect between subjective and objective recovery by which women who self-identified as in recovery from their ED actually still exhibited symptoms of the disorder (Bardone-Cone, 2012). Thus, the measurement of ED recovery through standardized quantitative assessment could facilitate a comparison of medically-driven and consumer-driven definitions of recovery. However, the most significant limitation of past research that the present study sought to fill was the lack of a formal application of PTG through ED recovery.

Method

Recruitment and Sampling

Exploratory, qualitative investigations typically employ small samples to enable an in depth case-by-case analysis, “sacrificing breadth for depth” (Smith & Osborn, 2007, p. 56). Through purposive sampling, researchers identify a relatively homogeneous population for whom the research question will be particularly salient (Coyne, 1997; Smith & Osborn, 2007). Sampling and data collection continue until saturation, the point at which no new themes are

identified during analysis (Guest, Bunce, & Johnson, 2006). Past research has indicated that saturation should be reached with a sample size between six and twelve participants (Guest et al., 2006). Whereas future studies investigate the generalizability of findings, the objective of initial qualitative investigations is to offer detailed analysis of themes specific to a particular population (Smith & Osborn, 2007).

For the purpose of the present study, purposive sampling was used to recruit women who were over 18 years of age, had been in recovery for more than two years, and felt that they had grown in at least one way through recovering from their ED. The criteria for two year recovery status was based upon research suggesting that dramatic gains and changes in recovery may be experienced for up to two years after the remission of symptoms (Noordenbos & Seubring, 2006). Participants were recruited through contacts within the treatment and research community and through snowball sampling in which past participants are asked to share study information with others who may be interested. Saturation was reached after the completion of ten interviews.

Participants

Women ranged in age between 20 and 53 years old ($M = 30.80$, $SD = 10.73$). All participants identified as Caucasian. Their EDs developed between the ages of 12 and 18 years ($M = 14.60$, $SD = 2.07$) and they continued to suffer with the disorder for between 3.5 and 22 years ($M = 10.70$, $SD = 6.43$). Participants had recovered from Anorexia Nervosa (AN; $n = 5$), Bulimia Nervosa (BN; $n = 1$), Eating Disorder Not Otherwise Specified (EDNOS; $n = 1$), and disorders that had changed in nature over time ($n = 3$). Nine of the ten participants received formal treatment for their disorders including intensive outpatient, partial hospitalization/day, inpatient, and residential programs in addition to medication management. Time in recovery ranged from 2 to 32 years ($M = 6.43$, $SD = 9.24$). At the time of the interviews, all respondents

scored below threshold for ED symptomatology using the Eating Disorder Diagnostic Scale (Stice, Telch, & Rizvi, 2000; recommended cutoff score: 16.0; $M = 5.3$, $SD = 4.3$).

Measures

Pre-screen questionnaire. An online pre-screen questionnaire was used to determine participant eligibility (see Appendix A). It inquired about general demographic information, as well as basic information about the experience of the ED including diagnoses, symptoms, the number of years spent suffering, and their length of time in recovery.

Interview. Interviews were conducted using a semi-structured schedule developed by the primary researcher for this project (see Appendix B). The interview schedule was divided broadly into four topics: life before and during the ED; treatment and the process of recovery; defining recovery; and life in recovery and experience of growth. However, for the purpose of the present paper, only the thematic structure emerging from the topics of defining recovery and the experience of recovery and growth have been reviewed.

The Eating Disorder Diagnostic Scale (EDDS; Stice et al., 2000). The EDDS is a 22-item self-report questionnaire of ED symptoms based on the diagnostic criteria for AN, BN, and binge eating disorder and includes behavioral, psychological, and physical manifestations of EDs (Stice et al., 2000). Items can be scored to confirm the presence of a diagnosable ED, or can be summed to create an overall ED symptom composite score. Sample items include participant ratings of the frequency of binge eating behavior and statements such as, “Over the past 3 months, have you felt fat?” with response choices ranging from 0 (“Not at all”) to 5 (“Extremely”). The EDDS has previously demonstrated high internal consistency for the standardized composite score (Cronbach’s $\alpha = .89$; Stice, Fisher, & Martinez, 2004). In the current study, the EDDS demonstrated adequate internal consistency (Cronbach’s $\alpha = 0.68$).

The Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). The PTGI is a 21-item self-report measure assessing positive changes in the wake of a traumatic event (Tedeschi & Calhoun, 1996). It assesses growth across five subscales: relating to others (seven items), new possibilities (five items), personal strength (four items), spiritual change (two items), and appreciation for daily life (three items). Each item is endorsed along a 6-point Likert scale ranging from 0 (“I did not experience this change as a result of my crisis”) to 5 (“I experienced change to a very great degree as a result of my crisis”). Sample items include “I established a new path for my life” and “I discovered I was stronger than I thought.” Scores are summed by subscale and a total PTG score is also calculated (with a maximum score of 105). The PTGI has previously demonstrated have high internal consistency (Cronbach’s $\alpha = 0.90$; Tedeschi & Calhoun, 1996) and acceptable test-retest reliability over two months ($r = .71$; Tedeschi & Calhoun, 1996). In the current study, the PTGI demonstrated adequate internal consistency (Cronbach’s $\alpha = 0.87$).

Procedure

Interested participants completed the online pre-screen questionnaire. After determining eligibility, interviews were scheduled and held either in person ($n = 4$) or over Skype ($n = 6$). Prior to beginning the interview, participants were provided with general information about the project and an overview of the interview schedule. They were given an opportunity to ask questions and provided oral consent to participate. Interviews were audio recorded and lasted between 70 and 95 minutes. Immediately after completing the interview, participants were emailed a copy of the consent form containing study information, researcher contact information and a link to the follow up questionnaire, which they were asked to submit electronically within 7 days. The online follow up questionnaire included the EDDS (Stice et al., 2002) as a way to

objectively confirm participants' recovery status and the PTGI (Tedeschi & Calhoun, 1996) to explore growth described during the interview to growth reported in the most common PTG measure. Upon submission of the follow up questionnaire, participants were compensated with a \$30 giftcard to Amazon.com.

Analysis

Interviews were transcribed verbatim by the researcher and coded using Interpretative Phenomenological Analysis (IPA), a highly structured qualitative analysis commonly used in clinical research (Lyons & Coyle, 2007). IPA is particularly apt for investigations that seek to understand the subjective experiences of participants and to analyze the meaning they attribute to personal experiences, states, and events in order to understand how they make sense of their worlds (Smith & Osborn, 2007).

In IPA, the analysis process begins with careful reading and re-reading of each interview transcription while attending to language, descriptions, and underlying meaning (Smith, Flowers, & Larkin, 2009). Each transcript is first read individually and analyzed using line-by-line coding which the researcher uses to identify preliminary themes. Preliminary themes are then clustered and carefully refined within individual interviews. The researcher must consistently revisit the original transcripts to ensure that themes match the participant's account, and therefore makes continuous revisions to themes and clusters. IPA values the depth of individual participant experiences and therefore does not require a certain percentage of participants to endorse a given theme for it to be considered meaningful or to be considered in analysis (Smith et al., 2009). Ultimately, a final table of superordinate (overarching) and subordinate (sub-themes) themes is constructed with direct references to the textual evidence supporting it from within each transcript (Smith & Osborn, 2007). The final product allows for connections to be drawn across

transcripts, while also highlighting the nuances of individual experiences.

Rigor in Qualitative Research

As discussed, qualitative research is concerned with in-depth analysis capturing the unique experiences of individuals and within a clearly defined sample rather than generalizability, as is the goal of traditional quantitative research (Coyne, 1997). As such, the terms *reliability* and *validity* do not readily apply to qualitative investigations. However, there are procedures undertaken within qualitative investigations that strive for *credibility*, *transferability*, *dependability*, and *confirmability* (Lincoln & Guba, 1985). Although terminology for these ideas and procedures is not entirely consistent within the qualitative research community, they represent steps to enhance the rigor of research investigations (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Further, some argue that techniques used to enhance rigor should not be employed after data collection to enhance post hoc analysis, but rather should involve ongoing strategies employed at each step of the research process (Morse et al., 2002). The present study drew from a range of the most widely supported verification strategies as outlined by Morse et al. (2002) to enhance rigor, which are described below.

Strategies to enhance rigor during data collection and preliminary analysis.

Qualitative research is an iterative process that involves shifting between design, literature consultation, data collection, and analysis (Smith & Osborn, 2007). For example, over time, researchers may make changes to the initial interview schedule, drawing upon analysis from past participants' interviews. This process helps to establish rigor by allowing the researcher to identify flaws in design and correct them before data collection is complete, ultimately resulting in richer data and analysis (Morse et al., 2002). The researcher in the present study went through multiple rounds of interview schedule development prior to beginning data collection by

soliciting feedback from researchers with backgrounds in qualitative methods and ED research, and by consistently reviewing the literature. Additionally, simultaneously conducting, transcribing, and analyzing interviews allowed for modifications to be made to the interview schedule as it was being used to collect data, resulting in changes to poorly worded questions, the order of questions, and additions of further questions and probes.

Furthermore, qualitative researchers must approach each stage of the research process with an awareness of pre-existing and developing assumptions, a process enhanced by carefully considering the role of personal perspective, prior experiences, and research background (Morse et al., 2002). By consistently reflecting upon these ideas, the researcher strives to maintain an open mind, challenging existing beliefs and emerging ideas. The goal is not to remove the researcher's perspective, but instead to consider how and why it develops and changes. The researcher in the present study engaged in reflective journaling to document observations, personal reflections, and emerging ideas, a process recommended when undertaking any qualitative investigation (Lincoln & Guba, 1985). Additionally, consultation with a supervisor was utilized to discuss these reflections and consider the role that they played in project development and analysis.

Strategies to enhance rigor during analysis. There are several techniques used to enhance rigor during qualitative analysis (e.g. Morse et al., 2002). In the present study, the researcher used a two-stage process to create and verify the coding scheme. First, consultation with a PhD-level clinical psychologist helped to finalize an overall coding scheme. The consulting researcher used IPA to analyze two interviews and worked with the primary investigator to confirm an overall coding scheme. Discussions resulted in modifications to the primary investigator's preliminary coding scheme and were then rechecked against the two

sample transcripts. The second stage involved collaboration with a Masters-level researcher trained in qualitative analysis who used the finalized coding scheme to re-code 40% of the transcribed interviews. There was high consistency between the primary investigator and collaborating researcher's codes. Any discrepancies between the collaborator's code identification and the primary investigator's code identification were discussed until they were resolved. These discussions helped to clarify the subtle differences in the operationalization of existing codes and elaboration of themes, ultimately enhancing the rigor of the study.

Results and Discussion

The present study analyzed the perspectives of ten women who have recovered from EDs to gain insight into whether psychological growth characteristic of PTG is one possible outcome from having recovered from an ED. Overall, results indicate that participants experienced powerful growth across multiple life domains that characterized and extended traditionally studied PTG. Together, participants' descriptions of PTG through ED recovery can be described by three superordinate themes: *New Relationship with Self*; *New View of Life*; and *Interpersonal Growth*. Table 2 provides an overview of these three superordinate themes and their related subordinate themes with the total participant endorsement listed. In order to understand why a particular theme or subtheme is indicative of PTG, it is necessary to begin with a brief explanation of participants' pre-illness and ED experiences before turning to an explanation of how a given theme is experienced in recovery.

Theme One: New Relationship With Self

Prior to the development of the ED, most participants described that they experienced an underdeveloped sense of self. This insecurity, in addition to crippling anxiety and perfectionism, left participants more concerned with pleasing others than in protecting their own wellbeing.

Most participants lacked self-esteem or self worth and experienced an inability to tolerate negative emotions. During the illness, any semblance of a sense of self was lost as the ED took control over their identities, daily routines, thoughts, and beliefs. Some women described that this happened almost intentionally, as if the ED provided them with a clear way to define themselves in the absence of being able to create a more positive, healthy identity. Universally, the process of recovery involved extensive work in connecting with themselves on a psychological, physical, and emotional level. The superordinate theme of *New Relationship with Self* represented all ten participants' descriptions of the way in which recovery represented redefining who they are, how they think about themselves, how they feel, and the ways in which they remain in touch with their thoughts, feelings, and emotions.

1.1: Strengthened identity/sense of self. All ten participants reported a strengthened identity as a result of their ED and recovery journeys: a sense of knowing who they are. Prior to the development of the ED, most women in the present study reported being extremely self-critical and insecure, traits that have been well-established as important etiological and maintenance factors for EDs (Bardone-Cone et al., 2010b). The ED became an identity that soon completely controlled the way that they thought about themselves. Thus, the process of recovery had involved liberation from the ED identity, in turn resulting in an opportunity to connect with themselves in a way that many believed would not have been possible had they not gone through their illness and recovery experiences.

Six participants described that one fundamental component of identity development had involved coming to understand what they liked, wanted, and believed. Leslie described her pre-ED tendency to be a people pleaser, prioritizing what others wanted from her. As such, a major component of her recovery had been figuring out what she liked and wanted, in addition to what

was good for her, stating, “I think it [recovery] is a growth in understanding who you are, what’s important to you, what’s not, what you like, what you don’t like, and... pursuing things you like, but also deciding, ‘Mm-mm no, I’m not interested in that or that’s not good for me.’”

Furthermore, Leslie described the way in which she believes the identity she developed through her ED and recovery experience was something she would never otherwise have achieved.

I think had I not gone through this, I would have been much more of a people pleaser... I used to say that about myself, you know I would sort of sense what people needed me to do or feel and I would just, that’s what I would do, and that was just much easier, but I think that... my life is so much richer and has a depth to it that I don’t think I would have found had I not had an eating disorder.

For Leslie, whose underlying instability in self-concept was directly implicated in the development of the ED, the process of recovery gave birth to a sense of identity she does not believe she would ever had created without her ED and recovery experiences—in other words, growth above and beyond what she would have been able to achieve without the trauma of the ED, representing a form of PTG not traditionally studied in existing research. Treating her own preferences and values as important and letting them guide her life choices in turn resulted in a “depth” and richness to life.

Additionally, all ten participants were able to recognize and express positive qualities when describing and defining themselves. When asked whether she learned anything about herself through her recovery, Katherine shared, “What I’ve learned about myself is that I actually like myself a whole lot more than I ever thought I would.” Words that were commonly used when asked to define themselves were *passionate*, *bold*, *compassionate*, *smart*, *capable*, *confident*, and *determined*, which starkly contrasted to the descriptions given of themselves before and during the ED. Hannah said that prior to the ED she believed she would never amount to anything and that when she was ill, she thought about herself as, “I have an eating disorder, I

suck at everything, um, I, I'm fat, yeah, I don't have much to contribute to the world." A common narrative described insecurity prior to the onset of the ED, followed by self-hatred or emptiness while ill, before finally giving way to empowerment in recovery. One past study of recovered individuals reported that they experienced an overall increase in self-esteem (Bjork & Ahlstrom, 2008), and the present study documented the ways in which this may have been indicative of PTG by comparing their pre-illness and ED experiences. Ultimately, participants' descriptions reflected the belief that they were capable of making a positive contribution to the world via relationships, professions, activities, and passions.

One universally described example of a positive quality that participants developed through their illness and recovery experiences was a sense of personal strength. Women described that recovering from the ED had seemed like an impossible feat and that recovery helped them to realize their power. For example, Melissa said:

I think it's really impacted who I am because whenever I've gone through difficult things since that, I think to myself, 'I made it through that high school period and college, like I lived through my teenage years into my 20s, and I can live through this too.' Like that was the hardest thing, it was very hard, and it was harder than any other thing I've done since then... like I got married and now I got divorced, and it's like getting divorced is very hard, but it's not hard like that was hard, like it just isn't... I mean, fighting with yourself over your own life is, um, so far that's been the hardest thing I've done.

Melissa was the oldest participant in the study (53 years old) and has also been in recovery for the longest period of time (32 years). It is therefore quite significant that through the 32 years that she has been recovered from her ED she has remained able to draw strength from the knowledge that she survived her ED. In light of the pervasive sense of inferiority, helplessness, and hopelessness that was part of the ED experience, it makes sense that finding the strength to recover allowed participants to develop an overall sense of personal strength. *Recognition of*

Possessing Personal Strength is also one of the five domains of traditionally studied PTG (Tedeschi & Calhoun, 1996), and has been described in a similar light: enduring, surviving and growing from an experience with cancer, military deployment, or loss of a loved one allows individuals to feel that if they can survive that trauma, they can survive anything. Participants' descriptions of personal strength in the present study therefore support the idea that an ED experience mirrors the same type of highly stressful life event that leads to PTG in other populations.

Beyond knowing themselves and appreciating their positive qualities, eight participants' accounts' revealed an experience of self-acceptance, characterized by their ability to accept themselves including their limitations, flaws and weaknesses. Prior to the development of the ED, participants described their desire to excel at each and every task or role in which they were involved. High levels of self-criticism that had preceded the ED for most participants were magnified during the illness, and women reported that they had been unable to let go of their mistakes, and dwelled upon their weaknesses and perceived flaws, placing greater value on the few things that they did poorly rather than the many things they did well.

Growth in recovery therefore meant that not only did they appreciate the parts of themselves that represented their strengths, but that they also understood and accepted the less desirable parts of their identities. Leslie explained this well, stating, "I think growth also means being comfortable once you understand... the good and the bad, or not even labeling them as 'good' and 'bad,' but the things that I like about myself and the things that maybe don't feel so desirable to me about myself, letting that still be okay." Statements like "I've gotten more comfortable in my own skin" (Zoe) and "I think it [recovering] has made me much more forgiving of myself. I feel like I am a lot easier on myself than I ever would have been"

(Madeleine), reflect that participants experience a level of trust and comfort that may not have been achievable without the experience of the ED and the process of recovery.

Taken together, the strengthened sense of identity that participants experienced in recovery was indeed indicative of overall PTG because it represented a resolution to pervasive deficits in self-image that had preceded the development of the illness and that were further heightened during the ED. The ability to know themselves, appreciate themselves, and acknowledge weaknesses represented their value in accepting a more holistic image of themselves, contributing to greater overall well-being.

1.2: Mindfulness and agency. Another way in which PTG through recovery was experienced for participants in the study was through a new ability to remain in touch with their thoughts, reactions, and physical feelings. In fact, the profound awareness of themselves across virtually all life domains represented one of the most widely supported manifestations of PTG. This self-awareness included awareness of stressors, strengths, weaknesses, what is “good for me” and “not good for me.” Claire, who spent more than ten years constantly cycling in and out of treatment for her ED, described that in spite of the illness’ destruction, her recovery gave birth to an important self-awareness:

[The eating disorder] has given me the ability to just be more self-aware, but I think not the eating disorder, but the treatment part of the process itself I think has allowed me to really become more aware of just my own choices and the way I’m reacting to things and my own thoughts and yeah I think it’s just allowed me to have more of that, an ability to reflect, too, on what choices I’ve made, what I’ve done, and what I can learn from it moving forward.

The ability to engage in ongoing self-reflection, to learn from prior experiences, and to monitor one’s own reactions and thoughts helped women in the present study to make meaning from the new challenges that they faced, to understand why certain events may lead to heightened stress,

and contributed to self-regulation that they had lacked both before and during the illness. Claire's description also highlights an important concept that was endorsed by multiple participants: the *process* of recovering from the ED *required* a certain level of self-awareness, which allowed them to articulate an extraordinary level of insight about what had caused and maintained the illness, helped them along the recovery process, and ultimately enabled them to beat the illness. This then translated into an ability to articulate the meaning of their ED and recovery experiences, and further, to remain self-aware in other aspects of life in recovery.

Six women in the present study also reported an ability to *apply* self-awareness through self-advocacy; in other words, using their self-awareness to seek support from others, to take care of themselves when stressed, or to advocate for their own needs. For instance, Leslie said, "I think growth is... a self-awareness, but it's more than that. It's being able to act on that self-awareness, so I mean for a long time I was very self-aware of when things didn't feel right, but I couldn't do anything about it." Her statement reflects that self-awareness alone was not sufficient to help her protect her needs; it was only meaningful when she *applied* that self-awareness. Her description of self-advocacy mirrors that of many participants' accounts of the process of recovery: one of the first steps towards recovery involved gaining awareness of triggers, what role the illness served, and the link between anxiety and ED urges; however self-awareness alone was not sufficient, and recovery required *application* of self-awareness through agency. This provides further evidence for the link between the process of recovery and experience of growth. For example, Leslie learned to apply self-awareness through self-advocacy to enable her to recover. Then, she described that she knew her marriage was no longer right for her (*self-awareness*) and in recovery found the courage to leave the relationship (*self-advocacy*).

Leslie's decision to leave her marriage can be described as a newfound ability to put herself first, a sentiment echoed in four other participants' descriptions of the steps that they take in recovery to prioritize their own health and wellbeing. They learned to put themselves first in their relationships, professional-life, and management of time, even when it meant potentially disappointing or frustrating someone else. For example, Julia described:

When I was in the hospital, my doctor's were like, 'You have to be selfish,' and I didn't understand what they meant, and what they should have said and didn't was um, 'You're allowed to prioritize your own needs,' and I never, ever, ever did that and like I think a huge piece of my recovery has been like articulating what I need.

Julia now knows what is good for her (*self-awareness*) and has the ability to advocate for herself, translating into clear communication with roommates, and at the time of the interview, she was in the process of leaving a job that she knew was making her unhappy. Fear of disappointing others had been a commonly described pre-illness experience for many participants, which made the ability to know and advocate for their needs in recovery particularly meaningful.

1.3: Strengthened connection to the body and mind. Participants described that they experienced a new connection to the body and mind as part of life in recovery, which seven viewed as a particularly strong manifestation of growth. They reported a strengthened connection to the physical body, which allowed them to stay in touch with their physical wants and needs, including a newfound ability to connect with hunger-fullness cues, sense fatigue and need for rest, and a new way of relating to the physical body through activities.

Natalie was one of the participants for whom connection to the body was the most important. In recovery and as an athlete, she takes her cues from what her body tells her it needs. She described, "I feel really firmly about my listening to my body, being calm, like if I run once a week, great, if I run five times a week, great, but I have no preference about those. Like, it's not like one is better than the other." Natalie's description of her new connection to her body is

particularly interesting in light of the fact that she had formerly been very driven by comparisons she would make to other people, modeling her own diet and exercise on the exercise routines and eating behavior of her friends. This sense of competition was exacerbated during her illness. Interestingly, Natalie was treated at an ED facility that had focused largely upon fostering a connection with the body. With no set meal times, meal plan, or exercise plan, patients were supported through the process of learning to be in touch with their bodies in a way Natalie described she never had been before. The fact that she feels passionately about her connection to her body in recovery, reporting a heightened enjoyment of exercise and appreciation for her body, provides further evidence for the link between the process of recovery and growth in recovery.

Five women in the present study expressed that life in recovery involved a new connection to emotions, which they had lacked prior to their recovery process. Several women had previously described the ED as a way to protect themselves from negative feelings. The sentiment that the ED was a way to “numb” feelings has been widely documented in ED individuals in past research, suggesting that poor emotion regulation and distress tolerance may be predisposing, etiological factors (e.g. Espeset, Gulliksen, Nordbø, Skårderud, & Holte, 2012). In the present study, Leslie articulated her ED and recovery experience as related to her relationship to emotions stating:

I think an eating disorder is so much about numbing your feelings and to me, growth is knowing what you feel... what I know now is that if I start to feel anxious, it's gonna pass, and if I start to feel angry or if someone's angry with me, it's going to pass and I'm not going to stay in a certain emotion, so growth is not being afraid of those more scary emotions.

Participants almost universally described extreme levels of pre-existing anxiety (and in some cases depression), which were difficult to tolerate. As such, the ED was a way to reduce their overwhelming experiences of the world into something manageable and controllable. Using the

ED to numb feelings, however, promoted disengagement, isolation, and exhaustion that resulted in a muted experience of all emotions (both good and bad). Leslie's statement shows that she now has an ability to tolerate distress, enhanced by insight about the transient state of uncomfortable feelings. Coupled with other coping skills and insight, she no longer is afraid of "scary" or uncomfortable emotions. Allowing themselves to feel negative emotions also allowed them to benefit from positive emotions, bringing what Claire described as "color" to life.

Consistent with current findings, one qualitative investigation with women recovered from EDs identified a core theme of *awareness and tolerance of negative emotion and self-validation* as a fundamental part of the recovery process (Federici & Kaplan, 2008), and a limited number of prior studies have documented that connection to emotions is an important part of the meaning of recovery (Bjork & Ahlstrom, 2008; Noordenbos, 2011; Pettersen & Rosenvinge, 2002). Additionally, quantitative research has suggested that recovered individuals have functional levels of emotional processing at comparable rates to healthy controls (Oldershaw et al., 2012). The present study builds upon these findings by supporting the importance of connection to emotions as part of the experience of recovery, and further suggests that this connection is an example of PTG. Prior investigations did not explore whether emotional processing in recovered individuals was indicative of PTG because it compared ED-recovered individuals to *others* (healthy controls) rather than to themselves as they were prior to the onset of the ED. Directly comparing participants' pre-illness, ED, and recovery experiences suggests that the connection to emotions may be indicative of overall PTG.

Two participants—Natalie and Melissa—emphasized that recovery represented the birth of a strong connection *between* the mind and body, a connection that fostered deeper understanding and acceptance of emotions and needs. The connection allowed them to use their

physical body cues to sense feelings like stress, anxiety, and discomfort. For example, Melissa clearly articulated how the connection between her body and mind helps her to maintain self-awareness and self-regulation, stating:

You know, something comes up and it's like, okay, I'll take a step back, take a breath, try to look at it and go, 'Okay, well what is this?... my shoulders are really tight. Why am I tight?...' It's like I'll counsel myself, like, 'Just take it easy, take a deep breath, relax. What's going on? Let's find out what's going on here.' Cause I usually feel it before something else, you know... It comes from my body first. Like I'll be tense and uptight and I'll be like, 'What's happening?'

Melissa is able to recognize physical cues as signaling emotional stress, and further, has an ability to talk herself through those difficult situations and uncomfortable feelings. Her description aligns with two prior studies: in a study of PTG through surviving breast cancer, participants described an ability to listen to their body signals and viewed them as a “barometer” by which to judge their overall health (p. 239), and in an ED recovery study, survivors reported increased ability to listen to body signals and use them as indicators of overall wellness (Björk & Ahlström, 2008). The direct connection provides further evidence for the way in which the mind-body connection fostered through ED recovery may be indicative of overall PTG.

Summary of *New Relationship to the Self* as PTG. Participants described the relationship with themselves prior to the onset of the ED as marked by insecurity, self-criticism, and an inability to know, acknowledge, or advocate for their wants and needs. Without the illness or recovery process, participants expressed that they believe they would have continued to undervalue and over-criticize themselves. Through the recovery process, they were forced to learn who they are, how they feel, what they like, and what they believe, ultimately creating an integrated self image in which they simultaneously value their positive attributes and accept those that are less desirable. As they learned to recognize and tolerate emotions, they discovered

that they are capable of handling challenges and uncomfortable feelings. They learned to stand up for themselves in a way that they never had been able to before. Their ability to come to know, connect, relate to, and advocate for themselves in this new way shows an overall value of themselves, their strengths, their weaknesses, their bodies and minds, and their ability to survive future challenges.

Several of the subthemes of *New Relationship to Self* reflect ways in which participants developed insights and views of themselves that people without mental illness more easily acquire (i.e. a stable identity, ability to appreciate positive qualities). At first glance, this seems to act as evidence against these themes being representative of PTG. However, it is important to remember that PTG compares the experiences that an individual had prior to a trauma, the experience that she would have continued to have without the trauma, and the experience that she has post-trauma. Women in the present study expressed that without the impetus of the development of the ED, which forced them to address underlying issues including pre-existing pathology implicated as a distal risk factor for EDs (i.e. chronic issues of instability in identity, crippling anxiety, and low self-worth), they may very well have continued to suffer from those issues indefinitely. It was thus the ED, sparking a dramatic state of decline in functioning, that served as more pressing motivation to grapple with and overcome their underlying issues. It was their recovery process that gave birth to growth above and beyond what they may otherwise have been able to achieve.

Theme Two: A New View Of Life

The second superordinate theme that emerged through discussions of life in recovery was the emergence of *a New View of Life*. Life before the ED had been marked by intensity, pressure, and extreme stress. Some stress was brought on by participants' unrealistic expectations of

themselves, and most also endured a variety of highly stressful life events including trauma, major life changes, family psychopathology, and overwhelming pressure imposed by others. Prior to the ED, participants reported that they lacked the ability to manage stress, let things go, or put things in perspective. The ED then became the way that they attempted to cope with stress, at the expense of eventually derailing all positive aspects of their lives. During the illness, they experienced heightened stress, perfectionism, and intensity, which created feelings of being overwhelmed, exhausted, disengaged, and hopeless about the future. Accessing hope for the future, gaining insight, and letting go of intensity was a defining part of the recovery process, which participants universally expressed generated new ways of interacting with the world and thinking about the future now in recovery.

The connection between growth related to view of life and the experience of a trauma has been previously explored in general PTG literature (Tedeschi & Calhoun, 2004). As previously mentioned, what characterizes a traumatic event that has the potential to lead to PTG is that it severely challenges the way individuals think about themselves, what they can control, and the future (Tedeschi & Calhoun, 1996). Coping in the aftermath of the trauma—in this case the ED—therefore involves re-conceptualizing one's place in the world, which for some individuals becomes a manifestation of PTG (Tedeschi & Calhoun, 1996; 2004). Results of the present study indicate that women who have recovered from EDs are capable of achieving this commonly studied manifestation of PTG.

2.1: New directions. All participants stated that recovery offered their lives new directions. Recovery allowed them to resume the parts of their lives that had been abandoned during the ED and from which they would have remained disconnected had they not recovered. Additionally, six participants described that they had specific dreams that were unattainable

when they were ill including entering serious relationships, completing their education, becoming independent, and having children. What made actualization of these existing goals a manifestation of PTG and not simply a return to typical functioning was the way in which participants felt that the insights, perspective, and coping skills garnered through recovering helped them to maximize their potential, better manage stress, and better perform in their new jobs and roles. For example, Madeleine described her life-long goal of becoming a doctor and discussed the role that recovery played in allowing her to fulfill that dream. Now that she has recovered, Madeleine is able to use the insights and perspective she gained through recovery to enhance her work as a medical student by keeping stress in check in a way that her peers are unable to, representing a manifestation of PTG.

Other participants described the ways in which recovery gave birth to the development of new passions, new goals, and a different future than they would have ever otherwise planned. For many, this passion was related to raising ED awareness and working with people struggling from mental illness or eating pathology. One participant published a book about her ED experience, two are public speakers about EDs, four currently work or are being trained as counselors, and two others focused on psychology in school. This manifestation of growth is related to traditional PTG's domain of *Identification of new possibilities for the future* (Tedeschi & Calhoun, 1996; 2004), characterized by a new path related to one's traumatic experience. For example, Tedeschi and Calhoun (2004) describe the experience of someone who endured trauma through loss of a loved one and decided to become an oncology nurse to support others facing similar struggles. In the present study, as in past research, participants expressed that using their personal experiences to guide future directions was empowering. For example, Natalie explained that she feels empowered as a student, friend, and teammate because of the insights she gained

through her recovery stating, “I feel like I have a voice that deserves to be heard... and I never felt like that before.” Developing a voice, a sense of purpose, or a passion to apply personal experiences in future endeavors offered participants a way to make meaning from their illness and recovery experiences by using them in an attempt to help others.

Collectively, participants in the present study described that their ED and recovery experiences drove their lives in new directions, either through allowing them to reach pre-existing goals with the added strength of new insights, or by helping them to develop new passions related to making a difference in the lives of individuals who are impacted by these devastating illnesses.

2.2: Gratitude. All ten participants’ stories and descriptions embodied a deep sense of gratitude. For example, participants commonly expressed gratitude for the chance that they were being given for a life in recovery. At one level, for participants who had neared death because of their ED, recovery represented a very literal second chance. For example, when asked if she thought she would recover, Claire said that she was absolutely certain she would not get better and that she would be dead before she was 30. Then, when asked to describe her life today, Claire said, “It’s amazing and if you’d asked me a couple years ago if I thought I would be where I’m at now, no! No way. But I wouldn’t change it for anything.” On the other hand, several participants described that even if recovery did not represent a literal second chance at life, it offered a second chance for a new way of living. For example, Hannah said:

I think that I could have physically gone to graduate school like with my eating disorder, but I wouldn’t be enjoying it like I would just be like getting through each day. And I’m, I enjoy my life now! Not to say that I don’t have times where I doubt that or you know or whatever, but in general, yeah, I’m just, I have things that I enjoy and I look forward to and I feel like to some extent, I believe in myself and my ability to achieve things.

Unlike Claire who envisioned that she would be dead, Hannah had expressed that she never thought her life was in danger. However, she had formerly viewed herself as destined to always be “miserable.” Though she sees the steps she has taken in life now that she is recovered to have been possible regardless of her whether or not she still suffered from an ED, she described gratitude for the new ability to engage in and enjoy her life in recovery.

On a related note, because life with the ED was described as “complete misery” and “desperately lonely” (Claire), “fractured” (Zoe), “total despair” (Hannah), daily life in recovery was viewed as a gift. Claire clearly articulated this gratitude stating, “I enjoy the things that are in my life so much now... it’s not all sunshine and flowers all the time, but even the not as great times, the times when you’re just sad or you’re angry or frustrated, even those times aren’t bad, like not that different.” Having spent 20 years with the ED and more than 10 years cycling through treatment programs, Claire is able to appreciate not only the positive experiences she has in recovery, but also the normal stress that comes with everyday life. Feeling disappointed or nervous about transitioning to a new phase of life is appreciated in light of the stress she had been forced to endure while she was ill.

Traditional PTG research has documented *Increased appreciation for daily life* as one of the five overarching domains of growth, manifested as recognition of things that might have once been taken for granted (Tedeschi & Calhoun, 1996). The sense of appreciation for daily life experienced by women in the present study aligns with this traditional domain of PTG.

Participants were eager to acknowledge the people and circumstances that had allowed them to recover, and extended their expressions of gratitude to acknowledge the people, opportunities, and experiences they now have in recovery. For example, they offered statements of appreciation for jobs about which they felt passionate, supportive colleagues, new opportunities, birth of

greater independence, and exciting experiences. Finally, nine participants expressed gratitude specifically for their relationships. Some women described being grateful for relationships that helped them on their journey to recovery and others communicated a general gratitude for the relationships that help make life meaningful. Maya stated, “I am sort of loving life, I guess you could say. I take value in relationships and in sort of the little things, but I think the biggest thing is that I value the opportunities that I’ve been given to continue a life.” In general, things that they may have taken for granted prior to their experience with the ED and recovery were now consciously appreciated.

2.3: A Sense of perspective. Collectively, women in the present study reported that prior to the illness they were constantly seeking to change and improve, striving to reach an unrealistic idea of perfection in their schoolwork, jobs, athletics, and other activities. They lived life by a strict set of rules, at first to manage anxiety and maximize performance, and after the development of the ED, they lived by even stricter and more destructive rules to maximize weight loss and hide ED symptoms. Through the process of recovering, they had gained an ability to keep things in perspective by looking at the bigger picture, reminding themselves of what really mattered most, reflecting upon the inevitable ups and downs of life, and moving on when facing serious challenges.

The sense of perspective that they reported and that is representative of PTG may be directly related to one of the fundamental components of the recovery process: learning to combat cognitive distortions and let go of obsessive ED-related thoughts, especially as they related to body image dissatisfaction. For example, Katherine had experienced intense body image disturbance beginning in early childhood, which had been a significant force driving her ED. She explained that during the recovery process, she learned to let go of her obsession with

body image and still today uses a sense of perspective to dismiss body dissatisfaction, stating, “If I think of, ‘Okay, I’m dissatisfied with my body,’ but... if I think in terms of bigger picture, that’s really not that big of a deal. It’s not something to really focus on.” Significantly, Katherine later noted that she is able to use the same sense of perspective to coach herself through other stressful or uncomfortable situations. She said, “I don’t feel the same desperation or, um, sense of urgency related to other distressing situations. It’s just, ‘This is what it is. I’m going to do X, Y, Z, and you know, if it works out, great! If it doesn’t, I know I can deal with it and I’ll be fine.’” The connection between her pre-ED struggle, recovery process, and growth again provides further evidence that the experiences participants had in the process of recovery (i.e. learning to put body dissatisfaction aside by looking at the bigger picture) directly impact the growth that they experience in recovery.

Shifting focus away from body image and reminding themselves of what matters most directly relates to a *Changed sense of priorities* that is one of the traditionally studied domains of PTG (Tedeschi & Calhoun). Change in priorities has been implicated as an especially important theme for individuals who have overcome physical health traumas (Hefferon et al., 2009). In a systematic review of PTG studies related to physical health traumas, survivors reported shifts in their priorities relating to how they spend their days, value of appearance or money, and the goals that they set (Hefferon et al., 2009). For example, one specific study with breast cancer survivors documented that participants experienced growth as a change in their priorities—for example, by not worrying about keeping the house neat—through cancer treatment and recovery (Horgan, Holcombe, & Salmon, 2011). In the present study, women reminded themselves that their overall health, well-being, and happiness were what really mattered most to them. This helped them to put aside body dissatisfaction and also to branch out by taking significant risks.

Rather than making tireless strides towards a more perfect image, better grades, or greater success, participants learned to value spontaneity, flexibility, and an ability to “go with the flow” (Claire). The things that mattered most were spending time with loved ones, staying true to their values and desires, engaging in activities that led to fulfillment, and maintaining balance.

Participants further described their newfound acceptance and appreciation of the significant challenges and disappointments that are inevitably part of life. The sentiment commonly expressed was that life is not about being happy all the time, but rather is about carving a path for oneself that feels exciting, challenging, rewarding, and fulfilling. Overall, women in the present study communicated an appreciation and acceptance of challenges and disappointments, strengthened by their newfound confidence in their ability to handle adversity. For example, Claire described the reaction that she now has to significant disappointments stating, “I can just have more perspective about things and have confidence that it’ll work out, somehow, someday it will work out and I have the abilities to make it work out, so it just, I can handle difficulties, problems, challenges, 110 times better.” Participants’ sense of perspective was often built upon a sense of personal strength previously described: they expressed the belief that they knew challenges would arise and that they could handle them. The ability to take challenges as they come, dismiss disappointments, and let things go represents growth in outlook that bolsters overall quality of life.

Summary of *New View of Life* as PTG. Prior to the development of the ED, participants lacked the ability to take a step back and approach life in a balanced way. Their lives were marked by high stress, high intensity, and poor ability to handle challenges in a productive way. In this sense, *a New View of Life* represents the ways in which the ED and recovery experiences resulted in PTG that led to a resolution of pre-existing issues. However, the theme also

represents the ways in which the experience of recovery led new directions, new priorities, and new perspective that are unrelated to pre-existing problems and therefore more closely mirror PTG studied in other populations.

Theme 3: Interpersonal Growth

Participants' pre-ED interpersonal experiences varied significantly. Some women described that they had strong relationships with family and friends prior to the onset of the illness, and others described that they had lacked close, meaningful relationships and had significant interpersonal problems particularly with family members. Universally, participants described that the ED led to the loss and deterioration of relationships, which became marked by superficiality, authenticity, manipulation, and deception. The illness created extreme feelings of isolation and loneliness as participants withdrew socially. However, the recovery process led to deepening of relationships with others, changes in the characteristics of relationships, and other interpersonal assets, which all became manifestations of PTG in recovery.

3.1: Strengthened relationships. Participants in the present study described that they experienced extensive interpersonal growth that was manifested both in terms of the strengthening of specific relationships and in terms of growth in the general quality of relationships through openness and authenticity. Five participants described specific relationships that had grown stronger as a result of recovery. For example, Leslie reported particularly strong family involvement in the recovery process and subsequent growth within her family unit. Notably, Leslie received treatment in a program that focused on inclusion of family. Family therapy groups specifically designed to empower patients and families together worked to combat some of the most commonly held misunderstandings about EDs (i.e. beliefs that they are a choice, that they are all about image) in addition to fostering support. Leslie described that

through family therapy, she was able to say things to her family that she had never felt comfortable sharing before, and that they remain an integral supports today. The strengthened connection to her family involving openness, authenticity, and facing such an extreme challenge together logically aligns with the description of overall increased closeness reported in traditional PTG research (Tedeschi & Calhoun, 1996). PTG literature has shown that survivors of other traumas often feel more connected to the people who supported them through their experience by helping them to figure out who was a real friend during their time of need (Tedeschi & Calhoun, 1996). Leslie's experience of increased family closeness through the process of coming together to help her recover supports the incorporation of family in the treatment process, which is not the norm in traditional hospital-based US programs; not only does Leslie feel that her family's support was essential in helping her to recover, but they experienced PTG at the family level through their involvement.

Interestingly, there were several women whose families were not involved in the recovery process, but who still experienced strengthened family relationships in recovery. For example, Katherine actively chose not to include her family when she entered ED treatment because she felt ashamed about her disorder and felt unable to broach such an emotional topic in light of existing family dynamics. Despite the fact that they were not involved in her recovery process, Katherine stated that their relationships are "*so much* better because of this whole recovery process." She attributed the closeness she now feels with them to the changes she made at a personal level, in turn bringing about a change in family dynamics and closeness. The importance and benefits of the authenticity Katherine was able to bring to her relationships was echoed in other participants' descriptions of relationship-related PTG in recovery.

Many participants described that life before and during the ED was marked by feeling compelled to hide significant parts of their identity and life experiences in order to portray a certain image of themselves, even to their very closest friends and family. As such, the empowerment and strengthened identity they experienced through recovery translated into more authentic relationships for nine participants. It appears that because these women were more in touch with who they are, what is important to them, and what they need—in addition to being comfortable advocating for themselves—they also experienced an increase in the authenticity of their relationships with others.

In recovery, eight participants described an ability to let others in, which included sharing about both past and present experiences. Openness was commonly expressed as it related to participants' ability to lean on others in hard times and also to share important parts of themselves including their history of an ED. Maya described that in the past, she would have reached out “superficially” when facing a challenging situation. This commonly described superficiality and tendency to hide problems seemed to be perpetuated both by the general isolative nature of the illness, but also by the pre-existing deficits in self-worth experienced by many of the women. Withdrawing from others and hiding the serious battle that they faced when struggling with the ED also maintained the illness. Then, during the recovery process, women described that letting others in was an essential part of successfully overcoming the ED. Thus, this once again provides evidence that the essential components of the process of recovery directly relate to the new values and growth experienced in recovery.

Two participants—Leslie and Melissa—are parents today and described that they are able to use the insights gained through recovery to be a better parent. In both cases, the women related their strengthened parenting to an ability to let their children be themselves and express

themselves freely, which appears to be related to the struggles that these two women faced within their own families. For example, Melissa's pre-ED, illness, and recovery experiences seem to have directly impacted her parenting style. She was the only participant who did not receive formal treatment for her illness, attributable to the fact that her parents chose not to directly acknowledge her very emaciated state and problematic behavior. As opposed to her mother's mantra of "everything is fine," Melissa described that as a parent, she frequently engages in conversations about challenges her children are facing. Melissa tries to offer insights about principles that helped her to achieve a greater sense of well-being stating, "My answers are not necessarily gonna be the best answers for her, and... I still supply them, you know I still believe my own truth, but it might not be her [daughter's] truth." Here, Melissa demonstrates a desire to be open and authentic with her children, acknowledge the hardships they face, offer them support, and yet still understands that she and her children may need different answers to life's greatest questions. These parent-child relationship qualities were missing from the relationships she had with her mother and father growing up, and through her recovery she gained insight about how essential they would have been to her well-being. As such, she works hard to incorporate those principles into her parenting style.

One prior study that looked at PTG in people who were currently struggling with substance use disorders similarly documented strengthened parenting skills as a domain of growth (McMillen et al., 2001). More specifically, it reported that participants felt better able to help their children if they were to face similar problems. The present study differed in the specific way in which participants experienced strengthened parenting, because women reported being better able to *separate* their own struggles from their children's as opposed to support them only in similar situations. This distinction may be attributable to the fact that both women

in the present study had described being relatively enmeshed with their parents when growing up, having extreme difficulty separating from their families and creating an identity. They therefore came to realize how important it is to foster open, authentic relationships with their children, and to encourage them to express themselves freely, become their own people, and find their own answers.

3.2: Increased empathy. Interestingly, six women independently and explicitly used the word “empathy” to describe a way in which they felt they had grown through recovery. Julia clearly articulated the relationship between the traumatic nature of the illness and the experience of increased empathy for others saying, “... I’ve been through something really fucked up, really invasive, and really, really hard, so I have a lot of empathy for people who are going through things.” Participants’ descriptions indicated that it may have been the raw, vulnerability they experienced when they were sick that most directly translated into increased empathy. Most commonly, they described empathy for people facing challenges associated with mental or physical illness. For example, Leslie described:

I think that I have so much more empathy for people who are struggling in general with any mental illness or physical illness or that um, life is super challenging when you struggle with that stuff and um [pause] not being so quick to judge people and I just think that idea of walking in other people’s shoes is a huge, huge thing... having to go through the therapy to recover... I just think I’m so much more empathetic, self-aware, that if I hadn’t had an eating disorder or didn’t go to therapy, I wouldn’t have had that.

What Leslie describes is empathy for people struggling with other illnesses, relating to past literature indicating that breast cancer survivors and bereaved individuals experience an increased level of empathy for others undergoing similar struggles to those that they faced (Horgan et al., 2011; Tedeschi & Calhoun, 1996). Having lived through the experience of the ED

and the struggle to recover, participants appreciated how challenging illness can be, extending empathy to others facing similar battles.

Leslie's statement also touches upon an idea that was endorsed by several other participants: increased empathy and decreased judgment may in fact have stemmed not solely from experiencing a challenging personal situation, but more specifically may have been related to group-based treatment for the ED. For example, Madeleine explained that in treatment, she was exposed to people from all walks of life struggling with a wide variety of mental health problems. The openness of these individuals and the connections that were formed through the treatment process helped her to develop empathy for others.

Summary of *Interpersonal Growth as PTG*. Participants' descriptions of the ways in which recovery generated strengthened relationships and increased empathy both align with and extend traditionally studied PTG. More specifically, growth in strengthened relationships that has been documented in past research (e.g. Tedeschi & Calhoun, 2004) was further specified in the present study by both strengthening of specific relationships (with family members and children) and in terms of greater authenticity and openness. Women described the fundamental role of support from others in their own recovery journeys and the way that principles of authenticity and openness that were instrumental in recovering now guide relationships. Having seen the significance of the individuals who did support them and the patience and kindness they were shown by a combination of providers, friends, and family members, these women were especially aware of others' struggles and felt a strong desire to be supportive of others.

Quantitative Assessment of Posttraumatic Growth Among Study Participants

Although the present study was a qualitative investigation, the PTGI (Tedeschi & Calhoun, 1996) was administered to the study participants to preliminarily test its utility with this

sample. While inferential statistics cannot be computed due to the small sample size, the PTGI is a well-established and widely used measure and thus an examination of the relative frequency of item endorsement and descriptive comparison to scores of growth in previously studied populations would serve to more easily compare PTG in this sample to other populations.

An overall PTG score was calculated from participants' responses to the PTGI (Tedeschi & Calhoun, 1996). The level of growth they reported ($M = 81.3$, $SD = 11.86$) appears remarkably similar to the level of growth reported by participants in Tedeschi and Calhoun's (1996) original validation paper ($M = 81.6$, $SD = 21.09$). Further, when attending to individual items on the PTGI (as displayed in Table 3) there is substantial overlap with themes of growth that emerged from interviews in the present study (displayed with an asterisks). Table 3 also reports the frequencies of scores endorsed for each PTGI item. The most highly scored item was, *I experienced a change in appreciation for the value of my own life*, which descriptively captures the empowerment expressed by women in the present study. Other highly scored items relating to results of the present study included *New opportunities are available that would not have been otherwise* (relating to *New Directions*), as well as *I discovered that I am stronger than I thought I was* (relating to *Increased sense of personal strength*).

Further support for the link between the PTG described in the present study and traditional PTG is evident from Tedeschi and Calhoun's (1996) original PTGI paper. In that original work, authors presented a review of literature on growth through adversity, which they then used to construct the PTGI. Their review reported three broad categories of growth: *Changes in self-perception*; *Changes in interpersonal relationships*; and a *Changed philosophy of life* (Tedeschi & Calhoun, 1996), which align with the three overarching categories of growth documented in the present study. Their research done to construct the PTGI resulted in a

classification of growth in five domains that do not equally align with growth reported in the present study; however, the fact that the original literature review that prompted the construction of the PTGI yielded a nearly identical conceptualization of growth as emerged in the present study is significant. Together, the overlap acts as preliminary support for further testing of the PTGI in ED recovered populations. Future investigation of PTG in ED-recovered individuals should account for the unique experiences of associated with the illness and ED recovery (e.g. the presence of underlying psychopathology, stigmatization of the illness, the psychological nature of treatment). Additionally, modifications to account for important domains of ED-PTG growth (e.g. self-awareness, strengthened identity) should also be explored.

Conclusions and Future Directions

The present study provided powerful evidence of PTG among a sample of women who have recovered from EDs and suggests the possibility that PTG may be highly related to the experience and process of ED recovery. These findings are significant because they change the prevailing conceptualization of EDs as destructive, life-long battles for which there is little hope of full recovery. The present study marked the first formal attempt to bridge PTG and Recovery Movement research, and provides preliminary support for the ways in which connecting these two frameworks can benefit each research community: PTG research is extended to a new population and Recovery Movement research has a concrete growth framework on which to build to document the potential for meaningful growth through mental illness recovery. Future studies should attempt to investigate whether existing PTG research on the correlates and predictors of growth similarly align with correlates and predictors of mental illness recovery.

One of the more practical goals of the present study had been to provide first-person narratives that might serve to inspire individuals affected by EDs. The message that full recovery

is possible, regardless of the length or complexity of the illness, has the potential to encourage and motivate people who are currently struggling. The potential impact of this message is especially powerful given the message of hopelessness that currently pervades the ED community. Participants in the present study expressed that they wished more information about recovery had been available to them while they were fighting to get better. They reported feeling hopeless and deeply skeptical of the possibility of recovery, stating, “For a long time on this process I was like, ‘I’m not meeting anybody who is recovered. I’m seeing people who have been in this for 30 years, so why should I believe that recovery is possible?’” (Maya). The majority of study participants strongly advocated for an increase in availability of recovery stories and information about the broad range of recovery experiences. Indeed, the calls for greater conversation about recovery from EDs echoes those made within other areas of the mental illness Recovery Movement. Significantly, many of the study participants noted that having a platform to share their journeys, their insights, and their experiences was itself empowering. As one participant stated, “I’m honored to be a part of it [the study]. I think, you know, if you have to struggle with something, it’s nice to know that some good stuff might come out of it” (Leslie). Therefore, it seems that involving individuals who have recovered from EDs in future treatment and research efforts has the potential to inspire sufferers and empower survivors, while simultaneously providing valuable information to researchers and providers.

Future research should address the limitations of the present study and extend findings. Although the exploratory nature of the investigation mandated the use of qualitative methodology and purposive sampling with a homogeneous population, future investigations will need to recruit more representative samples to determine the prevalence of PTG as it relates to ED recovery. As the focus of research shifts to generalizability, more diverse samples should be

included. Interviews with individuals at different stages of the illness and recovery process will be useful in understanding the temporal course of PTG through ED recovery and to investigate whether the course of one's recovery journey impacts the nature of growth experienced. To assist with ongoing investigations of PTG through ED recovery, a quantitative assessment similar to the PTGI could be developed and tested for use with ED-recovered samples.

In sum, this qualitative study of a sample of women who reported growth through recovery from EDs, although presenting certain limitations, provided strong evidence for the possibility for PTG for a population whose ability to sustain real recovery has long been doubted. It also underscored the importance of involving recovered individuals in future research efforts in order to broaden the conversations about ED recovery and enhance understanding of the illness and recovery process. The benefits to those who are struggling, and those who care for and treat them, could be deep and far-reaching.

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Table 1

Participant Demographic Information

Participant	Age	Years with ED	Recovered from	Years in Recovery
Madeleine	25	10	AN, BN, EDNOS	3
Katherine	35	15	AN, BN, EDNOS	4
Natalie	20	3.5	BN, EDNOS	2
Melissa	53	8	AN	32
Hannah	23	7	EDNOS	2.5
Julia	22	7	AN	2.5
Leslie	44	22	AN	5
Maya	23	3.5	AN	2
Zoe	32	11	BN	9
Claire	31	20	AN	2.25
<i>M</i>	30.8	10.7		6.43
<i>SD</i>	10.73	6.43		9.24

Note. All names are pseudonyms. AN = Anorexia Nervosa; BN = Bulimia Nervosa; EDNOS = Eating Disorder Not Otherwise Specified.

Table 2

Overall Thematic Structure: Experience of ED Recovery and Growth

	Theme	Endorsement
<u>Theme 1</u>	<u>New Relationship With Self</u>	
1.1	Strengthened sense of identity	10
1.2	Mindfulness and agency	10
1.3	Connection to mind and body	7
<u>Theme 2</u>	<u>New View of Life</u>	
2.1	New directions	10
2.2	Gratitude	10
2.3	A sense of perspective	8
<u>Theme 3</u>	<u>Interpersonal Growth</u>	
3.1	Strengthened relationships	10
3.1	Increased empathy	6

Table 3.

Item Frequency Distribution: Percent of Participants Who Endorsed Each Possible Score on the Posttraumatic Growth Inventory

Item	Score					
	0	1	2	3	4	5
1. My priorities about what is important in life*	-	-	-	10	50	40
2. An appreciation for the value of my own life*	-	-	-	-	30	70
3. I developed new interests*	-	-	10	40	40	10
4. A feeling of self-reliance	-	-	-	10	50	40
5. A better understanding of spiritual matters	20	10	10	30	20	10
6. Knowing that I can count on people in times of trouble*	-	-	-	20	30	50
7. I established a new path for my life*	10	-	-	20	20	50
8. A sense of closeness with others*	-	-	-	20	30	40
9. A willingness to express my emotions*	-	-	-	30	60	10
10. Knowing I can handle difficulties*	-	-	-	10	30	60
11. I'm able to do better things with my life*	-	-	-	10	30	60
12. Being able to accept the way things work out*	-	-	-	40	30	30
13. Appreciating each day*	-	-	10	10	60	20
14. New opportunities are available which wouldn't have been otherwise*	-	-	-	-	50	50
15. Having compassion for others*	-	-	-	20	50	30
16. Putting effort into my relationships*	10	-	10	20	30	30
17. I'm more likely to try to change things which need changing	-	-	10	20	50	20
18. I have a stronger religious faith	40	10	-	30	10	10
19. I discovered that I am stronger than I thought I was*	-	-	-	10	40	50
20. I learned a great deal about how wonderful people are	10	-	10	30	30	20
21. I accept needing others*	-	-	-	40	30	30

Note. Asterisk indicates a direct qualitative overlap with the thematic structure that emerged through interview analysis. Based on the *Posttraumatic Growth Inventory* (Tedeschi & Calhoun, 1996); Key: 0 = I did not experience this change as a result of my crisis; 1 = I experienced this change to a very small degree; 2 = a small degree; 3 = a moderate degree; 4 = a great degree; 5 = a very great degree as a result of my crisis.

Appendix A

General Information Questionnaire

PLEASE SEE https://dickinson.qualtrics.com/SE/?SID=SV_82F1O1hZzAcQa4BThe Dickinson logo is displayed in white serif font on a dark red rectangular background.

Thank you for your interest in participating in our research project! **Your story has the potential to help influence future research and to inspire people currently fighting Eating Disorders!**

Please take 5 minutes to respond to the following questions to give us an idea of who you are. A member of our research team will contact you within 48 hours to discuss further details of participation.

Submitting these responses in no way forces you to continue with the project. **You are free to withdraw your interest at any time.**

What is your name?

What is your email address?

What is your phone number?

How would you prefer to be contacted?

- Via email
 Via phone

How old are you?

What is your race?

- White/Caucasian
 African American
 Hispanic
 Asian
 Native American
 Pacific Islander
 Other

How old were you at the time of your Eating Disorder diagnosis?

Which Eating Disorder diagnosis did you receive?

Check all that apply.

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Eating Disorder Not Otherwise Specified (EDNOS)
- Other (please describe)

Please briefly describe the nature of your Eating Disorder in your own words.

For example, a short description of the most significant symptoms with which you dealt.

Please describe the type of treatment you received (e.g. *individual therapy, outpatient program, partial hospitalization, inpatient hospitalization, residential, medication*):

Total time you identify as having struggle with an Eating Disorder (in years)

Total time you identify as being in recovery (e.g. 3 years and 5 months)

Note: This can be your best estimate.

Please enter your 5-digit postal code (for interview scheduling purposes)

By submitting these responses, I consent to having my information used for contact purposes. I understand that I may withdraw my interest in this study at any time by contacting research team at moss@dickinson.edu.



Contact moss@dickinson.edu with any questions

Survey Powered By [Qualtrics](#)

Appendix B

Interview Schedule

Life before and during the Eating Disorder

I want to begin by getting an idea about who you were leading up to the development of your eating disorder, and what the experience of having an eating disorder was like for you.

1. Looking back, can you tell me what you view as the first signs of your eating disorder?
 - a. What was going on in your life at that time?
2. How did it progress or change as you got older?
 - a. Were there any life changes/events that impacted the course? (for example, made symptoms more severe?)
3. Can you describe one of the most significant ways that your life changed while you were sick? For example, a change in your social, family, academic/professional life?
 - a. Can you describe the most destructive aspects of your illness?
 - b. Did you notice that it disrupted life in any domains more than others?
4. What happened that led you to realize that it was something you needed help with?
 - a. What eventually caused you to enter treatment?

Treatment:

I'm now going to ask you several questions about the experience of treatment and the process of recovery.

1. What type(s) of treatment did you receive?
2. What was your attitude when you entered treatment? (Were you motivated to recover?)
 - a. If you weren't motivated at the beginning: What was it that happened that led you to want to recover?
3. The experience of treatment:
 - a. What do you think were the most beneficial parts of treatment?
 - b. Can you describe the most difficult parts of being in treatment?
 - i. How did you overcome/cope/manage/tolerate it?
4. Was there a turning point in your treatment?
5. Can you describe the most instrumental people or things that helped you as you recovered?

- a. For example, people, treatment, life goals?
- 6. Did you have an “ah-ha” moment when you were able to see evidence of your progress?
 - a. When did you first realize/feel that you were “in recovery”?

Defining Recovery

I've been reading quite a bit about defining recovery from an eating disorder, and there are some conflicting perspectives about the definition. Some people deny that “recovery” from an eating disorder is even possible. Other people use a combination of physical, behavioral, or psychological criteria. I am hoping you can help to shed some light on your recovery experience.

1. How do you describe/define “recovery” today?
 - a. Did that definition change over time as you progressed in treatment/life after your eating disorder? How?
2. When you were sick, did you believe that recovery was possible?
 - a. What contributed to that belief?
3. Is there anything that you wish you had known while you were ill that you feel would have helped you as you were going through the recovery process?

Reflecting on the experience of having an ED and recovering

The final general topic of conversation I'd like to explore is how you look back on your struggles with an eating disorder and where you are today.

1. Has your experience with an ED impacted who or where you are today? How?
2. Can you describe your relationship with your body? Do you think your relationship is pretty typical for someone your age/similar to your peers?
 - a. Are there any differences in how you think about your body now compared to before or during your eating disorder?
3. In terms of defining/describing yourself:
 - a. I know you said your ED started when you were young, but can you remember how you would have described yourself before your ED?
 - b. How would you have described yourself while you were living with an ED?
 - c. How do you describe or define yourself today?
4. In terms of defining/Describing your life:
 - a. How would you have defined or described your life while you were sick?

- b. How do you define or describe your life today?
5. How did you cope with challenges BEFORE, DURING, and AFTER your illness?
6. Are you doing things today that would not have been possible if you were still ill?
7. Where do you see your life going in the future?
 - a. Has recovering from your ED changed the way you think about the future?
8. What does the idea of growth through recovery mean to you?
 - a. Can you describe any ways in which you think recovering has led to growth?

Final thoughts

If it is okay, I'd like to close by asking you how this interview process was for you.

1. How often do you think about your history with an ED? In what ways?
2. Do you ever talk about your eating disorder with your close friends or family?
 - a. What about with new friends (who didn't know you while you were ill)?
 - b. Or with people who are currently struggling? Why or why not?
3. How does it feel to share your experiences of your eating disorder and subsequent recovery?
4. Is there anything I missed or anything else you would like to share?

Appendix C
Eating Disorder Diagnostic Scale
 (Stice, Telch, & Rizvi, 2000)

Please carefully complete all questions.

Over the past 3 months...	Not at all		Slightly		Moderately		Extremely
1. Have you felt fat?	0	1	2	3	4	5	6
2. Have you had a definite fear that you might gain weight or become fat?	0	1	2	3	4	5	6
3. Has your weight influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
4. Has your shape influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6

5. During the past **6 months** have there been times when you felt you have eaten what other people would regard as an unusually large amount of food (e.g., a quart of ice cream) given the circumstances?

YES NO

6. During the times when you ate an unusually large amount of food, did you experience a loss of control (feel you couldn't stop eating or control what or how much you were eating)?

YES NO

7. How many **DAYS per week** on average over the **past 6 MONTHS** have you eaten an unusually large amount of food and experienced a loss of control? 0 1 2 3 4 5 6 7

8. How many **TIMES per week** on average over the **past 3 MONTHS** have you eaten an unusually large amount of food and experienced a loss of control? 0 1 2 3 4 5 6 7 8 9 10 11 12
 13 14

During these episodes of overeating and loss of control did you...

9. Eat much more rapidly than normal? YES
 NO

10. Eat until you felt uncomfortably full? YES
 NO

11. Eat large amounts of food when you didn't feel physically hungry? YES
 NO

12. Eat alone because you were embarrassed by how much you were eating? YES
 NO

13. Feel disgusted with yourself, depressed, or very guilty after overeating? YES
 NO

14. Feel very upset about your uncontrollable overeating or resulting weight gain? YES
 NO

15. How many **times per week** on average over the past **3 months** have you made yourself vomit to prevent weight gain or counteract the effects of eating? 0 1 2 3 4 5
6 7 8 9 10 11 12 13 14

16. How many **times per week** on average over the past **3 months** have you used laxatives or diuretics to prevent weight gain or counteract the effects of eating? 0 1 2 3 4 5
6 7 8 9 10 11 12 13 14

17. How many **times per week** on average over the past **3 months** have you fasted (skipped at least 2 meals in a row) to prevent weight gain or counteract the effects of eating? 0 1 2
3 4 5 6 7 8 9 10 11 12 13 14

18. How many **times per week** on average over the past **3 months** have you engaged in excessive exercise specifically to counteract the effects of overeating episodes? 0 1 2 3
4 5 6 7 8 9 10 11 12 13 14

19. How much do you weigh? If uncertain, please give your best estimate. _____ lbs.

20. How tall are you? _Please specify in inches (5 ft.= 60 in.)_____ in.

21. Over the past **3 months**, how many menstrual periods have you missed? 0 1 2 3 n/a

22. Have you been taking birth control pills during the past **3 months**?..... YES NO

Appendix D
Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996)

Listed below are 21 areas that are sometimes reported to have changed after traumatic events. Please mark the appropriate box beside each description indicating how much you feel you have experienced change in the area described. The 0 to 5 scale is as follows:

- 0 = I did not experience this change as a result of my crisis
 1 = I experienced this change to a very small degree
 2 = a small degree
 3 = a moderate degree
 4 = a great degree
 5 = a very great degree as a result of my crisis

	<i>possible areas of growth and change</i>	0	1	2	3	4	5
a.	my priorities about what is important in life						
b.	an appreciation for the value of my own life						
c.	I developed new interests						
d.	a feeling of self-reliance						
e.	a better understanding of spiritual matters						
f.	knowing that I can count on people in times of trouble						
g.	I established a new path for my life						
h.	a sense of closeness with others						
i.	a willingness to express my emotions						
j.	knowing I can handle difficulties						
k.	I'm able to do better things with my life						
l.	being able to accept the way things work out						
m.	appreciating each day						
n.	new opportunities are available which wouldn't have been otherwise						
o.	having compassion for others						
p.	putting effort into my relationships						
q.	I'm more likely to try to change things which need changing						
r.	I have a stronger religious faith						
s.	I discovered that I am stronger than I thought I was						
t.	I learned a great deal about how wonderful people are						
u.	I accept needing others						