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# Exploring the Role of Relapse for Women in Recovery from an Eating Disorder

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# Exploring the Role of Relapse for Women in Recovery from an Eating Disorder

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ABSTRACT

Eating disorders are serious mental health problems with high relapse rates (Arcelus, Mitchell, Wales, & Nielsen, 2011; Herzog et al., 1999). Research has demonstrated that eating disorder populations show interpersonal deficits at baseline compared to comparison groups (Arcelus, Haslam, Farrow, & Meyer, 2013; Grissett & Norvell, 1992; Ivanova et al. 2015; Tiller at al., 1997), specifically in assertiveness (Behar, Manzo, & Casanova, 2006; Constantino & Smith-Hansen, 2008; Duchesne et al., 2012; Hartman et al., 2010). The goal of this research was to explore the variables related to relapse and make the social and interpersonal growth that occurs in recovery visible and bring additional understanding to the recovery process. Through a feminist phenomenological approach, 12 women from diverse backgrounds were interviewed via Zoom about their experiences of relapse and recovery from BN or BED. The themes that emerged from the women's stories were divided into two overarching themes: *Most Recent Relapse* and *Recovery.* To further describe these themes, subthemes were developed. Within *Relapse* the themes were organized into: *Intrapersonal Factors*, *Interpersonal Factors*, *Environmental Stress*, *Seeking Resources and Support*, *Motivations*, and *Navigating Relationships*. Within *Recovery* the themes were organized into: *Entry into Recovery*, *Intrapersonal Factors*, *Interpersonal Factors*, and *Environmental Stability and Community*. The findings of this study uncovered the intrapersonal and interpersonal challenges women face during relapse from BN or BED,

highlighted how participants function in recovery, provided insight into how they reflect on their journey and what challenges they continue to face in maintaining their recovery. The phenomenon of relapse was characterized by self-neglect, low self-compassion, intrapersonal disconnection, isolation, and environmental stressors. Recovery was characterized by increased self-care and self-compassion and openness and assertiveness in relationships. Implications of this study include treatment considerations related to screening and addressing health concerns or trauma that occur at the same time as an eating disorder relapse, developing self-compassion and coping skills, utilizing interventions that develop assertiveness, increasing the duration that women remain connected to therapy in recovery, and support the importance of interventions that address fat phobia.

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# CHAPTER ONE: INTRODUCTION

Eating disorders are significant mental health concerns, and as many as one third of those affected relapse after full recovery (Arcelus, Mitchell, Wales, & Nielsen, 2011; Herzog et al., 1999). Disorders that fall in this grouping are pica, rumination, avoidant/restrictive food intake disorder (ARIFD), anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED). The focus of this study will be on BN and BED as there is significant overlap in their presentation. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) outlines the diagnostic criteria for BN as including cycles of recurrent binge eating episodes followed by inappropriate compensatory behaviors to prevent weight gain that occur, on average, at least once weekly for three months. According the DSM-5, BED also is characterized by recurrent binge episodes and a sense of lack of control over eating during the episode, however BED does not include subsequent compensatory behaviors (American Psychiatric Association, 2013). In cases of BN and BED, these disturbances in eating are accompanied by a disturbance in the experience of weight or shape (American Psychiatric Association, 2013). A review on the epidemiology of eating disorders estimates that both BN and BED have a lifetime prevalence rate of up to 2% among women (Smink, van Hoeken, & Hoek, 2013). Further, epidemiological studies suggest that mortality rates of BN are higher than previously estimated at 3.9% (Arcelus

et al., 2011; Crow et al., 2009). The mortality rate for BED is difficult to determine due to mortality resulting from complications of other health concerns; however, it has been estimated at 2.9% (Smink et al., 2013).

This chapter will provide an overview of the literature surrounding eating disorders and associated deficits and provide a description of the study conducted. The first section discusses the causes of eating disorders and explores the relationship between interpersonal problems, specifically assertiveness and eating disorders. The next section discusses the gaps in the literature on this topic, specifically the limited investigation into how these populations function interpersonally in recovery. Next, this chapter explores the varied definitions of recovery, provides data on relapse and recovery rates, and summarizes qualitative research done on this topic. The chapter continues with a section about the purpose of this phenomenological study and the method. Finally, this chapter provides definitions of key concepts related to this study.

Eating disorders can be understood as the result of biological, psychological, social, and cultural factors (Choate, 2015). Problems in interpersonal functioning have been suggested as a core component of eating disorders and are thought to serve as risk factors for developing eating disorders (Hartmann, Zeeck, & Barrett, 2010). Interpersonal problems found among persons with eating disorders include a broad range of specific skill deficits and are related to social interactions and engagement in family, peer, and/or occupational contexts (Hartmann et al., 2010).

A review of the empirical literature noted that people with eating disorder psychopathology display specific deficits in assertiveness, social skills, social adjustment, and social support (Arcelus, Haslam, Farrow, & Meyer, 2013). People with eating

disorders perceive themselves as less socially competent/socially effective, and others from their peer group perceive them this way as well (Grissett & Norvell, 1992). These individuals also experience less emotional and practical social support, where practical support refers to concrete aspects of support such as financial assistance (Grissett & Norvell, 1992; Tiller at al., 1997), and overall display more social maladjustment than comparison groups (Grissett & Norvell, 1992; Herzog et al., 1986). Research shows, across various eating disorder diagnoses, women are more submissive and excessively affiliative (Constantino & Smith-Hansen, 2008), and have difficulties in expressing feelings, lower capacity to deal with strangers, lower ability to understand the perspectives of others, higher levels of distress in interpersonal situations, and higher levels of social inhibition (Duchesne et al., 2012; Hartman et al., 2010). One specific interpersonal skill deficit, lack of assertiveness, is believed to worsen eating disorder outcomes, perpetuate symptoms, and may even be a predictive factor in the development of an eating disorder (Behar, Manzo, & Casanova, 2006).

While the connection between eating disorders and social deficits, specifically low assertiveness, has been clearly established (Arcelus et al., 2013; Behar et al., 2006; Constantino & Smith-Hansen, 2008; Duchesne et al., 2012; Grissett & Norvell, 1992; Hartman et al., 2010; Herzog et al., 1986), there have been few investigations into how psychotherapy affects assertiveness among this population or how this population functions interpersonally in recovery. Some interpersonal deficits have been shown to improve throughout the course of group treatment; however, findings suggest that, even after group psychotherapy, problems with assertiveness persist (Tasca et al., 2012). One preliminary investigation with 13 participants found that a CBT-group-training

for assertiveness, emotional regulation, and binge eating behaviors resulted in increases in assertive behavior, improvements in emotional regulation, but did not significantly impact binge behaviors (Bandini et al., 2013). This study administered the *Scale for Interpersonal Behavior* (Arrindell et al, 1984), *Difficulties in Emotion Regulation Scale* (Gratz et al, 2004; Sighinolfi et al, 2010), *Bulimic Investigatory Test of Edinburgh* (BITE; Freeman & Henderson, 1988) at baseline and one and three months after a CBT-training to patients with BED, night eating syndrome (NES), BN, and eating disorder not otherwise specified (EDNOS). This study had a small sample size; it had no comparison or control group; and further information has not been published. Only one other study investigated the impact of an assertiveness training program among individuals with eating disorders (Shiina et al., 2005). Unfortunately, this study did not assess assertiveness directly and relied on a measure of self-esteem to assess participant improvement. In sum, research has pointed to assertiveness as a potential critical component of eating disorder recovery; yet, the research on this specific connection is sparse.

One problem with eating disorders research is the lack of a consistent definition of recovery. Studies have measured various factors contributing to symptom reduction and one found that at 7.5 years post-treatment, 74% of women with BN achieved full recovery and 99% achieved partial recovery (Herzog et al., 1999). Unfortunately, the same study found that as many as one third of women with BN relapsed after full recovery. It is not clear what triggers a relapse, but relapse is believed to be related to continued poor psychosocial functioning (Keel, Dorer, Franko, Jackson, & Herzog, 2005).

To help elucidate factors contributing to the maintenance and recovery from these illnesses, some qualitative research has been conducted to understand the experience of recovery from individuals' perspectives. Participants have noted that the recovery process is nonlinear, typically consisting of relapse (Bowlby, Anderson, Hall, & Willingham, 2015; Lindgren, Enmark, Bohman, & Lundström, 2015); however, research asking individuals what they believe contributes to relapse is sparse. Qualitative studies have emphasized the following themes as important aspects of recovery: self-acceptance, experiencing improved interpersonal relationships, gaining problem solving skills, building self-esteem, and developing tools to manage emotions (Lingren et al., 2015; Pettersen & Rosenvinge, 2002). Recovered professionals working in the eating disorder field were asked about factors that contribute to recovery based on their personal and clinical experiences, and they reported that this process consists of external and internal changes in functioning (Bowlby et al., 2015). While the importance of developing new skills and experiencing improvements in interpersonal and social functioning have been emphasized as important factors in achieving recovery, the research fails to expand on what specific skills are needed or how to develop them.

In sum, interpersonal and social deficits have not been a primary focus of research. Research has demonstrated that eating disorder populations show interpersonal deficits at baseline compared to comparison groups (Arcelus, Haslam, Farrow, & Meyer, 2013; Grissett & Norvell, 1992; Ivanova et al. 2015; Tiller at al., 1997), specifically in assertiveness (Behar, Manzo, & Casanova, 2006; Constantino & Smith-Hansen, 2008; Duchesne et al., 2012; Hartman et al., 2010), and they persist even after group treatment (Tasca et al., 2012). The process of recovery is nonlinear, often including relapse, and

consists of skill development, as well as changes in interpersonal and social functioning (Bowlby et al., 2015; Lindgren et al., 2015; Petterson & Rosenvinge, 2002). Qualitative research has yet to expand on what these social and interpersonal changes consist of and how they were accomplished among women who have relapsed and recovered from BN or BED.

## Purpose

This qualitative study focused on the experiences of women with a history of BN or BED who experienced relapse within three years prior to the study and, at the time of interview, identify as having been in recovery for at least six months prior to their study participation. These women were interviewed about variables related to their most recent relapse and recovery, with specific focus on interpersonal functioning and assertiveness and their perceptions of what led to relapse. Including people who have experienced relapse in the three years prior to the study allows these individuals enough time to regain recovery but ensures the experience of relapse is recent enough to be clearly remembered. The Inventory of Interpersonal Problems (IIP-64; Horowitz et al., 1988) was also given to participants to have a measure of objective interpersonal functioning for comparison. Qualitative methods were used as they help bring light to topics that have not previously been explored (Creswell, 2013). A phenomenological approach was used to explore how women experience their interpersonal functioning and assertiveness in relapse and recovery from BN or BED, as this method provides space for individuals to describe their lived experience of a shared phenomenon (Creswell, 2013). The primary research question that this study explored was: "How do women who relapse from BN or BED perceive what factors led to relapse and then recovery?" With this overarching question,

the goal of this research was to explore the variables related to relapse and make the social and interpersonal growth that occurs in recovery visible and bring additional understanding to the recovery process.

## Methodology

Participants in this study are referred to as co-researchers in keeping with qualitative and feminist viewpoints that assert that research should be collaborative and view participants as partners in this process (Lub, 2015; Moustakas, 1994). Co-researchers were recruited from social media eating disorder recovery support groups. They reported relapsing from BN or BED within the prior three years and reported being in recovery for at least six months prior to their interview. Based on recommendations from Creswell (2013) and sample sizes found in the literature on this topic, the goal sample size for this study was 10-15 women. Twelve women completed all parts of the research process. Co-researchers participated in a semi-structured, in-depth interview via Zoom (an online video conferencing tool), reviewed interview transcripts, completed The Inventory of Interpersonal Problems (IIP-64; Horowitz et al., 1988), and completed one follow-up interview. Interview protocol was developed based on current research related to relapse, recovery, and interpersonal functioning among women in recovery from BN or BED and was adjusted following a pilot interview to reflect suggestions. The protocol asked questions about their overall journey with an eating disorder, interpersonal variables, and intrapersonal variables at the time of their most recent relapse and in recovery. Interviews were transcribed and analyzed by this writer and the stages of

phenomenological analysis outlined by Moustakas (1994) were utilized. These stages included: obtaining epoché, phenomenological reduction, imaginative variation, and synthesis of meaning and essence (Moustakas, 1994).

## Definition of Terms

Assertiveness: Assertiveness can be described as how people speak up and make their feelings, needs, and thoughts heard by others (Levallius et al., 2016).

Binge: A binge is defined as "eating, in a discrete period of time, an amount of food that is definitely more than what most individuals would eat in a similar period and a sense of lack of control over eating during the episode" (American Psychiatric Association, 2013, p. 345).

Binge Eating Disorder: Binge eating disorder also is characterized by recurrent binge episodes that are accompanied by significant distress surrounding their binges. In BED, binge episodes are associated with three or more of the following: eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone due to embarrassment surrounding the amount of food being eaten, and feeling disgusted with oneself, depressed, or very guilty afterward (American Psychiatric Association, 2013).

Bulimia Nervosa: Bulimia nervosa is characterized by cycles of recurrent binge eating episodes followed by inappropriate compensatory behaviors (vomiting, misuse of laxatives, diuretics/medications, fasting, or excessive exercise) to prevent weight gain (American Psychiatric Association, 2013). People with BN have a self-evaluation that is unduly influenced by their body weight or shape (American Psychiatric Association, 2013).

Clustering: This is the process of identifying co-researchers' similar statements and grouping them into categories to determine common themes employed in the phenomenological method (Moustakas, 1994).

Co-Researcher: Phenomenological research views the process of research as collaborating and identifies participants as partners in research rather than subjects (Moustakas, 1994).

Epoché: A process where the researcher "brackets him or herself out of the study by discussing personal experiences with the phenomenon" (Creswell, 2013, p. 78).

Horizonalization: The first step of phenomenological data analysis where the researcher lists significant statements from interviews that elucidate the meaning of their experiences (Creswell, 2007).

*Health at Every Size:* An approach to viewing health and weight promoted by the Association for Size Diversity and Health that views the definition of health holistically. Practitioners of this approach "reject both the use of weight, size, or BMI as proxies for health, and the myth that weight is a choice" (Association for Size Diversity and Health, 2019). There is also a book of the same name that explores the research and implications related to this approach by Linda Bacon (2010).

Imaginative Variation: The stage of phenomenological data analysis where the researcher seeks to understand the meaning of an experience by examining and contrasting varying perspectives and contexts to develop a structural description of the experience (Moustakas, 1994).

Interpersonal Problems: Interpersonal problems found among women with BN or BED include a broad range of specific skill deficits and are related to social interactions

and engagement in family, peer, and/or occupational contexts (Hartmann, Zeeck, & Barrett, 2010).

Reflexivity: In feminist research, reflexivity is where the researcher engages in repeated critical reflection of the assumptions, biases and preconceptions they bring into the research.

Structural Description: A description about "how" the phenomenon being studied was experienced, which includes the setting and context (Creswell, 2007).

Textural Description: A written description of what the co-researchers experienced in relation to the phenomenon (Creswell, 2007).

## Summary

Eating disorders are serious problems that often have long-term consequences. Treatment has mixed results, and relapse is high. The research has focused on eating behaviors and weight gain without exploring how interpersonal variables impact outcomes. In this phenomenological study, women with BN or BED who identified as in recovery for at least six months were interviewed about their interpersonal functioning with specific emphasis on assertiveness and a quantitative measure of interpersonal functioning was administered to provide more context to interview data. This study explored how women who have relapsed but are now in recovery from BN or BED understand their social and interpersonal functioning. This study sought to deepen understanding surrounding the variables related to relapse, with specific attention on the role of assertiveness and interpersonal variables in this process. Questions focused on how these individuals perceived their interpersonal functioning at the time of relapse, in recovery, and what they believe led to relapse.

The next chapter provides an in-depth review of the literature surrounding interpersonal aspects of eating disorders, relapse, and recovery. The first section discusses eating disorder classifications and core components, and reviews the current status of the research on eating disorder relapse and recovery. It includes a review of the literature on specific interpersonal deficits including assertiveness and interpersonal problems and highlights how these variables have not been a primary focus of research.

# CHAPTER TWO: REVIEW OF THE LITERATURE

Eating disorders continue to have the highest mortality rate of any psychiatric illness, and as many as one third of those affected relapse after full recovery (Arcelus, Mitchell, Wales, & Nielsen, 2011; Herzog et al., 1999). Feeding and eating disorders are characterized by disturbances in eating behaviors, physical health, and psychosocial functioning (American Psychiatric Association, 2013). Epidemiological studies suggest that mortality rates of BN are higher than previously estimated at 3.9% (Arcelus, Mitchell, Wales, & Nielsen, 2011; Crow et al., 2009), and both BN and BED have lifetime prevalence rates of 2% (Smink, van Hoeken, & Hoek, 2013).

The focus of this literature review is on BN and BED as these disorders both include fear of weight gain, excessive concern surrounding weight or shape, and feelings of shame or disgust and distress regarding eating disorder behaviors (American Psychiatric Association, 2013). Additionally, they have significant overlap in etiology, and treatment has moved toward a transdiagnostic approach that suggests that there are common mechanisms that maintain eating disorders that have binge eating as a component (Fairburn, 2008; Fairburn, Cooper, & Shafran, 2003).

This chapter begins with an overview of the main features of BN and BED and their prevalence. The second section discusses the literature surrounding an interpersonal model of eating disorders, which proposes that deficits in interpersonal functioning are core etiological, risk, and maintenance factors for the development of an eating disorder,

specifically bulimia nervosa and binge eating disorders (Hartmann et al., 2010). The review of the literature focuses on adult women as the greatest risk factor for developing an eating disorder is being female (Striegel-Moore & Bulik, 2007) and the majority of studies include adult women as their sample. The third section reviews literature exploring interpersonal deficits associated with eating disorders, specifically the lack of assertiveness. In the fourth section, research on recovery and relapse from eating disorders is discussed, specifically the limited attention to interpersonal aspects of relapse and recovery. The final section provides a chapter summary, including the major limitations of the extant research.

## Features and Scope of Eating Disorders

According to the DSM-5, bulimia nervosa consists of cycles of recurrent binge eating episodes followed by inappropriate compensatory behaviors in order to prevent weight gain that occur on average, at least once weekly for three months (American Psychiatric Association, 2013). A binge can be defined as experiencing a sense of lack of control over "eating, in a discrete period of time, an amount of food that is definitely more than what most individuals would eat in a similar period" (American Psychiatric Association, 2013, p. 350). Recurrent compensatory behaviors can include self-induced vomiting, misuse of laxatives, diuretics or other medications, fasting or excessive exercise, with the intent to prevent weight gain. People with BN have a self-evaluation that is excessively influenced by their body weight or shape. BN is specified by severity based on the average number of episodes of bingeing and purging (American Psychiatric Association, 2013).

Similar to BN, BED is characterized by recurrent binge episodes. Binge episodes are associated with three or more of the following: eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone due to embarrassment surrounding the amount of food being eaten, and feeling disgusted with oneself, depressed, or very guilty afterward (American Psychiatric Association, 2013). People with BED experience significant distress regarding their binge eating and the binge episodes occur, on average, at least once weekly for three months (American Psychiatric Association, 2013). BED is also specified by severity based on the number of binge episodes.

Eating disorders are believed to be caused by a combination of biological, psychological, social, and cultural factors (Choate, 2015). While there is considerable debate surrounding the most important factors in developing an eating disorder, deficits in interpersonal functioning have been suggested as ‘‘core’’ components of eating disorders (Hartmann et al., 2010). Deficits in interpersonal functioning are thought to serve as risk factors for developing an eating disorder and help maintain the disorder (Hartmann et al., 2010). Interpersonal problems found among persons with eating disorders include a broad range of specific skill deficits including assertiveness and are related to social interactions and engagement in family, peer, and/or occupational contexts (Hartmann et al., 2010).

## Interpersonal Model of Eating Disorders

The interpersonal model of binge eating asserts that people use food to cope with negative emotions that arise from difficulties in interpersonal relationships (Ivanova et al., 2015). Based on this model, deficits in interpersonal skills lead to unsatisfactory

interpersonal relationships, and individuals then rely on binge eating to cope with interpersonal distress and avoid negative emotions (Fairburn 1997; Weissman, Markowitz, & Klerman, 2000). This model serves as the foundation for several evidence-supported treatments for binge eating such as Interpersonal Psychotherapy (IPT; Wilfley et al., 2002) and Group Psychodynamic Interpersonal Psychotherapy (GPIP: Tasca, Mikail, & Hewitt, 2005).

Several studies have evaluated the interpersonal model of binge eating. Wilfley et al. (2002) first compared a GPIP intervention to group cognitive behavioral therapy (GCBT) for 162 participants who met criteria for BED and found GPIP resulted in recovery rates from binge eating equivalent to those in the GCBT treatment at posttreatment and one year follow-up. Additionally, both group treatments had improvements in interpersonal functioning as measured by the Inventory of Interpersonal Problems (Horowitz et al., 1988) and the Assessment of Social Adjustment (Weissman & Bothwell, 1976). Ansell et al. (2012) surveyed a community sample of 350 women and found that the relationship between interpersonal problems and eating disorder psychopathology was mediated by depressive affect. Ivanova et al. (2015) examined the interpersonal model of binge eating further with a clinical sample of 255 women with BED. Structural equation modeling analyses showed that increased levels of interpersonal problems were associated with greater negative affect. Further, this study found greater negative affect was found to be associated with increased frequency of BED symptoms and psychopathology (Ivanova et al., 2015). The authors noted an indirect effect of interpersonal problems on BED symptoms and psychopathology that

was statistically mediated through negative affect, meaning that interpersonal problems exacerbate BED symptoms and that this partially can be explained by negative affect (Ivanova et al., 2015).

## Interpersonal Deficits among Eating Disorder Populations

A review of the empirical literature by Arcelus et al. (2013) also noted that people with eating disorder psychopathology have been found to display specific deficits in assertiveness, social skills, social adjustment, and social support. These specific deficits have been explored in the research literature among women with BN and BED and have been examined by investigating submissive personality styles, social enmeshment, lack of social competence, lack of perceived support, negative interactions and poor quality of relationships. (Constantino & Smith-Hansen, 2008, Duchesne et al., 2012, Hartman et al., 2010).

### Assertiveness

Individuals with BN often show interpersonal behaviors related to being submissive and are excessively affiliative (i.e., overly socially connected and enmeshed in their relationships with others; Constantino & Smith-Hansen, 2008). A study evaluating 60 obese women with BED, 60 obese controls without BED, and 54 normal weight controls on measures of interpersonal difficulties found that women with less assertiveness, lower ability to express feelings, lower capacity to deal with strangers, lower ability to understand the perspectives of others, and with higher levels of distress in interpersonal situations had a higher probability of meeting diagnostic criteria for BED (Duchesne et al., 2012). Similarly, Hartmann et al. (2010) compared 208 people in an inpatient clinic who had various eating disorder diagnoses and found that they had a non-

assertive interpersonal style, higher levels of social inhibition, and overnuturance (Hartman et al., 2010). The authors found that all groups reported less interpersonal distress, social avoidance, and nonassertiveness by the end of treatment; however, across groups, the generally nonassertive interpersonal style persisted (Hartman et al., 2010).

Additionally, assertiveness was found to be the personality trait that best predicted variance in treatment outcome among people with BN. A recent study investigated personality predictors of recovery among people with eating disorders (Levallius et al., 2016). In a sample of 128 adults with either BN or Eating Disorder Not Otherwise Specified, a classification that no longer exists in the DSM-5, authors assessed personality dimensions using the NEO Personality Inventory Revised (NEO PI-R) and eating disorder psychopathology using the Eating Disorder Inventory-2 (EDI-2) across a 16-week intensive multimodal treatment intervention. Symptom severity decreased significantly for the group after treatment and 90 participants (70%) were deemed "recovered". Multiple regression was utilized to determine if personality predicted the symptom score at treatment termination and found that participant baseline symptom severity and the broad domain, Extraversion were significantly related to improvement. Extroversion and Assertiveness, a facet of Extroversion, accurately predicted recovery in 73% of participants. Sixty-eight percent of the participants who were not recovered at the end of the treatment scored below average on the facet of Assertiveness compared to 48% of those who recovered.

Research has also compared assertiveness levels in women with eating disorders and women with other weight/shape concerns. One study compared 32 women with AN, 30 women with BN, 31 women who were obese dieters, 29 nonobese dieters, and 35

women without eating disturbances or weight concerns (Williams et al., 1993). Patients with eating disorders were differentiated from obese and nonobese dieters as well as a healthy comparison group due to their lower levels of assertiveness, lower self-esteem, and more self-directed hostility. Similarly, a more recent study looked at eating disorder psychopathology among 62 women that met DSM-IV criteria for an eating disorder and compared them to 120 female students who did not have an eating disorder. They administered a structured clinical interview, the Eating Attitudes Test (EAT-40), and the Rathus Assertiveness Scale (RAS) and found that women with eating disorders had lower levels of assertiveness compared to their counterparts who did not have an eating disorder (Behar et al., 2006). Overall, issues with assertiveness have been reported as deficits found among eating disordered populations (Constantino & Smith-Hansen, 2008; Duchesne et al., 2012; Hartmann et al., 2010).

There has been limited investigation into how treatment impacts assertiveness or how this construct is related to recovery. One study looked at the impact of a GCBT intervention that focused on assertiveness as measured by a subscale of the Scale for Interpersonal Behavior, emotional regulation, and binge eating behaviors among 13 people who completed treatment (Bandini et al., 2013). The authors assessed these three variables at baseline and at one and three months posttreatment. Preliminary findings indicated that people who took part in the training improved on measures of assertiveness and emotional regulation but not binge eating behavior. This study had a small sample size, high dropout, and did not report the length of treatment. Shiina et al. (2005) investigated the impact of an assertiveness training and CBT combined treatment on self-esteem based on the premise that people with eating disorders have low self-esteem. The

authors posited that by learning to assert themselves, group members would become more self-confident and therefore have reductions in BN symptoms. Out of a sample size of 25, 16 participants completed the treatment. All completers had significant improvements in binge eating behavior and social functioning (Shiina et al., 2005). The participants who did not complete treatment were significantly younger than the completers (20 years vs. 26 years) and also had significantly higher psychiatric comorbidity. While this study investigated the impact of an assertiveness intervention on self-esteem, assertiveness was not measured directly.

**Social Skill Deficits**

Research on social skill deficits is sparse and dated. Given that there is limited material to discuss, older studies were reviewed. Much like research on assertiveness, research has found that people with eating disorders experience greater social skill difficulties than comparison groups (Grissett & Norvell, 1992). Social skill difficulties have been measured using constructs of social competence, which are defined as socially effective behaviors, or behaviors that help people achieve their social goals (Schneider, Ackerman, & Kanfer, 1996). Grissett and Norvell (1992) found that patients with BN reported less social competence than a comparison group of women who did not meet criteria for BN and those with BN were also viewed as less socially effective by observers who did not know their diagnosis.

In addition to experiencing broader deficits in social skills, people with eating disorders appear to perceive themselves as having insufficient social support. Grissett and Norvell (1992) investigated a large sample of undergraduate women with and without BN and based on their findings, found that a risk factor for developing BN was

related to participants' reports of receiving less emotional and practical support from friends and family, compared to controls, where practical support refers to concrete aspects of support such as financial assistance. Another study investigated the social support networks of 81 individuals with BN and found that, compared to a control group of 86 non-eating disordered students, people with BN listed fewer important support figures (parents, partner etc.) in their lives and these support figures were perceived as providing poorer quality of emotional and practical support (Tiller at al., 1997). This study also assessed participants' perceived levels of support compared with their self-reported ideal levels of support and found that women with BN reported a significantly larger discrepancy between their ideal and actual support levels than controls.

Social maladjustment has been linked to eating disorder pathology through looking at levels of social anxiety, close relationships, social support networks, and interpersonal interactions. Grissett and Norvell (1992) investigated social adjustment of undergraduate women with and without BN and found that women with BN reported more negative interactions and poorer quality of relationships than a comparison group of women without BN. Similarly in a sample of 550 female graduate students who completed screenings for BN and social adjustment in the domains of performance at school/work, social and leisure activities, and family relationships, Herzog et al. (1986) found that 56 women met criteria for BN, which is significantly higher than population prevalence estimates. The students who had BN reported significantly more social maladjustment on all domains as compared to their counterparts without BN.

Studies also have investigated how recovery impacts social adjustment variables. In a cross-sectional study, Rorty et al. (1999) compared social adjustment among three

groups of women: 40 women who were actively experiencing BN, 40 women who were in remission from BN, and 40 women with no history of an eating disturbance in cross-sectional research. The group of women who were actively experiencing BN had the lowest levels of social adjustment (Rorty et al., 1999). Women who were in remission had significantly better levels of social adjustment than those actively experiencing BN, yet significantly lower levels of social adjustment than those with no history of an eating disturbance (Rorty et al., 1999). This research examined how recovered individuals compare to healthy controls on interpersonal domains.

## Defining Recovery from an Eating Disorder

Various definitions of recovery make it difficult to compare studies, yet overall, outcomes are mixed and relapse is high (Olmstead et al., 2014). Bardone-Cone et al. (2010) defined recovery from an eating disorder as having three components: (a) behavioral recovery, (b) physical recovery and (c) psychological recovery. According to Bardone-Cone et al. (2010), full recovery can be defined as no longer meeting diagnostic criteria for an eating disorder according to DSM-5 (physical recovery), having a body mass index between 18.5–24.9 (physical recovery); having no binge eating, purging or fasting in the past three months (behavioral recovery), and scores within 1 standard deviation of age-matched community norms on all the subscales of the Eating Disorder Examination-Questionnaire (psychological recovery) (EDE-Q; Fairburn & Beglin, 1994). Partial recovery is when a person does not meet at least one or more of the criteria for these components. In many studies, partial recovery is achieved when participants meet behavioral and physical recovery but not psychological recovery (Bardone-Cone et al., 2010). Until psychological recovery is met, these individuals do not resemble healthy

controls on a wide range of disordered eating measures, which suggests that psychological recovery is especially complex and important (Bardone-Cone et al., 2010; Keski-Rahkonen & Tozzi, 2005).

The multidimensional definition by Bardone-Cone et al. (2010) is more comprehensive than what most studies use to determine treatment outcomes; however, it does not directly assess interpersonal functioning. While there is a large body of literature investigating interpersonal functioning deficits, it has not been conceptualized as one of the stated components of recovery and has received limited attention in the eating disorder treatment literature.

## The Process of Recovery

There has been some qualitative research investigating individuals' experiences of recovery from BN or BED. Pettersen and Rosenvinge (2002) interviewed 48 participants with past or current AN, BN, or BED and asked about factors that contribute to recovery and what recovery means to them. Themes that emerged were: recovery involves self-acceptance, experiencing positive interpersonal relationships, gaining problem-solving abilities and gaining body satisfaction. Participants noted that symptom reduction was not necessarily a goal of recovery but served "as a means to accomplish more functional interpersonal relations, thinking, and problem solving strategies" (p. 69). While participants noted the importance of improved interpersonal and social functioning and developing new skills for achieving recovery, the interviews did not include follow-up questions to enhance understanding of these vague constructs.

Another study asked participants questions related to recovery. Lindgren, Enmark, Bohman, and Lundström (2015) utilized narrative interviews of 5 women who

assessed themselves as recovered from BN for at least three years to ask about their experience of recovery. Participants noted that this process is not linear, consisting of vacillations between hope and doubt that they could recover and 4 out of 5 reported relapse in their process toward recovery (Lindgren et al., 2015). Participants also stated that an explanation for their illness was essential for recovery (Lindgren et al., 2015). The authors also found themes of building self-esteem, accepting and learning to love oneself, and finding the right tools to manage their emotions as essential to achieving and maintaining health. Based on their research, Lindgren et al. (2015) conclude that women's ability to recover from BN is based on their self-efficacy and emphasized that treatment needs to bolster self-efficacy in order to be effective.

Bowlby, Anderson, Hall, and Willingham (2015) conducted a qualitative phenomenological investigation of 13 recovered professionals practicing in the field of eating disorder treatment and similar to Lindgren et al. (2015) found that the process of recovery was nonlinear and multifaceted. They stated that this process involved both changes in how they view themselves and function, as well as changes in behavior (Bowlby at al., 2015). Participants also cited the importance of developing meaningful relationships in their recovery process but did not discuss how their interpersonal or social functioning changed to accommodate this. While this research contributes valuable information about recovery from the individual perspective, it does not clarify what social skills people perceive as necessary for recovery or what variables people perceive are related to relapse.

## Relapse

Consistent with the larger body of literature on eating disorders, the majority of research on relapse focuses on people with AN. Additionally, this research tends to focus on rates of relapses with fewer studies looking at pre or posttreatment predictors of relapse and definitions of relapse, remission, and recovery vary widely. Reported rates of relapse among people with BN have remained stable over several decades. Mitchell, Davis, and Goff (1985) followed patients with BN at 12 and 15 months posttreatment from an outpatient eating disorder clinic and found that 40% of their sample relapsed and more than half of those who relapsed did so within 2 months posttreatment, while another third did so while still in aftercare. Among their sample, relapse was associated with stressful/difficult situations such as job, school and social pressures, and negative affective experiences such as feeling anxious, nervous, depressed or angry.

Some studies have investigated variables that may predict relapse. Grilo et al. (2012) looked at 117 women and found that the probability of relapse among people with BN (N=35) or EDNOS (N=82) was 43% and that negative stressful life events, specifically elevated work and social stressors, were significantly predictive of relapse. McFarlane, Olmsted, and Trottier (2008) found that 41% of their sample had relapsed after partial remission by 24 month follow-up and severe pretreatment caloric restriction, higher residual symptoms at discharge, slower response to treatment and higher weight-related self-evaluation were significant predicators of relapse. Keel et al. (2005) extended relapse research with the same cohort utilized by Herzog at al. (1999) for their 7.5-year follow-up study by focusing on post-remission relapse predictors and extending follow-up to 9 years. This prospective longitudinal design, following women who had a

diagnosis of AN or BN for 9 years, similarly found that one third of women who reached full recovery eventually relapsed. The authors found that among the women with an intake diagnoses of BN, women with greater body image disturbance and worse psychosocial functioning were at increased risk of relapse (Keel et al., 2005). Safer et al. (2002) investigated predictors of relapse among 32 women who completed 20 weeks of dialectical behavior therapy (DBT) adapted for binge eating disorder. They found that 28% of their sample had relapsed at the six month follow up and early age of binge eating onset and greater dietary restraint posttreatment were the predictors of relapse.

In sum, research has found rates of relapse among people with BN to range from about 30-40% and several factors have been found to be predictive of relapse (Arcelus et al., 2011; Grilo et al., 2012; Herzog et al., 1999; Keel et al. 2005; McFarlane et al., 2008; Mitchell et al., 1985). Relapse has been associated with stressful/difficult situations (Grilo et al., 2012; Mitchell et al., 1985); feeling anxious, nervous, or depressed (Mitchell et al., 1985); having greater body image disturbance and worse psychosocial functioning (Keel et al., 2005); as well as more severe caloric restriction, higher residual symptoms at discharge, slower response to treatment and higher weight-related self-evaluation (McFarlane et al, 2008) and earlier age of onset (Safer et al., 2002). While these findings indicate a connection between domains of interpersonal functioning and relapse, the research on this topic is minimal.

## Summary

Eating disorders continue to be a major mental health concern. The high relapse rates associated with these disorders seem to be the result of complicated etiological pathways, where eating disorders are believed to be caused by biological, psychological,

social, and cultural factors (Choate, 2015). Interpersonal deficits are believed to play a core role in the development and maintenance of eating disorders. Research has found that people with eating disorders have greater levels of interpersonal deficits than controls at pretreatment, and while interpersonal functioning improves as people move toward recovery, significant deficits persist. The literature indicates that varied views of recovery complicate deeper understanding of this process. The limited investigation of recovery from the individual perspective has indicated that interpersonal changes are part of this process, however little is known about these changes and what role they play in relapse. Gaining understanding of these mechanisms may enable the development of more effective treatments that can target and strengthen interpersonal skills needed for preventing relapse and maintaining recovery. The next chapter outlines the methods that were used for this study and describes the sample, measures, procedure, and data analysis.

# CHAPTER THREE: METHODOLOGY

Quantitative research methods have been used to explore various aspects of eating disorders, and more recently, qualitative methods have begun to be utilized to understand individual experiences of those struggling with these disorders. Through quantitative studies, it has been established that people with BN and BED struggle with a variety of interpersonal deficits, specifically assertiveness, even in recovery (Arcelus et al., 2013; Behar et al., 2006; Constantino & Smith-Hansen, 2008; Duchesne et al., 2012; Grissett & Norvell, 1992; Hartman et al., 2010; Herzog et al., 1986). While quantitative studies have uncovered this connection, more information is needed to more deeply understand mechanisms that are at play.

Qualitative researchers "study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 2011, p. 3). By using qualitative methods to explore the topic of interpersonal variables related to relapse and recovery from BN and BED, the mechanisms that perpetuate interpersonal deficits can be elucidated. Qualitative methods are particularly useful when researching topics that have not previously received much attention or when a specific phenomenon is not well understood (Creswell, 2013; Marshall & Rossman, 1999; Morrow, 2007). The phenomenon of interpersonal functioning in relapse and recovery among women with BN and BED has received minimal research attention. Qualitative research is a method that may help understand affective and emotional

experiences (Merriam, 2009), phenomenology was utilized in this study to expand on how people who relapse and recover from BN or BED perceive which interpersonal variables are related to relapse and recovery.

## Philosophical Framework and Assumptions

Conducting qualitative research requires the researcher to explore their philosophical assumptions, because they influence every aspect of the research study (Creswell, 2013). Philosophical frameworks describe how researchers view the nature of reality, what counts as knowledge, how values are related to inquiry, and what the process of research is (Creswell, 2013). The broader interpretative framework that I identify with as a researcher falls within social constructivism. This framework describes people who seek to uncover varied meanings of individual experiences and look for complexity of views (Creswell, 2013). Within this frame is the belief that experience is socially constructed through interactions with others and through "historical and cultural norms that operate in individuals' lives" (p. 25). Given my interest in the interpersonal aspects of relapse and recovery, this framework is appropriate for my research questions. Social constructionism relies on the process of inductively creating a theory about a topic rather than imposing a theory at the start of inquiry (Creswell, 2013). From this perspective, it is important to reflect on one's own background and experiences that influence interpretation of research data. Conducting research from a social constructivist framework consists of asking broad open-ended questions to allow participants room to construct meaning of their experiences (Creswell, 2013).

I identify as a feminist, which shapes the research I engage in. Based on this identity, I strive to create space for voices beyond those that are typically the focus of

scientific inquiry. The feminist framework that guided my methodology was feminist standpoint theory, where I, as the researcher acknowledge how peoples' subjective experiences are impacted by their varying identities and how these identities may impact the data (Silvia, 2013). Feminist research utilizes a methodical framework consisting of "challenging traditional scientific inquiry, interest in diversity, a consideration of power within the research design, and recognition of gender" (Silva, 2013, p. 351).

## Phenomenological Method

Given the framework's inductive approach to inquiry, phenomenology is a method that is often used by researchers who identify as social constructivists, as it consists of asking several individuals about a "phenomenon" to uncover the essence of it (Moustakas, 1994). The essence of a phenomenon is the product of analysis and is found through reducing interviews to the aspects of the phenomenon that are shared by all individuals who have experienced it (Creswell, 2013). Using qualitative methods, such as phenomenology, also aligns well with feminist research as the goal is to allow co-researchers to explore their experience with a phenomenon in their own words (Creswell, 2013). To learn more about the individual experience of assertiveness and interpersonal functioning, women who have relapsed and identify as in recovery from BN or BED were asked a set of open-ended questions to further understand how these variables are related to relapse and recovery. Interviews were conducted and analyzed with the goal of finding the essence of this phenomenon.

Moustakas (1994) outlined four major processes the researcher must engage in when conducting and analyzing phenomenological research: (1) obtaining epoche, (2) phenomenological reduction, (3) imaginative variation, and (4) synthesis. The first

process, obtaining epoche, occurred after the phenomenon was identified and before recruitment of co-researchers began. Phenomenological reduction, imaginative variation, and synthesis occurred during data analysis and will be described later in this chapter in the data analysis section.

Common practices of feminist research include: reflexivity, creating research collaboratively, examining power imbalances within the research and advocacy for social change through research (Silvia, 2013). The way I implemented these practices is discussed within Moustakas' (1994) four processes of phenomenology

**Epoche and Reflexivity**

Epoche is a term Husserl (1970) used to denote "freedom from supposition" (p. 577). Epoche is a process where the researcher "brackets him or herself out of the study by discussing personal experiences with the phenomenon" (Creswell, 2013, p. 78). While this does not remove all bias, it serves as a way for the researcher to set aside their experiences and focus on what participants are describing (Creswell, 2013). Feminist researchers believe that this attempt for objectivity is misguided and "that attaining full epoché, so that we can somehow stand aside from our own socio-cultural situatedness, is quite simply an impossibility - in research as in everyday life" (McNarry, Allen-Collinson, & Evans, 2019, p. 141). Alternatively, reflexivity is a practice central to feminist research where the researcher engages in repeated critical reflection of the assumptions, biases and preconceptions they bring into the research. Instead of trying to set them aside, they are reflected on and examined regularly throughout the research process.

Below, I identify and describe my experience with the phenomenon I researched and how my various identities impacted my experience of relapse and recovery from BN. Throughout the research process I also engaged in journaling to continuously attend to how my biases, assumptions, and socio-cultural situatedness may be impacting all levels of the research process and decision-making in analysis. I also utilized extensive memoing to document methodological decisions, reactions to participants and thoughts about the process, and attended psychotherapy to help provide space for me to explore and process my experience of this research. Critically and repeatedly engaging with my own experience allowed me to effectively be present in interviews and attend to my co-researchers experiences' and knowledge of the phenomenon more fully.

**Disclosure of researcher bias.** I became interested in the topic of eating disorders after struggling with one as a teenager and moving into recovery as a young adult. The experiences I had while actively struggling with an eating disorder, receiving treatment, and entering recovery greatly influenced the development of this study. To help organize how I arrived at this topic after an 18-year journey in illness and recovery, I will discuss my experiences before I received treatment, during treatment, and after.

*Before.* To begin, it would be helpful to discuss the context of how I developed an eating disorder. Throughout my childhood there were many ways I had little control over my life and food became a comfort, something that was used to mend, celebrate, and mourn. I remember ordering my annual back to school clothes from a catalogue and was devastated when they did not fit my body the way they fit the models. I felt stuck in a body shape I did not like and started "dieting" in the 8$^{th}$ grade. I fully committed myself to dieting to avoid the cruelty that accompanied overweight middle school girls and my

own self-loathing over my “misshapen” body. After months of restriction and success, I was thinner but so hungry and I believe my first binge and subsequent purge was born out of this combination of hunger, self-loathing and feeling like I had to change myself to be worthy of anything nice. By the spring of my freshman year of high school, my family had figured out something was going on, as evidenced by rapid weight-loss, excessive food intake, and locked doors.

*During.* My first treatment experience was not voluntary and I fired a string of therapists and psychiatrists who were all focused on weight restoration. There were forced family sessions where I refused to talk because I had no desire to change my behavior, since there were no negative consequences yet. Slowly I lost muscle tone and endurance and began falling behind in sports. I began having dental issues and horrible esophageal discomfort. By my sophomore year, I requested help. We tried to find an inpatient eating disorder treatment facility but living in a rural part of the country, at 16, I ended up in a general child inpatient unit that was inappropriate and ill suited to address eating disorders. There was an “eating disorder protocol” where meals were supervised and I was unable to use the bathroom for a specified amount of time after eating. I had my first exposure to group therapy during this treatment experience. After 5 days of pleading to leave to find an intensive outpatient experience and beginning the process of weight restoration, the team agreed that I could be discharged. During this experience I witnessed a teenage girl who was coming to the end of an extended hospitalization for her eating disorder appearing weight restored but still obsessed with her body shape and

weight and painfully self-conscious to “take up space”. Witnessing her leaving the facility opened my eyes to the amount of work I had ahead of me to reach meaningful recovery.

When I left the hospital, I began working with a treatment team consisting of a dietician, psychiatrist and a psychologist who specialized in eating disorders. Meeting with my psychologist was the first time I felt like I might be able to recover. She taught me that none of this disorder was really about the food or the weight and we began the nonlinear process of recovery. During our time, I learned the roles I held in my family and social groups and how these perpetuated my illness. I was always described as “easy going”, “happy-go-lucky”, “agreeable”, and “non-confrontational” as a child and I realized how some of these characteristics are parts of my core personality but some of them were a response to larger family and social dynamics, where it was easier and safer to take up less space. In our journey I learned how being weight-restored with "normal” eating behaviors was not enough for lasting recovery; I would have to start re-accessing feelings, opinions, and needs. I learned how my disorder was a way to push these things down, aside and away. I struggled with how to re-access these parts of myself and advocate for them, and it was painful to realize some relationships were unable to accommodate me as a full person with needs of my own.

I met with this therapist for several years and summers after I moved away to college. I initially resisted finding a treatment team while away at college and after periods of recovery and relapse, finally established a treatment team there. This was my second exposure to group therapy, and my first experience with an interpersonal process group. This group was the catalyst for my lasting recovery. This group consisted of

female college students who all had some form of an eating disorder and was run through the health center's eating disorder program at a large university on the east coast. I was in this group with fixed membership for one year and a group with some of the same people and new ones for another year. I had the tools to maintain physical and behavioral recovery prior to this experience after years of individual therapy, dieticians and medication management, but the experiences I had and witnessed over these two years in this group gave me tools to begin the process of psychological and interpersonal recovery. By the end of my first year of group, I had the realization that none of us saw ourselves the same way we saw one another; we were much kinder and forgiving to each other than we were to ourselves. After a year of fully seeing and knowing other group members and witnessing their beauty and strength, I could not reconcile how they continued to view themselves so negatively and recognized that they probably saw me the same way. This was the first time I felt that my negative self-views were really challenged. I also witnessed several women who had been chronically ill for a long time quickly relapse after achieving weight and behavioral recovery. One of these group members died in our second year, which was devastating and left me grappling with how treatment had failed her.

During our second year of group, there were two women who were consistently disruptive of the group process by missing groups, attempting to befriend members outside of group, breaking confidentiality, and monopolizing our time with unproductive stories. With my new self-concept as being someone worthy of happiness and health, I grew more and more frustrated over the weeks until finally one of our group facilitators provided an invitation for me to speak up. Over the next several months with the help of

the group, I began to develop my assertiveness and noticed how this changed my relationships with others and myself. I was able to speak up in relationships and be heard instead of suppressing my needs and feeling resentful. I realized that food and disordered eating had been my solace from all of the things I never said and with fewer unsaid things, I needed the disorder less and less. From this experience, I developed a strong belief that group therapy is uniquely suited to address the maladaptive interpersonal processes that occur alongside and perpetuate these illness.

*After.* With the tools I gained during my treatment journey I was able to enter and maintain recovery in physical, behavioral, psychological and interpersonal domains. I graduated from my undergraduate studies and pursued a career in psychology. In my Master's program, I completed a practicum at an outpatient eating disorder treatment program conducting group, individual, and family therapy, again noticing that some women met physical, and behavioral recovery but still experienced psychological symptoms of their eating disorder (preoccupation with weight and shape, etc.) or functioned in interpersonally maladaptive ways and eventually relapsed. I continued to be curious about this topic and planned to pursue my doctorate to work with this population and contribute to the research in the form of my dissertation.

When reviewing the literature surrounding eating disorder treatment to narrow down my dissertation topic, I found that there is little focus on interpersonal aspects of relapse and recovery, specifically assertiveness, which are the variables that were the most important for maintaining my lasting recovery. These experiences and biases have impacted the development of my research questions and will also impact my interpretation of research data.

In conducting this research, it is also important for me to acknowledge the identities that I hold and how they have shaped my journey and privilege of recovery. I identify as a cis, white, heterosexual woman, and this has positively impacted my access to the tools and resources I needed to reach recovery, pursue my degree, and conduct this research. Furthermore, I occupy a slim "straight-sized" body, which has significantly reduced the amount of policing I experience related to my appearance, size, behaviors, health choices, etc. While I believe all women are impacted by the adverse effects of fat phobia, I have not felt them as intimately or acutely as women who identify as fat or occupy larger bodies, and I experience fat phobia differently from those who hold other marginalized identities. I am forever grateful for the advocacy of fat activists and their often unrecognized contributions to this field and how they have benefited me.

## Methods

### Co-Researchers

Since participants are viewed as partners in the research process, participants will be called co-researchers (Moustakas, 1994). Referring to participants as co-researchers is also an important way to foster collaboration and an attempt to minimize power imbalances when conducting feminist research (Boylorn, 2008). Co-researchers were twelve women who reported relapsing from BN or BED within the prior three years but identified as being in recovery for at least six months prior to the study. Including people who have experienced relapse in the prior three years allowed these individuals enough time to regain recovery but ensures the experience of relapse was recent enough to be clearly remembered. Criterion sampling was utilized, meaning that all participants met certain criterion for inclusion in the study (Creswell, 2013). Co-researchers were

required to meet the following criteria: identify as a woman, be between ages 18-50, identify as currently in recovery from BN or BED for at least six months, and have experienced a self-identified relapse within the last three years. Additionally, pregnant women, women with current untreated mental health problems including depression, bipolar disorder, substance use disorders, recent suicide attempts, and schizophrenia, were also excluded from this study. This study focused on BN and BED as opposed to AN, as there is more limited information on relapse and recovery among these populations than those with AN.

This study looked at women who had a relapse within the prior three years to help understand interpersonal variables related to this event. It is important that these women identified as in recovery for at least six months to minimize risk that participating in this study could cause distress and lead them to use eating disorder behaviors. Women who relapsed more than three years prior to the beginning of this study were not included, as it may be more difficult for them to recall their social and emotional life events at the time of relapse. Women in recovery were the focus of this study in order to learn more about their perspectives on how interpersonal variables are related to relapse and also recovery. Women who were currently in treatment were welcome to participate as well as women who were previously in treatment and women who never received treatment. Women who did not experience relapse were not included in this research, as the goal was to understand interpersonal variables related to relapse, specifically assertiveness among this population.

**Recruitment of co-researchers.** Upon receiving approval from the Institutional Review Board at the University of Denver, I began contacting moderators of national

eating disorder organization listservs and eating disorder Facebook support groups. For eating disorder listervs, this research solicitation was sent via email. For Facebook support groups, the research solicitation was sent via Facebook message to group moderators/administrators (See Appendix A). The email or Facebook message was sent with the request to disseminate or post an informational paragraph (See Appendix B) that included a brief description of the study, inclusion criteria, participation requirements, and incentive. This email or message also included a link to the screening survey via Qualtrics for interested people to complete to make sure they met criteria for the study (See Appendix C). The screening survey asked questions related to participants' eating disorder including type, age of onset, time in recovery, if they experienced relapse, time since last relapse, and when and if they accessed treatment and what type, as well as demographic identities. Ultimately, none of the eating disorder listervs responded to my requests, but I was able to post information about the study in 18 eating disorder themed support or recovery groups.

A total of 93 women completed the screening survey. 22 women met study criteria and were contacted via email and invited to participate in the study (See Appendix D) and given the study consent form to complete and return via a secure file transfer system (See Appendix F). The 71 women who completed the survey but were ineligible were contacted via email, thanked for their time, and notified that they did not currently meet inclusion criteria for the study (See Appendix E). Of the 71 women who did not meet criteria, 5 did not identify as in recovery and reported a relapse within the last 6 months; 20 reported anorexia nervosa as the eating disorder they most recently experienced, 2 reported living abroad; 17 reported being in recovery for less than 6

months; 24 reported relapse within the last 6 months; one reported her most recent relapse as occurring more than 3 years ago; one was 53 years old; and one reported untreated depression.

Of the 22 who met criteria, 13 returned the consent form and scheduled interviews. Of the remaining 9 women who met criteria to be part of the study, one scheduled the interview but missed it due to a scheduling error and declined to reschedule, 6 never returned the consent form or replied to the email, and 2 did not respond in time to participate before recruitment ended. Of those 13, one woman reported utilizing eating disorder behaviors within the last 6 months and her interview was discontinued.

In sum, from the original 93 responses, a sample of 12 women were eligible and willing to participate in my study. One woman identified herself as Latina, two women identified as Hispanic, one woman identified as biracial, one woman identified as South Asian American, and seven identified as White or Caucasian. Six of these women reported struggling with BN most recently and six reported struggling with BED most recently. They ranged in age from 23 to 43 and the age of onset of BN or BED ranged from seven years old to 25 years old. Four identified as being in recovery from six months to one year, seven identified as being in recovery from one to five years, and one reported being in recovery for five or more years but experienced relapse about two years ago. Three reported their most recent relapse occurred between six months to one year ago, five reported their most recent relapse occurred about one year ago, one reported their most recent relapse occurred about one to two years ago, one reported their most recent relapse occurred about two years ago, and two reported their most recent relapse

occurred about 3 years ago. Five women identified as being in some type of treatment at the time of their participation, which included individual psychotherapy, group psychotherapy, medical nutrition therapy and/or medication management all at the outpatient level of care.

Definitions of relapse and recovery were identified by the co-researchers, however to ensure that they were on solid ground with their disorder, they were asked about behavior use within the last six months and none of them endorsed utilizing behavior consistent with a diagnosis of BN or BED. Determining timing of relapse and recovery proved challenging for most participants and many grappled with whether preoccupation with thoughts of food/dieting or engaging in dieting behaviors constituted a relapse and all struggled to define when recovery began. For some, they identified that they were in recovery starting when they began seeking treatment and experienced relapse while still in recovery and for others, recovery began only after their most recent relapse. See Table 1 for co-researcher descriptions.

Table 1
*Description of Co-Researchers*

| Co-R Pseudonym | Age | Race and/or Ethnic Identity | Age of Onset | Most Recent ED | Time in Recovery | Time Since Relapse | Treatment Received | Current Care |
|---|---|---|---|---|---|---|---|---|
| Dahlia | 23 | Latina | 12 | BN | 6 months-1 year | 1 year | Individual, medication, group, family, dietician | Case manager, drop in group |
| Daisy | 26 | Hispanic | 13 | BED | 1-5 years | 1-2 years | Individual, dietician | None |
| Holly | 32 | White/ Caucasian | 12 | BN | 6 months-1 year | 1 year | Individual, medication, group, family, dietician | Individual, group |
| Iris | 23 | White/ Caucasian | 16 | BED | 1-5 years | 6 months-1 year | Individual, medication, group, dietician | Individual, medication |
| Ivy | 29 | White/ Caucasian | 17 | BED | 1-5 years | 3 years | Individual | None |
| Jasmine | 43 | Biracial | 25 | BED | 6 months-1 year | 6 months-1 year | Individual, group | Individual, group |
| Lily | 33 | White/ Caucasian | 12 | BED | 1-5 years | 6 months-1 year | Individual, medication | None |
| Magnolia | 27 | White/ Caucasian | 15 | BED | 1-5 years | 3 years | Individual | None |
| Poppy | 27 | White/ Caucasian | 12 | BN | 1-5 years | 1 year | Individual, medication, group, family, dietician | Individual, medication |
| Rose | 41 | Hispanic | 23 | BN | 5+ years | 2 years | Individual, dietician | None |
| Violet | 24 | South Asian American | 13 | BN | 1-5 years | 1 year | Individual medication, dietician | None |
| Willow | 32 | White/ Caucasian | 7 | BN | 6 months-1 year | 1 year | Individual, medication, group, family, dietician | Individual, medication |

* Individual = individual psychotherapy, medication = medication management, group = group therapy, family = family or couples psychotherapy, dietician = medical nutrition therapy

## Measures

**Screening survey.** Co-researchers were invited to complete a screening measure to assess whether they met criteria for the study. The screening survey asked questions

about type of eating disorder, most recent relapse, and questions about treatment received. The survey also asked demographic information including age, relationship status, race and/or ethnicity. This survey was completed by potential participants via Qualtrics by accessing the link provided in the informational paragraph disseminated by site/group moderators via Facebook and eating disorder listervs. (See Appendix B).

**Semi-structured interview and follow-up.** Semi-structured, in-depth interviews were conducted via Zoom using interview protocol developed based on extant research related to interpersonal and social functioning among women who experienced relapse but were currently in recovery from BN or BED (See Appendix I for supporting research). Co-researchers completed one semi-structured interview that ranged from 50 minutes to 105 minutes. Co-researchers then completed a follow-up interview when additional questions were asked and they were given the opportunity to correct or provide additional information or feedback on their transcript. These interviews lasted from 10 to 45 minutes. (See Appendix H for interview protocol).

**Inventory of Interpersonal Problems (IIP-64).** The IIP-64 measures interpersonal difficulties and is composed of 64 items rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). It consists of eight subscales related to various domains of interpersonal problems: Domineering/Controlling, Vindictive/Self Centered, Cold/Distant, Socially Inhibited, Nonassertive, Overly Accommodating, Self-Sacrificing, and Intrusive/ Needy. The IIP-64 provides a total mean score as a global measure of interpersonal distress, with higher scores indicating greater interpersonal difficulties. The IIP-64 is a shortened version of the original measure, however it has

been used in various studies surrounding interpersonal functioning of people with eating disorders (e.g. Ivanova et al., 2015; Tasca et al., 2012).

The validity of this measure for use with diverse samples is unknown. The normative sample for this measure consisted of 800 18-89 year old people representative of the U.S. population in 1999 in terms of race and ethnicity, age, and years of education (Horowitz et al., 2003). Data from the U.S. Census Bureau was used to create a stratified sample to ensure the normative sample was representative, however, the racial and ethnic make-up of the U.S. population has changed significantly since 1999. Additionally, the way race and ethnicity are classified and labeled by the Census Bureau have also changed. Coefficient alphas for each subscale and the total score have been found to be adequate, .73 to .89 (Tasca et al., 2012) and test-retest reliability in a large clinical sample was $r = .98$ (Horowitz et al., 1988). The total score and four subscales (Socially Inhibited, Non-assertive, Overly Accommodating, and Self-Sacrificing) that were related to the constructs found in the literature as related to eating disorders are reported and discussed in Chapter Five. A standard score of more than 60 is considered "above average" and a score of more than 70 is considered a "high score" because it is two standard deviations above the mean and only 3 to 6% of the normative, non-clinical sample scored in this range (IIP-64; Horowitz et al., 2003). The manual does not discuss the implications of low scores, so no information is known about whether these provide any meaningful data. Co-researchers were given the link to complete this measure following the first interview and all completed it prior to their follow-up. I downloaded and interpreted the raw score reports from *Mind Garden's Transform™ System*, the online website that hosts the survey.

## Procedure

**Data collection.** Once a woman met criteria and completed the consent form, their semi-structured, in-depth interview was scheduled at a time of their choosing via email. Interviews were all conducted via encrypted Zoom sessions. Participants accessed the Zoom meeting via email link. The interview began by thanking the co-researcher for their time and interest, introducing the researcher, and revisiting consent and confidentiality to allow space for questions or clarification. They were told the ways their confidentiality would be protected and asked if they had a pseudonym they would like to use. None of the co-researchers had a name they preferred and preferred that I select one. I then discussed the purpose of the study, shared about myself and background and explored my interview approach, specifically that I would be conducting the interview from a feminist lens. I reiterated my appreciation for their collaboration, specifically that I would send their interview transcript to them to review and edit, and reminded them of the IIP-64 survey and follow-up interview. I then asked for verbal consent to record and began recording before starting the interview protocol. See Appendix G for the introduction to the interview protocol and Appendix H for the interview protocol.

The research question I hoped to address was: How do women who relapse from BN or BED perceive what factors led to relapse and then recovery? Within this broad question, I focused on the interpersonal variables related to this phenomenon. Moustakas (1994) states that the interview protocol should be guided by two broad questions with additional specific questions. The first broad question is about what a person experienced in relation to the phenomenon being studied and the second is about what influenced their

experience of this phenomenon. The interview protocol was developed based on a review of relevant literature of interpersonal variables related to BN or BED. See Appendix I for a list of the supporting literature for each question.

Prior to initiating these interviews, I conducted a pilot interview with a colleague who has a history of BN and identified as in recovery. She provided feedback on the format of the interview, structure of questions, and discussed areas missing from the protocol. She suggested adding a question that specifically elicits information about context of the environment at the time of relapse and entering recovery, so a question was added to explicitly ask if there were significant events that occurred around these two milestones. She also suggested that I ask what aspects of life and relationships are easier in recovery as a follow-up to the question about continued challenges.

The semi-structured interview began by asking participants generally about their eating disorder journey and the context of their most recent relapse. This was partially done to gain a broad view of their trajectory but also to ensure that participants felt they were on solid ground with their eating disorder for at least six months to ensure their safety. Following the opening questions, co-researchers were asked about various aspects of their social life and social interactions at the time of their relapse, followed by questions about intrapersonal variables at the time of relapse. I then asked the same questions but in regard to when they entered recovery and finished by asking continued challenges for maintaining recovery, aspects of relationships that remain challenging, and aspects of their life that are easier in recovery. I closed by asking if there was anything we did not cover that was important to their journey.

Interviews were semi-structured in that the protocol served as the basis for all interviews; however, this format provided room for the researcher to ask follow-up questions, adapt, and change questions as appropriate based on co-researcher responses. The interviews were estimated to last about one hour to one and a half hours and in actuality ranged from 50 minutes to one hour and 45 minutes long. Following the interview, co-researchers were sent a $25 electronic Amazon gift card.

Co-researchers were then asked to complete the Inventory of Interpersonal Problems (IIP-64; Horowitz et al., 1988), following the interview, to obtain a quantitative measure of interpersonal functioning and serve as complementary information to interview data. Following their interview, they were emailed a link to complete this survey and all completed it prior to the follow-up interview. The researcher downloaded score reports of these results and interpreted them with the use of the manual.

Following the interview, I wrote a memo about the experiences, any methodological thoughts I had regarding my interview protocol, any themes that emerged, and any additional information I needed to ask in the follow-up interview. Memoing, or maintaining reflective notes throughout the research process, was utilized following each interview and follow-up interview to aid in creating an audit trail and thus, enhancing credibility by ensuring the study can be examined and replicated (Rodgers & Cowles, 2007). After I wrote each memo, I transcribed the interview verbatim; I then listened to the recording again to check for accuracy.

All transcripts were sent to co-researchers for their review within two weeks of their initial interview via the University of Denver's secure file transfer system, transfer.du.edu for co-researchers to review for accuracy and completeness and to further

increase dependability of the study (Creswell, 2013). Once the transcripts were sent to co-researchers, follow-up interviews were scheduled with enough time for them to review via email. All audio-recordings and related documents were saved on the researcher's secure drive and following transcription, the audio recordings were deleted.

All co-researchers were able to review their transcripts prior to the follow-up interview and two sent back documents with additions and clarification via secure transfer system. These amendments were included in the transcript for analysis. Follow-up interviews took place via Zoom and began by asking co-researchers their general reactions to their transcript. All noted some form of discomfort with seeing their unedited and unfiltered thoughts but all described this as a positive experience, using terms such as "healing, cathartic, reflective, and accomplished" to name a few. They were then asked if they had any additions beyond what they already supplied and asked if it felt like an accurate portrayal of their experience. All co-researchers approved their transcripts and some discussed additional thoughts they had since the interview. They were then asked about other salient identities that they feel impacted their experience of their eating disorder journey and how they describe themselves in recovery. Follow-up interviews lasted from 10 minutes to 45 minutes depending on co-researcher's additional thoughts or comments. Co-researchers were given an additional $25 electronic Amazon gift card after the follow-up interview. I again created memos following these interviews. These interviews were transcribed in the same process and fashion as the first interviews; however, they were not sent to co-researchers for review at the recommendation of the Intuitional Review Board at the University of Denver who felt that this was exceedingly burdensome for co-researchers.

## Data Analysis

After all follow-up interviews were conducted and transcribed, data analysis began. NVivo 12 Software (2019) was used to organize and analyze the data. Moustakas (1994) outlined a revised version of the van Kaam method of data analysis to follow when using phenomenology as the research method. Before analysis can begin, Moustakas (1994) noted that data organization needs to be completed. In this phase, each participant's documents were uploaded to NVivo to aid in organization. These documents included interview transcripts (with participant feedback/edits), memos from interviews, and relevant email exchanges between the researcher and participant. Participants were classified by a set of attributes taken from the screening survey, including age, race and/or ethnicity, relationship status, eating disorder type (BN or BED), age of onset, time in recovery, treatment received, and current treatment.

**Phenomenological reduction.** The first stage of phenomenological data analysis is phenomenological reduction. It consists of repeated reviewing and memoing to assist in theme creation through reduction of the data (Moustakas, 1994). The first part of reduction is called horizonalization, which consists of highlighting or listing all statements or expressions made by the co-researcher in their interview transcript (Moustakas, 1994). At this point in analysis, all statements are considered equal and were reduced later in the process (Moustakas, 1994). These statements were discovered by reading each co-researcher's transcripts, memos, and significant email exchanges multiple times.

Next, I created a table for all statements organized by the co-researcher as part of the audit trail for this study. The researcher's direct questions and commentary was

eliminated. This process yielded a total of 914 statements ranging from 47 to 99 statements per co-researcher, see Table 2.

Next, the total list of these statements was reduced to those that seemed to provide information about how participants experienced the phenomenon in question. In determining what statements are relevant to the phenomenon in question, Moustakas (1994) suggests that two criteria are applied to each statement:

1. Does it contain a moment of the experience that is a necessary and sufficient constituent to understand it?
2. Is it possible to abstract and label it? If so, it is a horizon of the experience (p. 121).

These questions were applied to co-researcher responses and discussion. The documents were read and re-read to capture all relevant statements and statements that were not relevant to the phenomenon were deleted as well as repetitive responses as recommended by Moustakas (1994) to aid in the process of reducing the data into the themes. The majority of statements that were discarded contained information about their initial onset of their illness. For example, Holly discussed the development of her eating disorder:

> My mom had an eating disorder and she became hyper focused at some point on my weight. And so my parents used to pay me to lose weigh, and would only buy me new clothes if I weighed a certain amount and there were foods that my brothers were allowed to eat that I wasn't.

While important and significant to her eating disorder, some of this information was not necessary to understand the phenomenon of relapse and/or recovery. What remained

were 762 “horizons”, see Table 2. These horizons were added into a larger table organized by co-researcher classifying information and was imported into NVivo (2019) to assist with word frequency queries and grouping data.

Table 2
*Number of Horizons by Co-R after Reduction*

| Name | Statements | Horizons |
|---|---|---|
| Dahlia | 65 | 60 |
| Daisy | 92 | 75 |
| Holly | 47 | 42 |
| Iris | 83 | 75 |
| Ivy | 79 | 67 |
| Jasmine | 59 | 49 |
| Lily | 77 | 69 |
| Magnolia | 77 | 61 |
| Poppy | 69 | 52 |
| Rose | 99 | 66 |
| Violet | 81 | 79 |
| Willow | 86 | 67 |
| **Total** | **914** | **762** |

The next step in reduction was to cluster the “horizons” into themes, which consists of organizing the remaining relevant statements into like groupings (Moustakas, 1994). To accomplish this, I went through each statement in the table of remaining relevant statements, case by case, and assigned each one a descriptive label or code such as “isolation from supports”, “disconnection from feelings”, “developing identity”, “giving self permission”, and “ability to be present”. After all statements were given codes, I reviewed the list and wrote an additional memo about emerging themes.

While relapse and recovery exist on a continuum, it became clear that I needed to cluster codes into headings that separated the processes of relapse and recovery. During this phase, I grouped the codes created in the previous process into the broader categories of themes occurring during *Relapse* and *Recovery*. After the codes were sorted into these categories, I was able to group the codes into themes.

To complete the process of grouping codes into themes, I complied the list of codes and themes developed from memos and ran a word frequency query on the list of highlighted relevant statements to ensure my list was consistent with words utilized by co-researchers. I included the 50 most commonly used words that were four letters or longer from all of the co-researcher's relevant statements below, see Table 3. I excluded the following words due to their use as filler words or hesitation forms: just, know, think, really, kinds, things, even, also, little, much, and definitely. This process helps minimize bias when creating themes, because participants' own words are reviewed to ensure the most frequently used words are included (Silver & Lewins, 2014).

Table 3
*Word Frequency of Relevant Statements*

| Word | Count | Similar Words |
|---|---|---|
| feels | 551 | feel, feeling, feelings, feels, felt |
| times | 301 | time, times, timing |
| want | 278 | want, wanted, wanting, wants |
| people | 258 | people, peoples' |
| still | 241 | still |
| going | 226 | going |
| works | 170 | work, worked, working, works |
| body | 164 | bodies, body |
| back | 162 | back |

| | | |
|---|---|---|
| need | 158 | need, needed, needing, needs |
| talking | 157 | talk, talked, talking |
| good | 144 | good |
| help | 133 | help, helped, helpful, helping, helps |
| disorder | 131 | disorder, disordered, disorders |
| started | 131 | start, started, starting, starts |
| recovery | 126 | recovery |
| always | 123 | always |
| making | 121 | make, makes, making |
| better | 120 | better |
| taking | 120 | take, takes, taking |
| differently | 119 | difference, different, differently |
| friends | 118 | friend, friendly, friends |
| binge | 117 | binge, binged, bingeing, binges, bingeing |
| year | 115 | year, years |
| foods | 113 | food, foods |
| care | 110 | care, cared, careful, cares, caring |
| self | 108 | self |
| life | 107 | life |
| relapse | 107 | relapse, relapsed, relapses, relapsing |
| well | 106 | well, wellness |
| point | 102 | point, pointed, points |
| look | 101 | look, looked, looking, looks |
| able | 101 | able |
| hard | 99 | hard |
| guess | 98 | guess |
| relationship | 98 | relationship, relationships |
| thought | 94 | thought, thoughtful, thoughts |
| struggle | 93 | struggle, struggled, struggles, struggling |
| never | 86 | never |

From these lists, codes were grouped together into broader categories called themes and some themes were reduced, combined and coded into new broader themes. During this process Moustakas (1994) states that clustering the common aspects of the phenomenon into themes helps one arrive at the core aspects of the experience. These themes aim to provide a deeper understanding of the phenomenon in question (Creswell, 2013).

In the final stage of phenomenological reduction, the data were reviewed to identify the themes, concepts, and relationships that were most illustrative of the phenomenon in question as recommended by Silver and Lewins (2014). After the total list of themes was consolidated and grouped into their corresponding time period of relapse or recovery, each relevant statement identified previously was checked against the codes and themes developed. For this process Moustakas (1994) states that you must ask two questions about each code:

1. Are they expressed explicitly in the complete transcription?
2. Are they compatible if not explicitly expressed?
   If they are not explicit or compatible, they are not relevant to the co-researcher's experience and should be deleted. (p. 121)

This process was conducted with all codes and themes from memos and the frequency list and what remained were the validated themes (Moustakas, 1994). See Table 4 for themes. These themes were used to develop individual textural descriptions of what each co-researcher experienced in relation to the phenomenon. These themes and individual textural descriptions are presented and described in detail in Chapter 5.

Table 4
*Themes by Phase of Relapse and Recovery*

| **Most Recent Relapse** |
|---|
| Intrapersonal Factors |
| Co-occurring health concerns and trauma |
| Progression to relapse |
| Neglect of self |
| Low Self-Compassion |
| Intrapersonal Disconnection |
| Unsafe to be seen fully |
| Disorder and Food as Coping/Safety |
| Interpersonal Factors |
| Isolation and Hiding |
| Interpersonal Disconnection |
| Environmental Stress |
| Seeking resources & Support |
| Motivation for recovery |
| Navigating relationships |

| **Recovery** |
|---|
| Entry into recovery |
| Intrapersonal Factors |
| Attunement and identity |
| Acceptance |
| Self-care and Compassion |
| Freedom and Flexibility |
| Interpersonal Factors |
| Openness and assertiveness |
| Connection and presence |
| Environmental Stability & Community |

**Imaginative variation.** The next phase of phenomenological analysis consists of what Moustakas (1994) calls the Imaginative Variation, where the researcher "seeks possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals and approaching the phenomenon from divergent perspectives, different positions, roles or functions" (p. 97). The goal of this stage is to discover the structural description of the experience of the phenomenon, or "how" this

phenomenon was experienced, which includes the setting and context (Creswell, 2013). The textural description focuses more on the experiences and what happened while the structural description examines the setting and context in which the phenomenon is experienced (Creswell, 2013). The structural description includes "the underlying and precipitating factors that account for what is being experienced" (Moustakas, 1994, p. 98). These are presented in Chapter 4.

**Synthesis of meaning and essences.** In the last phase of phenomenological data analysis outlined by Moustakas (1994), textural and structural descriptions are integrated to create the "essence" of this phenomenon, or that which is shared by all who experience this phenomenon. The essence of the phenomenon is that which is common to all women in their experiences of interpersonal aspects of relapse and recovery from BN or BED.

## Validation Procedures

There are several ways that qualitative researchers validate their findings. Creswell (2013) suggests that the author of a phenomenological study should:

(1) Convey an understanding of the philosophical tenets of phenomenology.

(2) Have a clear phenomenon to study that is articulated in a concise way.

(3) Use procedures of data analysis in phenomenology such as the procedures recommended by Moustakas (1994).

(4) Convey the overall essence of the experience of the participants.

(5) Be reflexive throughout the study. (p. 260)

Throughout this study, I addressed each of these considerations. In this chapter, I described my philosophical framework and phenomenology specifically. I outlined the phenomenon I sought to study and detailed the procedures I used for data analysis as

outlined by Moustakas (1994). I have engaged in reflexivity throughout the research process, repeatedly memoing and utilizing journaling and psychotherapy to reflect on this experience and how my biases may be surfacing in each stage of the research. The results section will discuss the essence of the experience of the co-researchers.

Other ways qualitative researchers seek to validate their findings is by creating an audit trail. An audit trail enables others to see the detailed steps the researcher took throughout the process and enhance the study's credibility (Rodgers & Cowles, 2007). The audit trail includes raw data such as interview transcripts, the products of data reduction and analysis, such as the lists of relevant statements, meaning units or codes, themes, process notes such as memos and reflections of methodological decision making processes, and the final products of synthesis such as the structural and textural descriptions (Lincoln & Guba, 1985; Toma, 2011).

Qualitative researchers also utilize a practice called "member-checking" to enhance credibility of research findings. This process is a form of validation and increases the dependability of the study since participants review and verify transcript data (Creswell, 2013; Lub, 2015). Participants received a copy of their interview transcript within two weeks of the completion of their interview to check for corrections, completeness, and to provide additional feedback via Zoom.

Another way to enhance the validity of a qualitative study is to provide verbatim descriptions from co-researchers when writing up results (Wertz, 2005). Chapter 4 includes extensive verbatim passages about each theme from co-researchers.

Finally, a Master's student in Counseling Psychology conducted a reliability check to ensure that the relevant statements made by the co-researchers could be sorted

into the themes and subthemes created by the researcher. Percent of agreement was utilized to determine inter-rater reliability. While there is debate about what constitutes an acceptable level of agreement, 70% has been used by exploratory studies (Neuendorf, 2002). The inter-rater reliability ranged from 68% to 92%, with only one theme below 70% inter-rater reliability. See Table 5 for the inter-rater reliability of the themes of relapse and recovery.

Table 5
*Inter-Rater Reliability of Themes of Relapse and Recovery*

| **Themes of Relapse** | **Reliability (%)** |
|---|---|
| Intrapersonal Factors | |
| Co-occurring health/trauma concerns with ED | 82.35 |
| Progression to relapse | 70.00 |
| Neglect of self | 92.00 |
| Low self-compassion | 87.10 |
| Intrapersonal disconnection | 82.14 |
| Unsafe to be seen fully | 72.72 |
| Food as Coping/Safety | 77.27 |
| Interpersonal Factors | |
| Isolation and Hiding | 89.58 |
| Interpersonal Disconnection | 68.42 |
| Environmental Stress | 88.37 |
| Seeking resources & Support | 73.07 |
| Motivations | 70.00 |
| Navigating relationships | 71.42 |

| **Themes of Recovery** | **Reliability (%)** |
|---|---|
| Entry into Recovery | 80.00 |
| Intrapersonal Factors | |
| Attunement and Identity | 91.23 |
| Acceptance | 73.08 |
| Self-care and Compassion | 88.88 |
| Freedom and Flexibility | 83.78 |
| Interpersonal Factors | |
| Openness and Assertiveness | 91.07 |
| Connection and Presence | 74.29 |
| Environmental Stability and Community | 84.85 |

## Summary

A phenomenological method was used to uncover the essence of how women perceive what factors led to relapse and then recovery from BN or BED. The phenomenon and process of obtaining epoché were discussed. Co-researchers were described and their recruitment was detailed and data were collected via semi-structure

interviews and IIP-64 survey data. The data were then analyzed using phenomenological reduction, imaginative variation, and synthesis of the phenomenon. Validation procedures were explored. The next chapter will provide a detailed account of the results of each stage of phenomenological analysis including phenomenological reduction, imaginative variation, and synthesis of meaning and essences.

# CHAPTER FOUR: RESULTS

Chapter Four provides the results of this phenomenological study that addressed the main research question, "How do women who relapse from BN or BED perceive which factors led to relapse?" This study also addressed the question, "How do these women perceive which factors then led to recovery?" Within these broad questions, I focused on the women's experience of interpersonal variables related to the phenomena. To address the research questions the results are presented as follows: individual textural descriptions of each co-researcher, the themes that were discovered during data analysis, co-researcher reflections about recovery and continued challenges, a synthesized textural account of what the women experienced in relation to the phenomenon, the results of the Inventory of Interpersonal Problems (IIP-64), a structural description of how the women experienced the phenomenon, and finally the essence of the phenomenon created via integration of the textural and structural description of the phenomenon. The study results are organized by phase of data analysis. Although the co-researchers experienced multiple relapses in the course of illness, throughout this document relapse refers to the co-researcher's most recent relapse.

## Products of Phenomenological Reduction

This section outlines the results of the first stage of phenomenological data analysis, phenomenological reduction. It includes the individual textual descriptions, the

themes that emerged from interview data, co-researcher reflections and continued challenges, and the synthesized textual description of the phenomenon.

**Individual Textural Descriptions**

Textural descriptions of each co-researcher were created to give an account of the woman's experience with the phenomenon and provide information about their background. As recommended by Moustakas (1994), these individual textural narratives were later used to aid in synthesizing the data into the final textural description that discusses all women's experiences with relapse and recovery from BN or BED.

**Dahlia.** Dahlia is a single, 23 year-old, Latina woman who identified herself as being in recovery for about a year from BN. At the time of her most recent relapse over a year ago, which she described as her worst, she noted significant loss of her peer group's support, feelings of isolation, and feeling that the perpetrator of her sexual assault "got away with it". During this relapse she described herself as introverted, mean, apathetic toward herself, and disconnected from her family. When she did have social interaction, she described herself as not being present due to thoughts about food, eating disorder behaviors, or fears of judgment. She wanted to "seem like Superwoman when it came to work and school and didn't want to let anyone in too much." She declined opportunities for social interaction to keep up this façade. She entered treatment due to a chance encounter with a previous provider whom she trusted and began the process of active recovery again. While in treatment, she had the opportunity to pursue legal action toward her assailant and felt like this helped her move forward and invest in her recovery.

In recovery, Dahlia is a woman who comes across as "alive" and excited to be finally discovering her identity for the first time. She shows tremendous drive to

complete her undergraduate degree despite interruptions for treatment. She has rebuilt a close connection with her mother, describes herself as "present", outgoing, and transparent in social relationships. She states that when she is with people, she feels engaged and that her cognitive ability to attend to the present moment has increased since she is no longer preoccupied by thoughts of food, compensatory behaviors, or fear of negative evaluation. She described the process of becoming attuned to her bodily cues and needs and practices intuitive eating. She does not regularly attend any formal treatment at this time, but she has a case manager she can contact if she needs to re-engage in therapy. She believes that maintaining daily activities of self-care is essential for staying in recovery and described how she developed assertiveness to advocate for herself in terms of the support she needs both within herself (challenging eating disorder related thoughts) and in relationships with others. Dahlia appeared to continue to struggle with self-compassion. She feels that she is able to intervene when she has negative thoughts toward herself but wishes she was more compassionate when she makes mistakes. Dahlia reports that her body image has improved but she still has difficulty challenging ingrained thought processes about not wanting to "take up space".

**Daisy.** Daisy is an intelligent and driven 26 year-old woman who identifies as Hispanic and works in an eating disorder related field. On her screening form she indicated BED as the eating disorder she most recently experienced but in the follow-up interview she noted uncertainty as to whether she actually met criteria to be diagnosed during her most recent "relapse". Daisy described her most recent relapse occurring between 1-2 years ago and consisted of binge eating behavior. She stated that she was in graduate school, completing her training internship, living back at home with her family,

working part-time in the eating disorder field, and coping with family illness. She noted that she felt pressure to display perfect eating behavior since she worked in the field and she experienced shame when she felt she did not live up to this standard. She expressed difficulty speaking to the people in her social support system or seeking help, because she felt she could not disclose her imperfect eating habits due to her profession. She noted that she had difficulty expressing emotions and had poor coping skills which led her to "hold it all in" and cope with food and exercise. At the time of her relapse, she engaged minimally in self-care and struggled to find compassion for herself because she "continued to prove that she couldn't take care" of herself. Her self-esteem suffered due to feeling out of control over binges and comments made by others about weight gain.

Daisy noted that moving out of her parents' home, finishing school, and getting a job as significant context pieces about when she entered recovery, but she could not "pinpoint" the day she was recovered. She noted that in the process of differentiating from her family, she recognized that her family's culture was very diet focused. Daisy described the process of developing her voice to speak out against diet culture and noted that she began to advocate in a "vague way" when people made fat phobic comments and later discussed how in recovery she was able to explain how they affected her personally.

Through her recovery, she has developed a professional community and identity where she is passionate about the *Health at Every Size* approach, which adopts a more holistic definition of health than the larger medical community typically utilizes in conceptualizing determinates of wellness (Association for Size Diversity and Health, 2019). In reflecting on how her relationships have changed, she noted that she now feels much more connected to her family and said that before, her disconnection from them

was “behind closed doors” and wondered if they noticed how distracted she was. She is still challenged by identifying and expressing emotions but notes that she knows she has people she can go to and verbally express them. She learned that she identifies as someone who is exceptionally empathic and is deeply impacted by others’ struggles. In the past, she took on other people’s feelings to her detriment but now feels she can set reasonable expectations and boundaries for herself in this regard. She realized she was recovered when “food, eating, body image, and exercise weren’t on my mind occupying my thoughts or getting in the way of school, work, friends, and family.”

**Holly.** Holly is a 32 year-old married woman who identifies as White/Caucasian. She works in a helping profession in a medical setting and has been in recovery from BN for six months to one year. She is candid, funny, and active in her recovery. She discussed a variety of stressors related to long, intense work hours, attending school, managing co-occurring obsessive compulsive disorder, and worsening symptoms related to her Crohn’s disease at the time of her most recent relapse. Her work/school schedule left little time for self-care, and she was feeling increasing discomfort with vulnerability as she became more intimate with her now husband. She sought treatment to help her regain recovery due to fears of losing her husband and career and because her disordered eating behaviors were exacerbating her Crohn’s disease. Holly attended residential care for the second time and found this to be a very positive experience where she learned to identify emotions and communicate more effectively without needing the comfort of her eating disorder. She still has a small support circle but feels more connected and present in relationships since experiencing freedom from her intrusive symptoms. In recovery, Holly has made changes to her life to support recovery including working in a different

setting, discontinuing school, and engaging in self-care. She attends individual and group therapy and finds these supports beneficial. The continued challenges she faces in maintaining her recovery include: coping with fat phobia while working in a medical setting, managing her Crohn's disease, and continued discomfort with intimacy. She identifies as recovered and is able to use therapy to help her navigate these challenges.

**Iris.** Iris is a 23 year-old White/Caucasian woman who is in a relationship and reported that the eating disorder she most recently relapsed from was BED. She comes across as reflective and warm and although she makes light of various aspects of her journey, it is clear that she feels sadness related to how much space her eating disorder has occupied in her life. Around the time of her most recent relapse, about one year ago, Iris described a period of intense and prolonged stress related to school, work, and health demands while having minimal emotional support. She noted that she was taking a heavy load of courses during a shortened term, which she described as a "terrible idea", while working and feeling like she "had supports but then they were gone" due to her friends going back home from college during the summer. She described a gradual process of "slowly overeating" and becoming disconnected to her own affective experiences and not wanting to discuss her struggle with family or friends. She noted that she had little interaction with others while in relapse, but when she spent time with people she was disconnected, not asserting herself, and was preoccupied by thoughts of food or thoughts related to her eating disorder. She identified her self-care as "okay" but noted that she "definitely needed more of a break" than she gave herself. She made it through the stressful time, received treatment, and has not used behaviors since her most recent relapse, about one year ago. In recovery she feels more connected to her own

identity as “really artistic with writing and dance” and as a family member. She reflected on how much more present she is physically and mentally when spending time with family, specifically noting that she does not choose exercise over family time and is not preoccupied by eating disorder related thoughts. Iris discussed her development of assertiveness and learning to “take up space” through being involved in group therapy at her college which also helped her manage her social anxiety. She notes that she feels “pretty strong in recovery” but feels that it is something she has to “choose every day”.

**Ivy.** Ivy is a 29 year-old, married, White/Caucasian woman who grew up in a different country and moved to the US to complete her schooling. She identified BED as the eating disorder she most recently experienced and noted that her last relapse occurred about three years ago during a period of significant stress when she was working fulltime and attending school fulltime without any family support while navigating a hostile work environment. She discussed how her binge eating was a source of comfort during this stressful time and something she used to cope with her extreme exhaustion. Consistent with other women’s experiences, she did not talk with her support system about her struggles and felt she was “always putting on a good cover” and being “this extreme funny person”. Despite this, she still identified friendships as close and unaffected by her eating disorder. She is incredibly strong and approached her recovery with determination, seeking countless books and resources to “find an answer” and at times felt that something must be “wrong with me” because she “couldn’t puzzle it together” and enter recovery. She has been in recovery for about three years and her life has become much more stable as she “finally graduated from university” and found a job

where she is “accepted and respected”. She has a young child and noted that becoming a mother “helped me to see that there are things that are more important than those goals of achieving a perfect body” but at times struggles with self-compassion and “giving herself a break”. In terms of how she conceptualized her recovery she said, “a lot of those thoughts are still there, I'm just able to kind of ignore them”.

**Jasmine.** Jasmine is a 43 year-old single woman who identifies as biracial. She is matter-of-fact and speaks concisely about her experiences with her eating disorder. Her most recent relapse occurred about a year ago and she believes it was triggered by the death of her grandmother combined with every day stressors related to having numerous children. She noticed the relapse began by starting to isolate herself from other people and said she stopped “answering my door or my phone”. She became disconnected from her supports and her feelings by turning to “food for comfort”, often at night when everyone else went to sleep. She stopped engaging in self-care and stopped doing her hair and getting dressed for the day. At the beginning of her relapse, she was not in treatment. She re-engaged in treatment through an eating disorder program, participating in individual and group therapy when she realized she “couldn’t control it”. In recovery she feels connected to people in her life and makes sure to “have meaningful conversations” with her kids every day. She is deliberate in maintaining her self-care. She is able to assert herself when she needs to and she says she learned this skill by being in group therapy. In group she “learned that if I don’t, in my own terms, assert my feelings, whether it’s saying, ‘That felt bad or uh-uh’, then I'll eventually go back to the food.” It was inspiring to hear her pride when describing herself as “accomplished” and discussing how she feels like herself again. She noted continued struggles with

expressing anger and at times she experiences preoccupation with food when she has food in the house that she would have previously binged on. She is able to challenge these thoughts and "give them time and let them pass."

**Lily.** Lily is a 33 year-old White/Caucasian woman who is engaged to someone she has been in a committed relationship with "for so long it's like he's my husband". She is a mother of three children and her partner has significant health concerns. From our interview, she came across as a woman who has a lot of responsibilities and manages them with grace. Her most recent relapse from BED occurred about a year and a half ago and happened suddenly. Her partner was in the Intensive Care Unit (ICU) due to chronic health issues and on her way home from visiting, she stopped at several fast food restaurants and binged in her car. When she got home she remembered "just sadness". She described her existence during her relapse as "just ignoring everyday things" and spending a lot of time and energy "obsessing over food". She discussed positive experiences with treatment and engaged in Eye Movement Desensitization and Reprocessing (EMDR) therapy for her trauma history. Lily identified being in recovery for about a year and is insightful and animated when talking about how much better she feels. She feels like she is "an active participant in everything now" because she is not consumed by thoughts of food. She still thinks that she has to be cautious with food; she does not feel safe eating certain foods that were previously binge-eating triggers and discussed the continued challenges this presents with social eating. Her favorite part of recovery has been becoming "in-tune" with her body and feels much better physically.

**Magnolia.** Magnolia is a 27 year-old, single, White/Caucasian woman who is vibrant, witty, and intelligent. She shared her journey and talked about "what it's been

like to live as a fat person my whole life with everyone telling me that I'm too much". She possesses insight into the broader sociocultural context in which eating disorders occur and explored the implications of a fat phobic society. Her most recent relapse with BED occurred about three years ago while she was traveling abroad. She described it as lasting "longer than I had hoped it would". Prior to her relapse, she was in recovery for several years and had been practicing intuitive eating. Her relapse came on quickly and was related to the re-experiencing of past sexual trauma. She noted, "I was doing everything in my power to not see it and to not feel it" and began restricting and then bingeing again. Around this time she also had significant stressors related to transitions with finishing graduate school and internship. She utilized therapy and began the process of recovery and stated, "the recovery from that [relapse] was deeper, it was better because of it". She described how she was slowly finding her voice to speak out against diet culture in early recovery and "falling out of love with the thin ideal" and practicing assertiveness in her "safest relationships." Now, she works in the eating disorder field and actively advocates on broader levels "calling out the culture, calling out the beauty standards, and calling out how we got to these damn beauty standards." In recovery, she has a couple of friendships where she can communicate about her experiences and advocates for what she needs versus experiencing shame related to her body. She feels that she is able to connect to other people more deeply. For her, continued challenges are related to "living in a larger body" and getting explicit and implicit messages to "do whatever you need to do, no matter how destructive, to not look like yourself." She reflected on this process and said, "So much of this journey, like yes there's relapse but so much of it is just learning."

**Poppy.** Poppy is a 27 year-old, single, White/Caucasian woman who is courageous and resilient. Her most recent relapse with BN occurred about a year ago. She noted that the "turn of the year is always hard" to manage due to discomfort with family gatherings over the holidays and the pervasiveness of diet culture with "everybody making resolutions" and "everybody at work talking about weight loss". Poppy has well-controlled bipolar disorder but noted that this time of the year has historically been challenging in relation to her manic symptoms. She described a gradual process of social isolation and "putting on a brave face" when she would interact with people. At the same time, she was feeling that her ability to express emotions was "stunted" and like she was not "in touch with emotions". She described both her self-care and self-esteem as poor and also expressed difficulty related to her gastrointestinal (G.I.) disorder. She sought help and received support from her supervisor at work in her process to get care. She knew she needed to get better and if she did not, she would be "giving up my license to practice and the value of my education". Her family became involved in her treatment on her terms and in a way that fostered her autonomy. She is open about her journey and feels confident to assert herself and advocate for her needs in a variety of settings. Poppy has to maintain a restrictive diet to manage her G.I. disorder and expressed some concern over weight change in our first interview. She is well connected to care and feels that, "even with the struggles that have happened in the last couple of weeks, reflecting on why I have stayed in recovery and who I am now that I am in a healthier place is still kind of the resounding factor." Between our first and second interview, a member of her treatment team disclosed Poppy's current weight due to concerns about weight-loss. Since she learned her current weight, she has had to "fight for her recovery".

**Rose.** Rose is a 41 year-old married woman who identifies as Hispanic. She is the only woman who identified her most recent relapse from BN as more of a "thought relapse," where she did not return to purging but began controlling food intake and restrictive thinking. Although she did not endorse it as a behavioral relapse, she was utilizing restrictive behaviors as a means to lose weight. She described a combination of stressors that culminated in her beginning to return to habits of restriction. At the time of her relapse, she felt that she had made significant progress on things like self-esteem and self-compassion which enabled her to recognize that she was experiencing disordered eating thoughts about a year ago and stated, "it was more confusion than anger or disappointment" that she was having those thoughts. Noticing her beginning to become more restrictive in what she allowed herself to do and eat, her husband spoke up during her relapse and said, "I want my wife back." Rose said that her relationship with her husband was a big motivator to seek care before she experienced a more severe behavioral relapse, as she felt her previous marriage was adversely impacted by her eating disorder and she did not want the same for this relationship. At this time, she was beginning to become aware of how much people talked about food and "frame everything through this weight lens that is pretty restrictive and narrow" and discussed how she navigated friendships with this dawning awareness. She read *Health at Every Size* (Bacon, 2010), a book discussing the principles of this approach, and felt like everything clicked and she "couldn't unknow" it, so she sought a therapist with this specific training and noted, " I was about to go headlong into that nonsense, like just dive straight into the deep end and she helped me kind of avoid that." In recovery, Rose is brave, in-tune with

herself, and unashamed to speak up and push back against fat phobia. She examined how she experiences the world as a woman in a larger body and is committed to living in alignment with her value of social justice.

**Violet.** Violet is a 24 year-old, single, South Asian American woman who came across as wise and genuine during our interviews. Her most recent relapse with BN occurred about one year ago during a time of significant transition and instability. She noted that she completed college and had been working on her thesis and using food to cope with long difficult hours of writing. She was unsure about her next steps and was living back home with her parents for a period before starting a new job. She was isolated at this time and felt that she did not have many meaningful interactions. She did have a couple of close friends whom she felt would have been "capable of having a very candid conversation with about how I was feeling and what was going on, but I didn't want people to know that I had this problem." She said, "I tried to seem like everything was fine even though there were a lot of things bothering me". Violet noted apathy and self-neglect and felt that she always struggled with assertiveness in personal relationships because she wanted to be accepted and validated. She noted disconnection between her behavioral escalation toward relapse and desires to maintain her health and felt that, "I just really didn't want to go down that road, but I felt like I couldn't really control it." Violet discussed her entry into recovery as gradual and not "the result of any momentous decision." She noted that the behaviors grew "cumbersome" for her and she gradually worked to replace them with more adaptive coping skills. Although she achieved physical recovery, she noted that she still suffered from low self-esteem and negative self-talk, which she continues to work on. In recovery, she is someone who has

meaningful relationships and said, “When I did develop some really meaningful friendships, where I felt like I didn't have to be ‘on’ all the time, where they really valued me as a person and appreciated me, that's when I entered recovery.” She also cares less about what others think of her and thinks that maturity helped with this process. She continues to struggle with being hard on herself and ensuring she engages in self-care behaviors consistently. Ease with social eating and flexibility are things she experiences in recovery. Violet still struggles with asserting her own needs and feels that, “if it's a friendship or a relationship that I'm afraid of losing or afraid of [them] changing their opinion of me, then I think I would not really express my needs.” She reflected on how “feeling feelings” without food is challenging at times but also stated that she is able to recognize that, “not everybody has to like me, and I don't have to be all things to all people.”

**Willow.** Willow is a 32 year-old, engaged, White/Caucasian woman who has been in recovery from BN for about 1 year. She experienced her most recent relapse just over a year ago while facing several stressful situations. She was living away from her family of origin and working in a stressful environment. She and her fiancé were also struggling financially and working long hours to ensure they would “stay afloat”. Willow has a history of trauma, which she described as a key component of what caused and maintained her BN. Her eating disorder served as protection and safety during her trauma. She reported feeling isolated and secluded from others, and disconnected from her internal experiences at the time of her most recent relapse and noted, “It was easier to check-in to the disorder and let the protector take over”. She and her fiancé moved back to where her family of origin lives and re-engaged in therapy, including trauma work, and

found stable housing and finances. In recovery, Willow is assertive and funny. She is dedicated to her recovery and works actively to maintain a lifestyle that supports it. She noted that she is more transparent and up-front about her needs and discussed the process of her family and herself learning who she is for the first time. She plans to pursue a career in the eating disorder field and hopes to open a treatment facility to fill a void in services provided in her community. She notes, "I went through this for a reason. There's a purpose to this. I survived this for a reason and so that's what drives me to step up."

**Themes**

The 762 horizons, list of codes and themes from memos, and the word frequency list of the most commonly used words by co-researchers in their relevant statements were used to create the final themes. Based on these data, the phenomenon of relapse and recovery from BN or BED was divided into two broader themes that served as organizing categories: *Relapse*, and *Recovery*. To further describe these themes, subthemes were developed. Within *Relapse* the themes were organized into: Intrapersonal Factors, Interpersonal Factors, Environmental Stress, Seeking Resources and Support, Motivations, and Navigating Relationships. Within *Recovery* the themes were organized into: Entry into Recovery, Intrapersonal Factors, Interpersonal Factors, and Environmental Stability and Community. Table 6 displays the co-researchers who endorsed which aspects of each theme. Each theme, including its subthemes, is described in the following section.

Table 6
*Theme and Subtheme Endorsement by Co-Researcher*

| **Themes** | **Co-Researcher** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | Totals |
| **Most Recent Relapse** | | | | | | | | | | | | | |
| Intrapersonal Factors | | | | | | | | | | | | | |
| Co-occurring health concerns and trauma | x | x | x | x | | x | x | x | x | x | x | x | 11 |
| Progression to relapse | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Neglect of self | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Low Self-Compassion | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Intrapersonal Disconnection | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Unsafe to be seen fully | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Food as Coping/Safety | x | x | x | x | x | x | x | x | x | | x | x | 11 |
| Interpersonal Factors | | | | | | | | | | | | | |
| Isolation and Hiding | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Interpersonal Disconnection | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Environmental Stress | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Seeking resources & Support | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Motivations | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Navigating relationships | x | x | x | x | | | x | x | x | x | x | x | 10 |
| **Recovery** | | | | | | | | | | | | | |
| Entry into recovery | | x | | x | x | | x | x | x | x | x | x | 9 |
| Intrapersonal Factors | | | | | | | | | | | | | |
| Attunement and Identity | x | x | x | x | x | | x | x | x | x | | x | 10 |
| Acceptance | x | x | x | | x | x | | x | x | x | x | x | 10 |
| Self-care and Compassion | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Freedom and Flexibility | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Interpersonal Factors | | | | | | | | | | | | | |
| Openness and Assertiveness | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Connection and Presence | x | x | x | x | x | x | x | x | x | x | x | x | 12 |
| Environmental Stability and Community | | x | x | x | x | | x | x | x | x | x | x | 10 |

Co-Researcher 1= Dahlia, 2=Daisy, 3=Holly, 4= Iris, 5=Ivy, 6=Jasmine, 7=Lily, 8=Magnolia, 9=Poppy, 10=Rose, 11=Violet, 12=Willow

## Themes of Relapse

The first grouping of themes falls into the broader category, *Relapse*. All of these themes were described by co-researchers as occurring or being related to the time

they most recently relapsed. It is important to note that for this study, there was no clear criteria for what constituted a relapse. Some women felt that the use of any restrictive, compensatory, or bingeing behavior was considered a relapse and others felt that psychological symptoms meant they relapsed. Rose noted that she did not return to a full-blown episode of BN but began the process of restricting with the intent of weight-loss. Some women noted prolonged periods of bingeing and/or purging as their most recent relapse and others, like Lily, noted that her last relapse consisted of one severe binge. It was important to allow the women to self-identify their most recent relapse, because this study was concerned with more than the physical and behavioral symptoms of eating disorders. Inclusion of all perceived experiences of relapse enhanced understanding of this phenomenon.

**Intrapersonal factors.** This subtheme included: (a) co-occurring health concerns and trauma, (b) progression to relapse, (c) neglect of self, (d) low self-compassion, (e) disconnection, (f) unsafe to be seen fully, and (g) food as coping. These themes and subthemes will be discussed below.

***Co-occurring mental and physical health concerns and trauma.*** Co-occurring is the term used to describe the health concern or trauma that occurred at the same time as the co-researcher's eating disorder relapse. Eleven of the women noted either a co-occurring mental health concern, a physical health concern, or trauma as related to their relapse. All of these women mentioned some type of co-occurring mental health struggle around the time of their relapse. Women reported these co-occurring difficulties with varying severity and not all stated that they were formally diagnosed, but all identified these aspects of their intrapersonal experience as important in understanding their relapse.

Women drew the connection between experiencing a return of symptoms of depression, anxiety, inattention, or mania and the urge to revert to eating disordered behaviors as coping mechanisms. An example of how these women understood the connection between their co-occurring mental health concern and their eating disorder was described well by Lily when she explored how bingeing helped her cope with inattention. She noted how she sought food to try to help her focus and also as a comfort when she felt overwhelmed. Lily stated:

> I have ADD pretty bad. I struggle with it a lot and food gives me those "feel good" feelings and it stimulates me. Sometimes when I have a million things to do, it's too much to process and I just end up sitting there and that's a lot of the time when my binges would happen is when I do have a lot of things to do but I can't process it.

Six women noted physical health conditions that impacted their journey to varying degrees. They noted experiencing digestive issues at the time of their relapse. All of these women explored how their condition was impacted by their use of eating disorder behaviors and their eating disorder was also impacted by constantly feeling unwell. An example of how these women perceived the connection between their eating disorder and digestive health concern was discussed by Holly. She noted:

> I have Crohn's Disease, so whenever those symptoms act up, typically my eating disorder can get bad just because it's very G.I. related. So last summer I was having a lot of trouble with my Crohn's and the [eating disorder] symptoms that I turned to or had been using….like everything just got exacerbated by the fact that

I was sick. And so I was really decompensating quickly so I ended up going into residential. The Crohn's disease was what tipped it from a little struggle to a full-blown relapse.

Eight women discussed an event or experience that caused them to re-experience feelings related to previous trauma, which then contributed to their relapse. Co-researchers all explored how these past traumatic experiences and triggering events weighed on them and hindered their progress toward recovery. An example of how the women discussed this experience was a statement that Dahlia made in relation to a sexual assault she experienced earlier in her eating disorder journey. She said, "I think that was something that really hindered my recovery and made me feel like I couldn't heal because I have that in the back of my head like 'Oh he got away. I'm not doing anything…I'm going downhill and he's going uphill.'"

***Progression into relapse.*** All twelve women discussed their progression to what they described as their most recent relapse. Nine women discussed their relapse as a gradual process where they used behaviors or found themselves having eating disordered thoughts periodically and slowly slipped into a full relapse. Several women expressed experiences that closely resembled the process Violet recounted when she said, "I think that I was a little bit in denial at first. It started out like, 'Oh I did it yesterday but I won't do it tomorrow, I won't do it the day after that''.

Three women described a specific event that occurred when they began to utilize eating disorder behaviors as a means of coping. All three women discussed a process similar to the one Lily noted, where she relapsed when her husband was ill:

> He ended up in the ICU and I remember going home because I had, I mean I have kids, so I had to come home. On the way home, and it was probably like midnight…I went to Whataburger and got like two different meals and then I went to Jack in the Box and then I ate that when I got home and was… just sadness.

Control came up for all 12 women in various ways when discussing their progression to relapse. At some point during their relapse, all of the women realized that their behavior was out of control. Violet articulated an experience that all 12 women noted:

> When I realized it was really becoming a problem again I think I felt scared. At that point I've been very well-educated about all the health consequences and things like that and I just really didn't want to go down that road but I felt like I couldn't really control it.

***Neglect of self***. All 12 women reported self-neglect at some point in their process to relapse and during relapse. For some this manifested as apathy toward themselves, lack of self-care, and/or a lack of identity outside of their eating disorder. Nine women discussed feelings of apathy during the time of their relapse. A common example of how this theme occurred for women was represented by Violet's explanation of her self-care.

> It was not good. I kind of enabled myself. I would do things like deliberately eat food that I knew would make me purge afterwards but I just didn't really care. I would be like 'Well, if I felt like eating a half of a cake or an entire pizza.' I would just do it. I also didn't exercise. I would watch a lot of Netflix. I didn't

> make myself stick to a schedule of any sort. And intellectually I know all those things are not good for you but emotionally, I just didn't really care. I think I was kind of apathetic.

All of the women noted deficits in their self-care practices. Generally, the women discussed how environmental stressors resulted in limited time and/or financial ability to engage in self-care practices. Ivy provided an example of this theme, “There was no time really back then. Even if I would've wanted to do something for myself, there was no room financially or time wise to do anything really, so there was no self-care.”

Six co-researchers reported that they were not completing daily acts of self-care such as showering. For example, Jasmine noted, “I mean it’s not hard to just let yourself go. It’s an easy thing to slip into, it’s hard to come out. I wasn't doing my hair; I wasn't getting dressed for the day. Those were the major ones.” Self-care deficits were consistently noted by all of the women.

Five of the women noted that their identity felt consumed by their eating disorder, as it left little time or room for anything else. Dahlia provided an example of how the women talked about neglect of their identity. She said, “I had to ask myself ‘Well who am I without my eating disorder?’ because that's just been a huge part of my identity for a while.”

***Low self-compassion.*** All 12 co-researchers noted various ways they were hard on themselves at the time of their relapse. Daisy provided an example, similar to others, about how low self-compassion was displayed. She noted that although she knew self-compassion was part of recovery, she struggled to embrace it fully due to the fact that she was having episodes of binge eating. She said,

> You have to come from a place of compassion to recover… I knew all of that, and so I think it was like an internal battle of trying... And so before relapsing I think I just did a better job of it. I didn't let a binge lead to another binge and all of that. While I was relapsing, at that point it was just so hard for me to be compassionate toward myself, as much as I wanted to be, because I just…I kept proving to myself that I couldn't take care of myself. Also, having gained some weight when I was bingeing, receiving comments from others, mostly family, about my weight gain and being around weight-focused/appearance-focused people also made it much harder to be compassionate towards myself when other people were clearly not as compassionate about it.

***Intrapersonal Disconnection***. Intrapersonal disconnection was a theme endorsed by all participants. It consisted of women noting disconnection from their own feelings and needs. When asked about their ability to express emotions during the time of their relapse, women noted that they were not in touch with their feelings. An example of how this was commonly expressed can be seen in Holly's statement about her beliefs about emotional expression and relapse.

> Emotions are a hard one for me. It's almost like I disconnect from them. So it's like I don't even know that I'm feeling all these things because I just really cut off awareness of what I'm feeling a lot of the time. But especially then, it was like I kind of felt nothing. And anything I did…everything was kind of muted. I didn't really feel much. I didn't really acknowledge what I maybe was feeling. I didn't even like try to figure it out. I just kind of ignored it. I didn't know what to call

> it. I didn't know what to do with it, so then I was like "OK let's use an eating disorder behavior and make this go back to where it came from."

Other women discussed intrapersonal disconnection in terms of being detached from their needs at the time of their relapse. This often came up when discussing their ability to assert themselves. Many noted that they did not know what their needs were, so they could not assert them and some talked about how this skill is still a "work in progress". An example of this was discussed by Violet.

> At the time of my relapse, I think I was kind of floating. I didn't really have…I wasn't interacting with people very much. I didn't feel like I had needs that I felt like I needed to assert. I think it's [low assertiveness] definitely related to why I had this problem at all so I would say it's related to the relapse also.

This intrapersonal disconnection seems to be a key experience of this phenomenon and part of what leads to relapse but also maintains the relapse.

***Unsafe to be seen fully.*** While most women noted that it would have been beneficial for them to have social supports who knew what they were going through, most of them were concerned about how they would be perceived if they asked for help and how this would impact their relationships. All of the women discussed how they did not want to show that they were struggling at the time of their relapse. There were various barriers to speaking openly about their struggles including shame/embarrassment and fear of being a burden. Ivy provided an example of how shame surrounding behaviors and relapse in general was present for many women. She noted,

> I was kind of embarrassed to tell them that you know when I come home I will eat two pizzas. I didn't feel very good about myself… you know I had a lot of bad

> thoughts about my finances, about my lack of willpower. Back then I was already like looking in some books, so it just kind of like… it added up to the idea that so many people were able to figure it out and I still can't.

Fear of being a burden was a reason cited by eight women for not disclosing their relapse with others. This barrier contributed to interpersonal isolation and prevented the women from reaching out to social supports for help. Violet noted concern surrounding how her relapse would impact her parents whom she felt she had burdened with her initial episode of BN. She provided an example that was commonly discussed by other co-researchers. "So I felt kind of conflicted because on the one hand, I wished I could discuss this more openly with them and not have it be a huge secret, but on the other hand, I felt like I had already burdened them by going through it once." She also noted that she was concerned about burdening her friendships as well.

> I just didn't want to burden people. When I did make the effort to meet up with people and hang out with people, I didn't want the conversation to be about my issues. I guess I was just…I wasn't used to reaching out to people for the purpose of talking about that. That would have felt kind of strange to me. I think just how I want to be perceived, I didn't really want to be perceived as the friend who has issues all the time. Because these people like, many of the friends I'm thinking of, they had been supportive to me at other points. So with the relapse it was like I don't want to beat a dead horse. I don't want to kind of push up to their limit of being supportive to me.

***Eating disorder as coping and safety***. Eleven women discussed using food or eating disorder behaviors as a coping strategy. An example commonly described by

many co-researchers, was said by Daisy, when she explored how both food and restriction served as coping skills. She noted, “I don’t think I every really had any skills to manage my stress, anxiety, or emotions in general and food had always been an outlet whether restricting or overeating.”

Eating disorder behaviors were used to cope with unpleasant tasks and the disorder itself was seen as a protective strategy. Willow provided an example of how several of the women noted that during times of stress, the eating disorder behaviors helped them to complete difficult tasks.

> I'm a photographer so editing was a huge binge process, because it was like I would be editing and I would binge for like two hours straight and then purge it and then start again. It would be like an all night process where I was just bingeing and purging like every couple hours. It was my mechanism of safety and I had to get through life and I had to deal with things. And that was, that was my safety and that was my net.

Food and behaviors served as coping strategies for these women to manage difficult intrapersonal experiences as well as interpersonal discomfort.

**Interpersonal factors.** All of the co-researchers were asked about different domains of their functioning in social relationships. These domains are referred to as interpersonal factors. This subtheme included (a) isolation and hiding and (b) interpersonal disconnection.

***Isolation and hiding***. Isolation was a theme endorsed by all co-researchers. This occurred for some due to environmental circumstances, such as moving to a new city, but all noted isolating themselves from other people and hiding aspects of themselves.

Jasmine provided an example similar to those from other co-researchers who noted that they were interacting with very few people and how their behavior contributed to isolation. Jasmine noted, “I would say I isolated myself. Outside of my children I would say I wasn’t answering my door or my phone as much as I should have.”

All of the co-researchers also noted that they were hiding or guarded at the time of their relapse. This was related to hiding feelings and reactions, hiding food, hiding behaviors, and hiding their bodies. This theme differed from the intrapersonal theme, *Unsafe to be seen fully,* as it related to ways co-researchers were hiding in relationships and includes actions taken to conceal their experiences, whereas *Unsafe to be seen fully* consisted of internal feelings of shame and fear of being a burden. An example of how several co-researchers described hiding themselves was explained by Jasmine as she shared how she hid her feelings. “I guess because I don't like letting people know I'm mad, I would hold the anger. I would say that I just didn't want to hurt anybody’s feelings back then”.

***Interpersonal Disconnection***. All of the women noted how their isolation and avoidance of certain situations resulted in feeling disconnected from their support systems and people in general. For some this looked like physical disconnection from interaction, where they were not spending time with others. An example of this experience was provided by Daisy. She reflected, “I can say for sure that it negatively impacted my social relationships, and it definitely separated me from my family especially because I just didn't want to be around people who weren't going to be helpful to me.”

Nine of the co-researchers endorsed interpersonal disconnection due to efforts to "always put on a good cover" as Ivy noted. Many noted that they continued to interact with people but were not able to feel connected and reported feeling that they were not present. An example of how co-researchers expressed this feeling was discussed by Holly in reference to how she appeared to others versus how she felt internally. She stated, " I was not really present in any of my relationships. I mean I was very functional but no one knew anything that was going on." Similarly, Violet stated,

> I would say I had, I had two or three really strong friendships that I could confide in about anything. But a lot of my friendships were more like surface level, so I felt kind of like I, I had a lot of interactions with people but they weren't necessarily meaningful for me or, or I felt like even with my really close friends, I would have liked to talk to them more about this and kind of my stress and what was going on but I didn't really want to ruin the times we were hanging out.

Six women discussed how they functioned in relationships by assuming a "people- pleasing" style and striving to be perfect in all domains, which contributed to interpersonal disconnection. By subverting their needs and always trying to reach unattainable standards, these women felt interpersonal disconnection because they were not themselves in interactions. Violet described this experience that was discussed by six women and said, "Right before I entered recovery I think I was a big people pleaser. I just wanted people to like me, and I wanted to be invited to things. I wanted to feel validated by people." This however led to validation of a version of herself that was not genuine, which resulted in feelings of disconnection. Interpersonal isolation and disconnection were related to relapse for all women and seemed to perpetuate the relapse.

**Environmental stress.** All of the co-researchers were asked about significant events at the time of their relapse. During the relapse, all women noted various aspects of environmental stress and many noted a combination of multiple stressors that occurred simultaneously with their relapse. Many women detailed significant decreased quality of life related to these stressors and it seems to them that their eating disorder served as a way to "survive the storm". An example of how multiple stressors converged at the time of relapse was noted by Willow:

> We were getting ready to move cross-country. We were struggling financially. My fiancée was paying the bills and I was working as a nanny to cover the move…So it was just…like it all came spiraling at once. And it was too much to handle emotionally and physically and mentally.

Several of the co-researchers described experiencing stressors related to harsh work environments and explored how this contributed to their relapse. For example, Ivy discussed how several stressors converged at the time of her relapse and noted how this occurred while she was working in a hostile work environment and experiencing difficulty related to navigating a new language in a new country with minimal support:

> That was like a really crazy ass year when I had to go to school, I worked in the restaurant, and I had like really terrible coworkers who were treating me really badly. So that was a combination of extreme exhaustion, and when I say extreme it would be like a year with like two days off, working, going to school, doing homework, trying to graduate with my degree. And you can hear my accent and understand, I was doing a restaurant job back then, it was like terrible, extremely hard. I had to pay for my rent, pay for everything. So I needed a full time job,

> taking fulltime classes. And on top of that I had like a set schedule with my restaurant, because it was related to my school so it was like one day start early, one night start late, it would have been very hard for me to go and find another place to work. So I couldn't really afford to move on and I was really stuck with this terrible place and people who were just treating me like shit. So that was the worst relapse that happened back then.

These stressful environmental factors combined with ineffective inter and intrapersonal skills to create a context where eating disorder behaviors were utilized to cope.

**Seeking resources and finding sources of support.** All 12 of the co-researchers discussed seeking resources or sources of support in their process from relapse to recovery. For five co-researchers, this was discussed as seeking information or alternative perspectives to the dominant narrative of diet culture and fat phobia. For example, Rose discussed her experience learning about the pervasiveness of fat phobia and learning about the guiding principles of the *Health at Every Size* approach, specifically that the weight-loss industry profits off of ineffective treatments and that using weight and size/shape as determinants of health is inaccurate and often leads to poor outcomes (Association for Size Diversity and Health, 2019; Bacon, 2010).

> I had read *Health at Every Size* [the book]…I couldn't unknow that. I remember driving, we were on a road trip and I was just listening to it and she's talking about how these studies were funded by these different companies and different industries and I just remember this rage like "fuck them". You know these things that these people have been telling

> us forever, and it’s bullshit. And so now I can’t unknow that and so now I'm struggling with what I know and also what I'm feeling and how do I reconcile that.

For these women, this new awareness led to seeking treatment to help them understand and examine internalized fat phobia, validate their experiences, and develop resilience to cope with weight and size based discrimination.

For other women seeking support was in the form of treatment. Four women mentioned Eye Movement Desensitization and Reprocessing (EMDR) therapy to help with their trauma history. An example of how co-researchers discussed the benefit of EMDR for their journey toward recovery was provided by Magnolia. She noted:

> The other piece that was huge is that I was in trauma counseling the whole time, using EMDR. So at the same time just really digging into some of those core beliefs and childhood shit and what led me to want to numb out chronically and working through some of those, processing them, healing from them, creating boundaries with my family and working on normalized eating, working towards taking power away from those thoughts of moralizing food [good vs. bad foods] and just because my parents say it's evil [food], doesn't mean it actually is.

**Motivations**. Motivations for recovery was a theme discussed by all women. Motivations that were commonly discussed were: fear, discomfort, and fatigue from the disorder. An example of how multiple motivations were discussed as shown in a description Holly provided about how she realized she needed treatment. She noted:

> I knew I couldn’t continue living the way I was living because I just really wasn't happy and like my brain was just so focused on food all the time like I felt like

despite everything else I was doing I wasn't getting anything done. And then my eating just felt so out of control like I couldn't, like I just I don't know. It was like I couldn't stop bingeing and purging, at the same time like my G.I. stuff was so bad and like I knew that like my behaviors were making it worse, so I was like physically feeling really awful, emotionally feeling really awful…And initially I was like unsure if I was gonna go but then it was kind of like um I just kind of felt like I had nothing left to lose at that point. I felt like I was going to lose my marriage, I was going to just like lose everything, like lose my job if I didn't like get myself better.

**Navigating relationships**. Ten of the co-researchers discussed how moving out of relapse required them to function differently in relationships in a pro-recovery way and their early attempts at doing so. These women discussed how they had to practice new ways of interacting that would serve their recovery. For example Magnolia noted, "I was learning how to communicate in my safest relationships, communicate conflict or resentment or whatever, and I was still terrified of it."

These women discussed how individual psychotherapy, medical nutrition therapy, or group therapy provided a space to practice navigating relationships in a pro-recovery way. For example, Iris discussed how group therapy served as a place to practice new ways of functioning in relationships:

We talked a lot in group about how it was kind of a practice space for the real world, so you could practice taking up space or you could practice expressing

> something that you wanted to communicate to someone else or practice feeling emotions you know. So I think that's how I got better at taking up space in the actual world is because of group.

**Themes of Recovery**

Recovery consisted of the themes (a) entry into recovery, (b) intrapersonal factors, (c) interpersonal factors, and (d) environmental stability and community.

**Entry into recovery.** All 12 women discussed their entry into recovery from their relapse. Nine of them discussed this as a gradual process, whereas three identified a clear time when it began. An example of how recovery as a gradual process was described was given by Violet. She described how different aspects of recovery occurred at different times.

> I would say when I recovered, it wasn't like a momentous decision; I wouldn't say it was the result of specific actions I took. I think I just kind of distracted myself with other things that canceled out the actual behavior but not necessarily the underlying feeling so I think all throughout I still struggled with low self-esteem or not having a good body image.

Most of the women discussed how difficult it was for them to pinpoint when recovery began and reflected on this in their follow-up interview.

**Intrapersonal factors.** This theme contains several subthemes: (a) attunement and identity, (b) acceptance, (c) self-care and compassion, and (d) freedom and flexibility.

***Attunement and identity.*** Ten women discussed aspects of being in-tune with themselves as part of being in recovery. Women discussed attunement with experiences

like feelings, desires, needs, and physical processes. Dahlia reflected on this process, which was something commonly discussed.

> I just try to check-in with myself and listen to my body and listen to my wants and needs and what's going on emotionally with me, I think that's a huge difference because I never used to do that, if something happened, I would just really dismiss it and not listen to what my body wanted, and I think now I'm listening and taking care of myself. I think that's made all the difference.

An additional component of attunement was noted by some co-researchers. They noted that in recovery they were able to feel attuned with themselves and also seek support when they were unable to effectively process or cope. Magnolia provided an example of this experience that several women noted.

> Into recovery and now, I would say I'm very good at identifying emotions. And if I have something that I'm like "this is full of a lot of emotion", I'm good at seeking out places where I can unpack it. So it's more about like for me the skill of "all right, we don't know what's going on, let's figure it out" and I have the resources to do that.

Several women noted becoming attuned with their identity for the first time. Ivy provided an example of how many women voiced this experience.

> I'm kind of like discovering myself for the first time really because the last time I was free of all those thoughts I was 17. I was a kid with my sister in [her home country]. So it was a big thing to wake up at 26 in a different country and be like "What do I like?" And I had no idea…So trying new things, seeing if that's something I would enjoy at this stage of my life. It's been a great change.

With this newfound attunement and identity discovery, it appeared from interview data that women then experienced acceptance of various domains of their experience.

***Acceptance.*** Ten of the women discussed the theme of acceptance. For some this consisted of accepting their past, having others accept them, accepting their body, or just being more accepting of things they cannot change. Magnolia provided an example that discussed this acceptance on an individual level and a broader level that other women also echoed.

> I would say it was a huge part of my recovery that I kind of detached from putting so much energy and power into this idea that if my body looked a certain way I would be more lovable and successful and etc. etc. and just accept reality for what it is. Some people will love me more because of my personality and some will love me less because of how I look. And that's just what it is and where do I want to invest in? And, what are my values?

Another aspect of acceptance that occurred commonly among these 10 women was the acceptance of their mistakes. For Poppy, she discussed an acceptance of her own "humanness":

> I make it a point to really kind of look at what I can and can't control and reflect on whether there is something that could have been done on my part that could have changed the situation. And even if there was something I could have done differently, just kind of accepting it for what it was and moving on.

Another aspect of acceptance that was discussed was receiving acceptance from others. For example, Ivy discussed how she found a stable job and noted, "I found a good job where I was accepted and respected and people know just my worth or appreciated what I

bring to the table." Self-acceptance seemed to create an environment where women could maintain healthier interpersonal and intrapersonal patterns.

***Self-care and self-compassion***. All of the women discussed the importance of engaging in self-care as important in their recovery. They also discussed this trend at the same time they experienced a shift to treating themselves more compassionately. Self-care was described in terms of functional self-care like showering, rest, and sleep, while others discussed ways of treating themselves more compassionately as part of self-care. Lily provided an example of how this subtheme was commonly experienced by the co-researchers:

> I shower every day…things like you're supposed to do. And you know just doing simple things like brushing my teeth and planning out what I'm going to eat that day, for the most part and that's better now than it was before because I'm able to take the time to stop and really think about things and take care of myself more.

Women also commonly discussed the relationship between recovery and self-care. Iris noted:

> When I entered recovery, I think it was pretty good; I think I was trying to exercise and sleep on a regular schedule. I don't know if I was making the effort to do those things or if I just did those things and that's what enabled me to recover. It's kind of a chicken or the egg thing. But I do notice it when I do not engage in the behaviors as much as, I was sleeping more regular hours, I was not isolating myself. I was just happier in general.

***Freedom/Flexibility.*** All women noted feeling more free and flexible in their lives in recovery. Some women, like Poppy noted they feel free to be themselves.

> And just like feeling more free in situations where I felt completely trapped. And so I can tell that like I joke a lot more, and like my sense of humor is back and I'm much less irritable. I notice that I'm kinder to people when I normally would have probably hated what they were doing and just things like that that have been positive.

Women also commonly discussed freedom and flexibility related to food and social experiences. Iris stated,

> I feel like I could be a lot more flexible when plans change or things go wrong. Um, what else...I mean there are simple things like I can go out to eat and stuff with friends or whatever, which I never let myself do before.

**Interpersonal factors.** Interpersonal factors consist of aspects of functioning that occur between two or more people. This theme contains the following subthemes: (a) openness and assertiveness and (b) connection and presence.

***Openness and assertiveness.*** All women discussed being more open or assertive in relationships as critical in their recovery. For some this was discussed in terms of sharing how they were doing in relation to their eating disorder with supportive people and for other co-researchers, this meant speaking up about their needs and advocating for themselves. A common way co-researchers described themselves was discussed by Dahlia. In regard to her social relationships, she described herself as, “open and outgoing, transparent” and felt that “that alone has helped me make me more authentic friendships”.

Twelve women discussed pushing back against eating disorder related thoughts, nine talked about how they asserted their needs and advocated for themselves in interactions with others, and four highlighted how they speak up about broader systemic oppression and body discrimination. Dahlia discussed how she regularly "talks back" to her eating disorder and related thoughts, challenging ingrained ways of thinking, which was commonly discussed by these women.

A common way the nine women talked about assertiveness was in interactions with friends. For example, Magnolia discussed advocating for her needs in her interactions with her friends related to her body size on amusement park rides when she stated,

> So finding that kind of neutral language to even advocate with my friends like "I'm not sure we're both going to fit" and it not being this shameful thing, just being the reality that there is mass and there are physical limitations. And so having fun with my friends and being able to be the advocate for my body size.

Among the four women who noted assertiveness on a broader level, this was often discussed in terms of advocacy and speaking out on social media. For example Poppy discussed her new openness and advocacy related to recovery, her journey, and mental health awareness and stated, "I mean I've been an advocate for things on Facebook and people if they follow me on Facebook they very likely know my story. I'm certainly not as hesitant or scared anymore."

As these women were able to openly communicate and assert themselves, they were able to feel more connected and present in relationships.

***Connection and presence***. All women noted that they feel more connected to the people in their lives and their freedom from their eating disorder enabled them to be more present. An example of how this was commonly discussed was provided by Jasmine. She noted that in relapse, she interacted with her children but was not as engaged with them due to her preoccupation with food. Now she noted, "Oh I make sure to talk to them everyday and have meaningful conversations. I actually want to know about their day at school versus in relapse, I may have asked but I really didn't care to hear about their day at school." Being more connected was expressed by many co-researchers and described well by Daisy when she said,

> I would say my relationships are certainly…I feel more connected now and my friends, even though I never, I still never really disclosed to everyone, like only my closer friends [about relapse]. I don't even know if they did or didn't notice, but I feel a lot less distracted and more present in relationships now than I did before.

**Environmental stability and community**. This theme consisted of broader aspects of co-researchers' life contexts. Finding stability and creating community seemed to coincide with reaching recovery. Ten women discussed the theme of stability in their experience of recovery. Daisy provided an example of how this stability occurred after she finished school.

> I think that going out of my internship, getting a job, like all that stuff at that time was such a relief. I felt like I was able to like relax a little bit more and I would say that I was less stressed. I was seeing my sister less often, that was helpful just because she wasn't like a positive influence I

would say in terms of eating, things like that and, like body image and I also moved out from my parents' place last year, which was definitely helpful.

Five of the women spoke of community as part of their process of achieving stability. An example of how women talked about the role of community in their recovery was provided by Magnolia. She noted,

> Community from then to now is black and white different. It's one of the reasons I went into working in a treatment center for eating disorders, for the community of working there. So community was really intentional. My best friend, she lives across the country but she's so great. She's just amazing. And she even read some books and just really tuned in. And that has been huge, because I now have someone who I can say… like last week I was having some symptoms that weren't explained by what we thought it would be explained by and my dad had called after I met with the other doctor here was just like "Well I know how to make you feel better but you're determined to do your own way." Which was him saying like, "You need to lose weight but you're not gonna". And I could call her and she immediately knew what that meant and knew the context and knew the background. And was frustrated for me. And so just her frustration kind of eradicated the annoyance and the voices I had in my head about my dad and my failure and how it's not actually a choice dad. I don't actually get to choose my body size unless I'm actively restricting. It's going to land where it's going to land. So, all that to say I have people I can go to now and I didn't then.

## Reflections and Continued Challenges

All of the co-researchers were asked to share their reflections about their journey and any continued challenges they still face. Reflections consisted of making meaning of their journey, conceptualizing recovery and exploring positive and negative treatment experiences.

### Reflections.

***Meaning making***. Five women explored ways they seek to make meaning of their journey with an eating disorder. Willow and Rose both want to pursue a career in a helping profession and four other participants already work in a helping profession, with two working in the field of eating disorders. Willow noted,

> I said this to my therapist over and over again; there's a reason I went through everything I did in my life. And if I don't find a purpose for it, I'm going to feel like I went through it for nothing and then I'm going through all
> this trauma work for what? So I've got to put it to use. So I'm getting a psych degree and then I will most likely get my PhD. Down the road we [co-researcher and her fiancé] want to open a treatment facility for eating disorders.

***Conceptualization of recovery.*** Others just reflected on their overall journey and discussed how they view themselves. They described themselves as accomplished, proud, strong, and resilient. Others reflected on recovery in general and some felt that their eating disorder will always be with them. Rose noted, "I'll never not be in recovery. I'll never not be recovering. It's always gonna be this thing that I have to be aware that it's in my back pocket at any point and it can rear its ugly head if I don't keep it contained."

Others felt they were recovered. For example, Daisy noted,

> I felt like I was recovered when food, eating, body image, exercise, when they weren't on my mind, occupying my thoughts, to the point where I was, it sounds very cliché but like it wasn't getting in the way of like, school, work, friends, family.

Others fell somewhere in the middle. Magnolia stated,

> But as far as like recovered from the eating disorder, I'm definitely to a place, I have noticed, I can't imagine wanting to go back there, and yet, sometimes life presents us with tragedy so deep that anything feels better than that.

***Positive and negative treatment experiences***. All women had either positive or negative experiences with treatment along their journey. For some women this consisted of a discussion about therapy. Lily noted, "I was doing, EMDR, it helped significantly. I think that dealing with the other things in my life, the trauma that I experienced like as a kid and stuff that. Dealing with that definitely helped."

Others like Ivy noted negative experiences related to a therapist's theoretical orientation to psychotherapy that led to feelings of hopelessness.

> At school, they provide like a free psychologist kind of thing. The theory behind what he was preaching or what he was treating based off of was the idea that you need to look in your past and once you do that…once you find out, not necessarily past like childhood, but once you've figured out what triggered things, you're gonna be fine. So for me, I was at the stage where I was like "Okay, I know that probably my childhood or what happened with my mom affected me

> and then I came here, I was lonely la la la. Now what?" So I kind of learned all of the things, what my triggers are, and I'm not even an inch closer to stopping doing it. So there was this whole frustration with the process and with feeling kind of like I went to the doctor, I read all these books and spent so much time that I don't have trying to find an answer, so there might be something wrong with ME. So that was kind of like on top of hating the way I look, I also couldn't understand why I couldn't puzzle it together still. So it was very frustrating.

Two co-researchers talked about their discomfort in a group therapy setting where they noted difficulty "taking up space", however both felt it was beneficial for them. Iris noted,

> I really like group therapy a lot. It was hard for me to talk for the majority of it….To take up space in the group and be like it's my turn to have the floor but I think that was really helpful to put myself in that uncomfortable space and that situation. But it was also just so positive to hear people voice the same things that you were experiencing or that were going through your head.

**Continued Challenges.** Women noted continued challenges related to body image and weight change, self-compassion, "taking up space", fat phobia and diet culture, coping with emotions, and social aspects of food.

***Body image and weight change.*** Several women discussed how unintentional weight change in either direction was difficult to cope with. Poppy discussed her restrictive diet related to her G.I. issues and noted that this has been difficult to cope with.

> The only real trigger that I've had lately has been like that question of weight loss because I know that I have lost some weight because of just the way that my clothes fit and the way that I feel and things like that, so I have to be really careful about body checking [compulsive touching, pinching, pulling, etc. parts of the body to evaluate weight and/or shape].

Others noted improvements in body image but no one noted consistent positive views toward their body. Some women noted that they feel neutral or accepting toward their bodies and at times experience gratitude but this seems to be a continual challenge. For example, when asked about her relationship with her body, Magnolia noted,

> I would say it's in flux but there's a lot more compassion and a lot more tolerance for the grey in between that. Some days I feel loving towards my body and some days I don't and just allowing myself to be where I'm at. So I wish I was like, "I feel great about my body." But the reality is that I feel ambivalent in some ways. I feel I am becoming more and more grateful.

Several women acknowledged the cultural forces that shape their experience of their bodies. Violet noted,

> Specifically in terms of body image, I think in recovery, it's not that I love my body it's just that I have less thoughts about it, I don't really care as much as before. I can say that I care a little bit and I think that just comes from like being in a culture where it's just such a big piece of things and how we're judged and perceived.

***Self-compassion.*** Eleven women discussed a continued desire to improve their self-compassion. Some women are able to be more accepting but a theme among 11

women was difficulty being “gentle” with their expectations of themselves. Jasmine noted, “It's getting better. I still wouldn’t say it’s real strong but it’s better than it was.”

***Fat phobia and diet culture***. Six women discussed difficulty in recovery related to existing in a fat phobic culture. Rose discussed how this impacts her daily and how she responds to it.

> Diet culture is everywhere. It’s ads on Facebook, the person who just lost 50 pounds on keto [ketogenic diet] in 8 days, it’s on magazine covers, it's in the blatant fat phobia that exists out on the Internet and in the world. It’s small airline seats, airline seat belts. It’s everywhere. And, I don't get silent anymore. The way that I cope is by speaking life into it.

Magnolia also identified how this culture impacts her and other women who identify as fat or large bodied differently than “straight-sized” women who fall within the narrow fashion industry standard sizes.

> Living in a large body sucks. I mean there's so many daily challenges everywhere, everywhere telling us to essentially like “don't be yourself.” And do what you need to do, no matter how destructive. And
> it's implicit; it's in the chairs we sit in. It's in the language of commercials.

***Social aspects of food and eating***. Seven women noted improvements in functioning in social situations where food is involved but noted continued difficulty navigating judgments or challenging ingrained thought patterns surrounding food. Lilly noted how she continues to struggle with social eating and having to explain that she does not eat certain foods.

> Sometimes in my head like “it would just be easier for me to eat it you know than to explain to somebody” or explain to family, which is something I don't like doing and having to explain to like my in laws why I can't eat her lasagna you know. And then of course the feelings that come along with that the shame or whatever of them being angry with me or you know just having to explain to everybody why I'm not eating those certain things you know.

Other women noted difficulty eating freely in social settings as well. Iris stated that she sometimes forgets that going out to dinner is no longer something she punishes herself for but the immediate reaction to eating out is guilt, which she works to challenge.

The individual textural descriptions, themes, and co-researcher reflections and continued challenges were then utilized to uncover and create the synthesized textural description of what the co-researchers experienced in relation to the phenomenon.

**Synthesized Textural Description**

There were many different stressors the co-researchers experienced around the time of their relapse. For some it was a combination of work, school, and personal life stressors and for others it was loss, but all women noted at least one significant stressor that prompted them to “seek the comfort of food” or revert to behaviors for protection. Relapses were varied in severity and duration. For one woman, this consisted of what she described as a “thought relapse” with diet-related restricting behaviors, where she began the patterns of restricting and sought care before she dove “headlong into that nonsense”. Some women noted a gradual progression to relapse where the behaviors started to “creep in”, while others noted an event that happened and led them to use behaviors to do “everything in their power to avoid seeing it or feeling it”. The women

varied on their time in relapse, some reported one severe binge with lasting thoughts and others reported a relapse that lasted months but all felt out of control at some point.

During their relapse, the women felt "disconnected" or "out of tune" with their internal experiences and became apathetic, "stopped connecting" to their needs, and their self-care was adversely impacted. The women struggled to varying degrees with low self-compassion and feeling like they would do whatever they needed to "just fit in". They all reported "isolation or seclusion" either due to circumstance or because their eating disorder and behaviors were "taking over". Some had difficulty asserting themselves in all domains of life but all had trouble sharing their struggles and advocating for what they needed in relation to their eating disorder. In varying ways, all women expressed the feeling that it was unsafe for them to show themselves fully to others and show that they were struggling. For some they were fearful of being a burden and others just noted discomfort with this level of vulnerability. All of the women had motivations for seeking recovery ranging from fear for their health and relationships, to growing tired of the "cumbersome" behaviors. Some sought specific eating disorder treatment in residential or outpatient programs while others sought trauma treatment in this process to address historical trauma that was impeding their recovery.

All of the co-researchers discussed a process of having to advocate for themselves or assert their needs in relationships and/or treatment and noted mixed success and importance of this skill in their recovery. In recovery, some communicated openly about their struggles with supportive people and felt that this "openness" was significant for helping them live more authentically and furthering their recovery. For others, they achieved increased feelings of authenticity by getting behaviors under control and feeling

like their internal experiences were now in accordance with how they presented themselves to the world, which furthered their recovery. All women noted increased "attunement" with their internal experiences and identities and are generally more accepting of their history, body, and themselves. They noted significant relief and feel more "free" in recovery. They experienced increased freedom from thoughts about food, disordered eating behaviors, and preoccupation with other peoples' perceptions of them. They feel able to develop their identity, be flexible, and think about their future. In relationships they are "present" in ways they were not before and feel that they have developed more "meaningful" connections with people in their lives. They feel more open and forthcoming in general now that they are in recovery and are able to be more assertive and advocate for themselves and stand up to larger oppressive cultural forces.

All women noted increased stability in recovery related to having more steady finances, completing school, and/or having a steady job. Some noted increased feelings of community through existing relationships, professional identity, and social media supports. They have varied opinions about recovery and where they are on this continuum and all reflected on challenges they still face in maintaining their progress.

**Inventory of Interpersonal Problems (IIP-64)**

The IIP-64 has been used with eating disorder populations and is thought to measure various domains of interpersonal problems. This measure was given to co-researchers as another data point in an attempt to understand relapse and recovery. The raw scores were converted to standard scores based on the appropriate normative sample. The normative sample consisted of 400 "non-clinical" women who were selected to be representative of the U.S. population in terms of racial and ethnic identities at the time of

the 1999 census (Horowitz et al., 2003). Limitations of the use of the measure will be discussed in further detail in the discussion section; however, it is important to note that there was no discussion of the psychometric properties of this measure with non-native English speakers which may impact the validity of one co-researcher's results. Although this measure has been used with eating disorder populations, in this study, the sample was small, the measure was only given in recovery, and the scores were quite variable. Based on these concerns, it is not possible to make any definitive statements about what these scores mean, however some of these scores may have some validity including the fact that none of the women scored in the "high" range on the total score of the inventory.

**Total score.** The total score represents a person's difficulty across the various domains of interpersonal functioning. A high score indicates that a person experiences significant impairment and distress in interpersonal functioning. None of the total scores for co-researchers were greater than 70, which may be reflective of the fact that the co-researchers are functioning generally well in interpersonal domains in recovery. Four co-researchers scored in the "above average" range, which is consistent with the level of difficulty these women reported in interpersonal relationships. Three of these women reported relapse within the last year.

**Socially inhibited.** People who score high on this scale can be described as experiencing feelings of anxiety and may be cautious and feel embarrassed often in social situations and as such, they may find it hard to socialize (IIP-64; Horowitz et al., 2003). These people may be described as introverted or distant and have limited their social lives to avoid negative evaluations of others (IIP-64; Horowitz et al., 2003). Six co-researchers scored in the "above average" range. For some, this finding was consistent

with how they described themselves, such as Holly, who described herself as struggling with intimacy and Iris, who reported social anxiety. For example, Holly noted, "Intimacy is still a struggle, I don't know, getting close to somebody is still hard for me."

**Nonassertive.** People who score high on this scale may struggle with a significant lack of confidence and low self-esteem (IIP-64; Horowitz et al., 2003). They tend to doubt themselves and avoid situations that would require them to be an authority or challenge others. They struggle with being firm in the face of opposition and "other people's disapproval or negative evaluation threatens their already shaky self-esteem, so they avoid making their wishes and needs known." (Horowitz et al., 2003, p. 44). Four women scored in the "above average" range on this scale. This was consistent with all of their reports of continued challenges in recovery. For example, Willow noted that she feels much more assertive now, but discussed that this process is not yet automatic and requires practice. Violet echoed this sentiment and stated, "I've never really been good at that [assertiveness]" in social relationships.

**Overly accommodating.** People who achieve a high score on this scale report "people pleasing" tendencies, where they struggle to say "no" and are easily persuaded in order to gain approval from others (IIP-64; Horowitz et al., 2003). They may struggle to express anger and feel that assertiveness may offend others, so they subvert needs to maintain relationships (IIP-64; Horowitz et al., 2003). Four women scored in the "above average" range on this scale. Three of these women discussed how people-pleasing was something they struggled with at the time of relapse, which may account for their elevated scores in recovery.

**Self-sacrificing.** People who score high on this scale are people who have positive traits such as warmth, kindness, forgiveness, and helpfulness that have become problematic (IIP-64; Horowitz et al., 2003). They may be too eager to help, overly generous, and have a hard time setting limits or boundaries with others and may feel that they place others' needs before their own (IIP-64; Horowitz et al., 2003). They may have difficultly expressing negative feelings with people they care about (IIP-64; Horowitz et al., 2003). The same four women who scored in the "above average" range on the Overly Accommodating subscale also scored in the "above average" range on the Self-Sacrificing subscale. A couple of these women noted continued struggles, even in recovery, with placing their needs first.

Table 7
*Inventory of Interpersonal Problems (IIP-64) Scores*

| Co-R | Socially Inhibited | Non-assertive | Overly Accommodating | Self-Sacrificing | **Total** |
|---|---|---|---|---|---|
| Dahlia | 46 | 55 | 69 | 63 | **59** |
| Daisy | 46 | 45 | 45 | 38 | **41** |
| Holly | 67 | 55 | 47 | 52 | **54** |
| Iris | 60 | 63 | 53 | 56 | **55** |
| Ivy* | 53 | 60 | 77 | 72 | **70** |
| Jasmine | 42 | 38 | 42 | 41 | **39** |
| Lily | 53 | 75 | 67 | 78 | **65** |
| Magnolia | 62 | 57 | 58 | 54 | **59** |
| Poppy | 63 | 57 | 47 | 43 | **56** |
| Rose | 55 | 40 | 38 | 45 | **45** |
| Violet | 62 | 70 | 60 | 56 | **64** |
| Willow | 67 | 68 | 71 | 68 | **66** |
| **Mean** | **56** | **57** | **56** | **56** | **56** |

* Psychometric properties of this measure for use with non-native English speakers are unknown, so scores should be interpreted with caution.

## Imaginative Variation

The next stage of analysis, *Imaginative Variation,* is the second stage of phenomenological data analysis and consisted of creating the structural description that tells how the phenomenon came to be (Moustakas, 1994). Themes from participants were compared across various attributes to learn how this phenomenon is experienced similarly or differently and how certain variables impact how the phenomenon was experienced. Coded data were examined according to the attributes that were established for each participant (e.g. eating disorder type, age of onset, time in recovery, treatment received) in order to deepen an understanding of relapse and recovery.

### Structural Description

A structural description was assembled from what the participants stated had influence on their experience of the phenomenon (Moustakas, 1994). The co-researchers' experiences of relapse and recovery were shaped by their level of disconnection from their internal experiences, their ability to advocate for themselves in treatment and relationships, and time since most recent relapse. All women noted a degree of intrapersonal disconnection from their internal experiences when they were in the midst of relapse; however, those who noticed when they "started to not feel the same" and sought treatment or support to address it earlier reported fewer impairments in intra and interpersonal functioning in relapse and now. For Magnolia this occurred early in her behavioral relapse and prompted her to seek treatment. Some women noted a prolonged progression to relapse that resulted in significant self-neglect and apathy, which took longer to dig their way out of and noted continued challenges with a variety of intra and interpersonal skills in relapse and now.

Women were asked to describe their ability to ask for what they needed from people in their lives and all noted impairments in the domain of their eating disorder and some described difficulty with this skill of assertiveness across multiple domains. The women who noted more generalized difficulty with asserting themselves and advocating for their needs, noted more continued intra and interpersonal challenges in recovery. Those who felt more confident in these skills noted challenges in recovery related to contexts outside of themselves, such as living in a "diet culture, fat phobic society."

The women who reported more than one year since relapse reported fewer impairments in intra and interpersonal functioning. Additionally, they reported that even if they did not feel they could effectively cope with certain stressors, they had supportive places, like friends, therapy, or community where they could "unpack it". Women with more recent relapses discussed continued discomfort or challenges related to having to "feel their feelings" instead of seeking comfort in food to "numb" themselves.

**Synthesis of Meaning and Essences**

The final stage of phenomenological data analysis is described in the following section and consists of the *Synthesis of Meaning and Essences*. In this section, the textual and structural accounts are combined and presented to describe the "essence" of the phenomenon (Moustakas, 1994). Eleven women noted that their eating disorder or food served as a source of coping or safety when faced with various and combined stressors and this led to intrapersonal disconnection and neglect. Some women experienced disconnection between their actions (using eating disorder behaviors or thoughts) and their desires (recovery) and others experienced disconnection from their internal experiences in general and felt "numb". Whatever the cause, this disconnection resulted

in self-neglect and inability to advocate for their needs. These women all felt "unsafe to be seen" fully by others due to fear of being a burden or shame and did not share their struggles, which led to isolation or hiding aspects of themselves from the world. The impetus to seek recovery was varied but all recognized they "couldn't keep living like that". Some women sought resources or support and all women began the task of addressing intrapersonal deficits. Through practicing self-care and developing self-compassion, the women felt free to be more transparent and open in relationships, which led to improved interpersonal functioning including feelings of connection and presence with others. The process of recovering comes with varied and continued challenges which are experienced differently based on proficiency with various intra and interpersonal skills and the amount of time that has elapsed since relapse.

This chapter presented the data collected from the co-researchers. Individual textural descriptions were created to provide information about co-researcher backgrounds and to give an account of their experience with the phenomenon. The themes that were discovered during data analysis were detailed. The co-researchers' reflections about recovery and the continued challenges they face to maintain their recovery were outlined. A synthesized textural description of what the women experienced with the phenomenon was presented and followed by the results of the IIP-64. Next, a structural description of how the women experienced the phenomenon was presented. Finally, the essence of the phenomenon was created via integration of the textural and structural description of the phenomenon. The next chapter discusses the implications of these findings, the limitations of this study, and recommendations for future research.

# CHAPTER FIVE: DISCUSSION

This study was designed to capture the essence of relapse among women in recovery from BN or BED and explore associated interpersonal variables. Some of the findings from this study are consistent with previous, although limited, research on relapse and recovery from eating disorders. In this chapter, the major findings of this study and their implications are discussed.

## Co-Occurring Health Concerns and Trauma

In this study, the co-researchers described a physical health, mental health, and/or traumatic history along with their eating disorder at the time of their relapse. This finding is consistent with prior literature that found high comorbidities among this population (Hudson et al., 2007) and high rates of trauma (Dansky et al., 1997; Johnson et al., 2002). The added challenges that co-occurring conditions present may contribute to the development and course of eating disorders, however additional research is needed to understand how these complex conditions contribute to eating disorder relapse, development, and course.

## Self-Compassion

Self-compassion was a theme for all of the co-researchers. What was repeatedly discussed was that the women were not compassionate toward themselves. Some discussed holding themselves to high standards and experiencing guilt when they failed

to achieve these standards, while some explicitly stated poor compassion toward themselves at the time of relapse. Self-compassion has been investigated in relation to eating disorders and interventions intended to increase self-compassion have been found to result in positive outcomes. Compassion-focused therapy (CFT; Gilbert, 2005, 2009) is a treatment approach built on the premise that reducing feelings of shame will reduce symptoms of psychopathology. This treatment approach has been evaluated with a transdiagnostic eating disorder sample and individuals with greater decreases in shame in the first four weeks of a 12-week CFT treatment program experienced faster eating disorder symptom reduction (Kelly, Carter, & Borairi, 2014). The current study found that women reported low self-compassion at the time of relapse and for eleven women, this was something they cited as a continued challenge even in recovery. These findings point to the importance of treatments designed to improve self-compassion early in the course of treatment and indicate that having "booster" type sessions or support for the development of self-compassion even in recovery would be beneficial.

A theme of recovery is increased self-compassion of the women. Many co-researchers discussed the importance of having compassion for themselves in this process and with the absence of behaviors and shame, they felt more free and flexible in their daily lives and accepting toward themselves. These findings extend previous qualitative research which found themes of building self-esteem, accepting and learning to love oneself, and finding the right tools to manage their emotions as essential to achieving and maintaining recovery (Lingren et al., 2015).

### Intrapersonal Disconnection and Attunement

A clear theme was that all of the co-researchers noted feelings of disconnection from their internal experiences at the time of their relapse. This was discussed as a disconnection from emotions, physical sensations, desires, and needs. One way they experienced disconnection was by using food to cope with and avoid difficult emotions, which is consistent with the literature supporting the interpersonal model of binge eating. This model asserts that people use food to cope with negative emotions that arise from difficulties in interpersonal relationships (Ivanova et al., 2015). These findings suggest that some of the interpersonal difficulties women face in relation to their eating disorder may be the result of a disconnection that makes it hard for them to access their feelings.

An exciting finding was the theme of intrapersonal attunement. In recovery, co-researchers explored the process of becoming attuned to their internal experiences as they decreased their use of "numbing" eating disorder behaviors that led to intrapersonal disconnection. This study provides evidence that this may be a continued challenge even in recovery. Five of these women noted that this is a continued challenge for them and described how in recovery they now have to "feel feelings." Violet provided a poignant example:

> If I felt like somebody disliked me I would kind of distract myself from that feeling with the bingeing and purging. Now if somebody doesn't like me, I won't binge and purge over it but I will actually feel the sting that somebody doesn't like me.

## Relapse Progression, Stressors, and Stability

All of the co-researchers discussed their progression to relapse. Prior research details some variables that are related to why women experience relapse, including stressful/difficult situations (Grilo et al., 2012; Mitchell et al., 1985), body image disturbance and worse psychosocial functioning (Keel et al., 2005), as well as more severe caloric restriction, higher residual symptoms at discharge, slower response to treatment and higher weight-related self-evaluation (McFarlane et al, 2008) and earlier age of onset (Safer et al., 2002). This study provided additional depth on how the co-researchers experienced their progression to relapse. For some, relapse was a gradual process of increased stress and decreased ability to cope. For others, a specific event occurred that resulted in their use of food to cope. Learning more about how women experience their progression to relapse may enable the development of effective intervention strategies to prevent relapse from occurring or lessen the severity and shorten the duration of a relapse.

The co-researchers in this study all discussed a combination of several stressors that occurred at the time of their relapse. These stressors were many and varied and consisted of job, school, housing, loss, and financial stressors. These findings are consistent with prior research that found relapse was associated with stressful/difficult situations such as job, school and social pressures (Mitchell at al., 1985).

Women discussed how increased stability of stressors was related to their recovery. For some this was related to completing schooling or finding stability in housing or employment. Others explored how they found community in this process and how that bolstered stability. Petterson and Rosenvinge (2002) qualitatively investigated

what factors were helpful for women in the recovery process. They found that important relationships were cited by the women as significant factors in recovery, which is consistent with the current study's finding that community was related to recovery. The current study extends prior findings and provides more information about the environmental factors women cited as important for their recovery process.

### Social Support

Another interesting theme that was highlighted was that the co-researchers felt it was unsafe for them to be seen fully. This meant that they withheld important aspects of their lives. This was evidenced by the fact that they did not feel they could tell supportive people in their lives that they were relapsing and/or that they did not want to be perceived as a burden by others. This finding connects to prior research that found people with eating disorders perceive themselves as having insufficient social support (Grissett & Norvell, 1992). While all of the women described sources of social support, none of them felt comfortable telling their support systems about their relapse when they were struggling. All of the co-researchers noted feeling disconnected from their social support at the time of their relapse. For some this was related to spending less time with social support because they were engaging in eating disorder behaviors and some were physically present but emotionally disconnected and distracted.

### Assertiveness

Co-researchers explored ways they were hiding aspects of themselves in relationships and how this was connected to hiding their needs, opinion, and desires. For some, this was discussed as suppressing themselves due to wanting validation and described themselves as "people pleasing". Being overly affiliative was found in co-

researchers' discussions about wanting to acting in ways that would result in others including them and approving of them. These findings are consistent with prior research that found people with BN and/or BED often show interpersonal behaviors related to being submissive, are excessively affiliative (Constantino & Smith-Hansen, 2008) and display a non-assertive interpersonal style, and higher levels of social inhibition (Hartman et al., 2010).

All co-researchers explored how they functioned differently in relationships in recovery. They all noted that they were more open in relationships and for some, this included increased assertiveness. They explored ways they were open in relationships and how they advocated for themselves and communities affected by eating disorders and diet culture in general. Co-researchers also explored how increased openness and direct communication resulted in increased feelings of connection in relationships. Others discussed how experiencing freedom from their previous preoccupation with food and concerns about their body weight and shape allowed them to feel more present. These findings are consistent with prior research that found individuals who recover from eating disorders experience more extroversion and assertiveness compared to peers who did not recover after treatment (Levallius et al., 2016). While many co-researchers explored improvements in assertiveness and openness in recovery, assertiveness was discussed as a continued challenge for several co-researchers. This finding is consistent with prior research that found that even after treatment, problems with assertiveness persist (Tasca et al., 2012). The current findings extend research on this topic by providing rich descriptions of how these variables are experienced from the individuals' perspectives.

## Strengths and Limitations

The findings of this study were consistent with the prior limited literature on relapse and recovery from BN or BED and provided new insights into this topic. This qualitative research aimed to deepen understanding surrounding social and interpersonal functioning in relapse and recovery from BN or BED, as qualitative research is particularly useful in understanding affective and emotional experiences (Merriam, 2009) and phenomenology in particular can help uncover experiences or meanings that were previously unknown (Creswell, 2013).

This study shone a spotlight on relapse, which is rarely studied but all too common of a phenomenon. It is the first study to use individuals' perspectives to understand assertiveness and overall intrapersonal, interpersonal, and social functioning among women who have experienced relapse and are now in recovery from BN or BED. The majority of the prior research on this topic mainly focused on individuals with AN and assessed behavioral symptom reduction, with very little focus on intrapersonal and interpersonal aspects of these disorders. There was prior quantitative data to suggest how many people relapse and recover, however, this study provides a deeper understanding of intrapersonal and interpersonal functioning in relapse and recovery among these women from their own perspectives.

Another strength of this study was the diversity of the co-researchers on a number of variables. Co-researchers were diverse in age, age of onset, treatment received, and time in recovery, which enabled this study to capture the aspects of BN and BED that are universally experienced in relapse. Co-researchers were also more diverse in terms of race and ethnicity than the samples found in majority of research on eating disorder

populations with five co-researchers identifying as a racial or ethnic minority and the remaining seven identifying as white or Caucasian. Research previously presented a homogenous view of the women who experience eating disorders, which was the result of poor representation of women of diverse backgrounds in research. More recently, literature provides evidence of a more equal distribution of eating disorders among diverse populations and no significant differences in symptoms between various ethnic groups in the United States have been found (Forbes & Frederick, 2008; Franko, et al. 2007; O'Neill, 2003; Shaw et al., 2004; Striegel-Moore et al., 2003). Although the sample size of the current study was small, these co-researchers captured the variability of those who experience eating disorders.

While this study provided rich descriptions of the phenomena of relapse and recovery from BN or BED, there are several limitations that are important to delineate. First, although generalization is not the goal of qualitative research, the research design was a qualitative study with a small sample, making generalizations of findings to the larger population difficult. Another limitation is that this study does not have multiple time points to compare how the co-researchers functioned at different point in their journey. Additionally, while I took steps to minimize subjectivity, it is a significant factor of qualitative research methods (Creswell, 2013). I engaged in several practices to be reflective and bracket out my biases, however it is likely that they were still present throughout the research process.

I wanted to create research collaboratively and be conscious of power imbalances within the research as is recommended when conducting feminist research (Silvia, 2013), so I deferred to co-researchers on how they defined relapse and recovery. This may

represent a research limitation as there is significant variability in where co-researchers were in their eating disorder journey at the time of the study, on the other hand, this may capture a picture of reality in the relapse process. All women had indicated that they had not utilized eating disorder behaviors within the six months prior to the study but beyond that, definitions of being in recovery were varied and many women struggled to pinpoint the timing of their last relapse or time in recovery. Although this may make it difficult to compare experiences across co-researchers, allowing co-researchers the freedom to define their experience of relapse and recovery may have provided a fuller picture of these processes.

Additionally, a limitation of this study is related to the IIP-64 (Horowitz et al., 1988). While this measure has been used in previous research and showed adequate psychometric properties, the manual did not discuss the implications of low scores. The validity of this measure for use with diverse samples and non-native English speakers is also unknown, which represents a limitation of this measure, as the sample was fairly diverse. Additionally, due to the study's small sample size, the ability to interpret findings from this measure was limited, yet, it is an interesting finding that none of the co-researchers scored in the "high" range, indicating that they are not experiencing a high number of interpersonal problems in recovery. Even with these limitations, the findings from this study have significant implications.

## Implications

This study has important implications for clinical practice. According to a comprehensive review of the literature on eating disorder treatment conducted by a special task force of the American Psychiatric Association, the best psychotherapy

treatment approaches for BN and BED consist of individual psychotherapy, group psychotherapy, family, and marital therapy (Yager et al., 2005). Some individual treatment approaches that have empirical backing address the thoughts that maintain the eating disorder; others address behavioral components; while others focus mainly on interpersonal mechanisms impacting the development and maintenance of the disorder (Yager et al., 2005). All modalities have been associated with reductions in eating disorder symptomology; however, until recently interpersonal variables have rarely been included. An exciting result from this study is that the findings support the importance of treatments that target interpersonal aspects of these disorders.

**Variable Definitions of Recovery**

When reflecting on their experience, co-researchers discussed their overall journey with an eating disorder, how they conceptualized their recovery, and also explored positive and negative experiences with treatment. What emerged from the interview data was a range of how people view recovery and the role of their treatment in this process. Some individuals felt that their eating disorder will always have a presence in their mind and they will always be recovering, whereas others described themselves as fully recovered. Some co-researchers noted that they still had to "work everyday" to maintain their recovery and challenge thoughts to engage in behaviors. Ideally, the goal of treatment would be freedom from functional impairment related to their eating disorder. The finding that some women still felt some presence of intrusive thoughts related to their eating disorder indicates that treatment needs to continually address aspects of recovery outside of behavioral and physical indicators of recovery and possibly have treatment follow-up to help prevent relapse.

### Treatment Experiences

All women had either positive or negative experiences with treatment along their journey. Among those who had positive experiences with treatment, many discussed the importance of engaging in EMDR to address past traumas in their process toward recovery. All of these women noted prior treatment experiences but felt that they were unable to progress toward lasting recovery until they addressed their trauma history. Eight women discussed a history of trauma when asked about their eating disorder relapse and recovery. These findings indicate that it is important to screen for trauma when working with people with BN or BED and ensure that it is addressed in treatment.

### Body Image and Weight Change

A continued challenged the co-researchers noted in recovery was related to body image and weight change. None of the co-researchers felt that they had a stable, positive body image and several noted discomfort surrounding intentional or unintentional weight change. Some women placed less emphasis on the importance of the way their body looked and some reported gratitude at times toward their body, but no one reported consistent positive feelings or acceptance toward their body. Some women attributed their body image disturbance to the overarching cultural forces that view thin bodies as the ideal. These findings indicate a need for treatment to address body image disturbance, increase tolerance/flexibility related to weight fluctuations, and resilience to harmful media messages.

### Self-Compassion

Self-compassion was cited as a continued challenge by eleven women. Women noted persistent traits of perfectionism, not allowing themselves rest, or being hard on

themselves when they fail to reach high standards. Due to the relationship between low self-compassion, shame and relapse, utilizing a compassion-focused approach such as CFT when working with women with BN or BED is indicated to help further develop this skill and maintain recovery.

**Assertiveness**

Several women noted continued difficulty with assertiveness and "taking up space" in recovery. They noted challenges related to expressing their opinions or needs in relationships. Three women discussed their experience of group therapy in relation to developing assertiveness or learning how to speak up. They noted discomfort with the exercise of receiving support but felt that it was important for the development of assertiveness.

Group therapy and its interpersonal structure have gained support as an effective treatment for persons with eating disorders and is particularly relevant regarding interpersonal deficits among this population. Group treatment can be as effective as individual therapy in the treatment of eating disorders (Burlingame et al., 2013; Novonen & Broberg, 2005), especially targeting physical and behavioral symptoms of eating disorders (Lee & Rush, 1986), and may even show advantages over individual therapy in addressing deficits in social functioning (Chen et al., 2003). Several recent studies on group treatment for BN and BED have found reductions in eating disorder psychopathology (Safer, Robinson, & Jo, 2010) and general psychopathology (Tasca et al., 2005). They also have found that group treatment facilitates more secure attachment following treatment (Maxwell et al., 2014), improves emotion regulation, increases self-efficacy (Wnuk, Greenberg, & Dolhanty, 2015), and reduces interpersonal dysfunction in

a variety of domains (Tasca et al., 2012). While group therapy is an effective intervention for interpersonal deficits, issues with assertiveness have been found to persist even after GCBT or GPIP treatment (Tasca et al., 2012), suggesting that group therapists working with eating disorder populations may need to pay special attention to issues surrounding assertiveness and target this component more directly in group treatment.

**Fat Phobia and Diet Culture**

Several women explored the ill effects of existing in a fat phobic, diet-obsessed culture on their recovery. These effects were felt by all of the women who mentioned this as part of their continued challenges in recovery but was experienced uniquely by the women who identified as living in a larger or fat body. For these women, they experienced overt criticism about their body's failure to conform to cultural standard of thinness. The findings of this study provides support for the importance of treatments like *Health at Every Size* that work to dismantle internalized narratives that equate thinness with health and happiness and build resilience to harmful messages found in the media. Additionally, these findings point to important broader implications related to challenging diet culture and weight stigma. For several woman, advocating against the dominant narrative that says "thin bodies are the only good bodies" was critical in their recovery. Engaging in advocacy to change these narrow views on broader levels may help solidify recovery and insulate against relapse

**Social Aspects of Food**

Social aspects of food and eating was a challenge that women noted experiencing in recovery. Some noted that previous ingrained thoughts about needing to restrict or

compensate after larger meals still occurred, but in recovery, they were able to challenge these thoughts. Others struggled with others' judgments related to their food choices or worried about what people think when they go to the restroom after eating a meal. Some eating disorder treatment programs have experiential components, which include things like eating meals with family or going out to dinner. This may be an important aspect of treatment to continue while in recovery to help cope with residual challenges as they arise.

### Future directions

More research is needed to understand intrapersonal and interpersonal variables related to relapse and recovery. The findings of this study reveal several potential future directions for research. This study found several intrapersonal and interpersonal deficits in relapse that occurred within the same timeframe as environmental stressors. Future directions could include investigation into intrapersonal disconnection, perceived causes of non-assertiveness in relapse and recovery, investigation into the conditions that would enable women in danger or in the process of relapsing to reach out for support/treatment, and treatment studies comparing the effects of different treatment approaches on the development of assertiveness.

A notable new finding from this study was that women experience intrapersonal disconnection during the time of their relapse. Some noted that this was the result of using their eating disorder to "numb out" and avoid feelings. Others were uncertain which came first: did they became disconnected from their feelings which then led to disordered eating? Or did they develop disordered eating and subsequently feel disconnected? More research is needed to understand the timing and relationship that

interpersonal disconnection has with relapse. A possible way this could be accomplished would be using measures to track intrapersonal attunement beginning at younger ages to understand how these skills function prior to the onset of disordered eating.

Another future potential research question is what prevents women from being assertive at the time of their relapse. Some women noted that they were disconnected from their internal experiences, which may have contributed to their lack of assertiveness and others felt that they were hiding and assuming a people-pleasing role in relationships, but it was not clear what the barriers were to asserting themselves. Some women discussed subverting needs to feel validation, but more information is needed to understand this relationship, how they developed more assertiveness in recovery, and what aspects of assertiveness are continued challenges in recovery. It may be useful for future research to ask women what barriers they perceived as preventing them from asserting themselves. Additionally, treatment studies including measures of interpersonal functioning and assertiveness would be useful in learning more about how these variables may change in relapse and recovery.

The findings from this study indicate that people who are in the process of relapsing have difficulty reaching out for support. Future research should investigate the conditions that would enable women in danger or in the process of relapsing to reach out for support and/or treatment. Since openness and assertiveness were found to be related to the experience of recovery from BN or BED, future research should seek to develop and test treatment interventions and prevention programs that foster open communication and assertiveness. Specific social skill development groups or programs within schools may be useful in aiding in the development of these skills and helping young women and

girls have fulfilling social interactions that may insulate them from future interpersonal disconnection. Additionally, longitudinal studies would allow for longer follow-up periods to track how people function following interventions targeting assertiveness and may provide useful information about the relationship between assertiveness and long-term recovery.

## Conclusion

The findings of this study revealed the intrapersonal and interpersonal challenges women face during relapse from BN or BED. It highlighted how the co-researchers function in recovery and provided insight into how they reflect on their journey and what challenges they continue to face in maintaining their recovery. Findings from this study indicate a need to foster the development of assertiveness at several junctures across the course of these illnesses and support the need for prevention and early identification and intervention due to the early age of onset. All of these women eventually found a way out of their eating disorder and for many, it began by telling someone they were struggling. In recovery, assertiveness was represented in discussions about feeling more open with other people and speaking out against cultural forces that seek to perpetuate shame and low self-compassion. All of the women reflected on their experience of sharing their stories with relapse and recovery in this study and noted feelings such as "pride" and "empowerment". It is an honor for me to collaborate with these co-researchers who felt their participation in this study continued their journey to "take up space".

# REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Ansell, E. B., Grilo, C. M., & White, M. A. (2012). Examining the interpersonal model of binge eating and loss of control over eating in women. *International Journal of Eating Disorders*, *45*(1), 43-50.

Arcelus, J., Haslam, M., Farrow, C., & Meyer, C. (2013). The role of interpersonal functioning in the maintenance of eating psychopathology: a systematic review and testable model. *Clinical Psychology Review*, *33*(1), 156-167.

Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies. *Archives of general psychiatry*, 68(7), 724-731.

Arcelus, J., Whight, D., Langham, C., Baggott, J., McGrain, L., Meadows, L., & Meyer, C. (2009). A case series evaluation of a modified version of interpersonal psychotherapy (IPT) for the treatment of bulimic eating disorders: A pilot study. *European Eating Disorders Review*, *17*(4), 260-268.

Arrindell, W. A., de Groot, P. M., & Walburg, J. A. (1984). De Schaal voor Interpersoonlijk Gedrag (SIG); Handleiding Deel I. Lisse, The Netherlands: Swets & Zeitlinger.

Association for Size Diversity and Health. (2019). *HAES® Principles.* Retrieved from *https://www.sizediversityandhealth.org.*

Bandini, L., Sighinolfi, C., Menchetti, M., Morri, M., De Ronchi, D., & Atti, A. R. (2013). 1111–Assertiveness and eating disorders: the efficacy of a CBT group training. Preliminary findings. *European Psychiatry*, *28*, 1.

Bardone-Cone, A. M., Harney, M. B., Maldonado, C. R., Lawson, M. A., Robinson, D. P., Smith, R., & Tosh, A. (2010). Defining recovery from an eating disorder: Conceptualization, validation, and examination of psychosocial functioning and psychiatric comorbidity. *Behaviour research and therapy*, 48(3), 194-202.

Behar, A. R., Manzo, G. R., & Casanova, Z. D. (2006). Lack of assertiveness in patients with eating disorders. *Revista médica de Chile*, *134*(3), 312-319.

Bowlby, C. G., Anderson, T. L., Hall, M. E. L., & Willingham, M. M. (2015). Recovered professionals exploring eating disorder recovery: A qualitative investigation of meaning. *Clinical Social Work Journal*, *43*(1), 1-10.

Boylorn, R. M. (2008). Participants as co-researchers. In L. M. Given, *The SAGE encyclopedia of qualitative research methods.* Thousand Oaks, CA: Sage Publications. Retrieved from https://search-credoreference-com.du.idm.oclc.org/content/entry/sagequalrm/participants_as_co_researchers/0

Burlingame, G. M., Strauss, B., & Joyce, A. (2013). Change mechanisms and effectiveness of small group treatments. In M. J. Lambert (Eds.) *Bergin and Garfield's handbook of psychotherapy and behavior change*, *6*, 640-689. New York, NY: John Wiley & Sons.

Chen, E., Touyz, S.W., Beumont, P.J.V., Fairburn, C.G., Griffiths, R. et al. (2003). Comparison of group and individual cognitive–behavioral therapy for patients with bulimia nervosa. *International Journal of Eating Disorders*, 33, 241–254.

Choate, L. H. (2015). *Eating Disorders and Obesity: A Counselor's Guide to Prevention and Treatment*. New York, NY: John Wiley & Sons.

Constantino, M., & Smith-Hansen, L. (2008). Patient interpersonal factors and the therapeutic alliance in two treatments for bulimia nervosa. *Psychotherapy Research*, *18*(6), 683-698.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches.* Thousand Oaks, CA: Sage.

Crow, S. J., Peterson, C. B., Swanson, S. A., Raymond, N. C., Specker, S., Eckert, E. D., & Mitchell, J. E. (2009). Increased mortality in bulimia nervosa and other eating disorders. *American Journal of Psychiatry*, *166*(12), 1342-1346.

Dansky, B. S., Brewerton, T. D., Kilpatrick, D. G., & O'Neil, P. M. (1997). The National Women's Study: relationship of victimization and posttraumatic stress disorder to bulimia nervosa. *International Journal of Eating Disorders*, *21*(3), 213-228.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative research*. Sage.

Duchesne, M., de Oliveira Falcone, E. M., de Freitas, S. R., D'Augustin, J. F., Marinho, V., & Appolinario, J. C. (2012). Assessment of interpersonal skills in obese women with binge eating disorder. *Journal of health psychology*, *17*(7), 1065-1075.

Fairburn, C. G. (2008). Eating disorders: The transdiagnostic view and the cognitive behavioral theory.

Fairburn, C. G. (1997). Interpersonal psychotherapy for bulimia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), Handbook of treatment for eating disorders (2nd ed., pp. 278–294). New York, NY: Guilford Press.

Fairburn, C. G., & Beglin, S. J. (1994). Assessment of eating disorders: Interview or self-report questionnaire? International Journal of Eating Disorders, 16(4), 363-370.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. *Behaviour research and therapy*, *41*(5), 509-528.

Forbes, G. B., & Frederick, D. A. (2008). The UCLA Body Project II: Breast and body dissatisfaction among African, Asian, European, and Hispanic American college women. *Sex Roles, 58,* 449–457.

Franko, D. L., Becker, A. E., Thomas, J. J., & Herzog, D. B. (2007). Cross-ethnic differences in eating disorders symptoms and related dis- tress. *International Journal of Eating Disorders, 40,* 156–164.

Freeman, C. P., & Henderson, M. (1988). The BITE: indices of agreement. *The British Journal of Psychiatry*, *152*(4), 576-577

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of psychopathology and behavioral assessment*, *26*(1), 41-54.

Grilo, C. M., Pagano, M. E., Stout, R. L., Markowitz, J. C., Ansell, E. B., Pinto, A., ... & Skodol, A. E. (2012). Stressful life events predict eating disorder relapse

following remission: Six-year prospective outcomes. *International Journal of Eating Disorders*, *45*(2), 185-192.

Grisset, N. I., & Norvell, N. K. (1992). Perceived social support, social skills, and quality of relationships in bulimic women. *Journal of Consulting and Clinical Psychology*, *60*(2), 293.

Hartmann, A., Zeeck, A., & Barrett, M. S. (2010). Interpersonal problems in eating disorders. *International Journal of Eating Disorders*, *43*(7), 619-627.

Herzog, D. B., Dorer, D. J., Keel, P. K., Selwyn, S. E., Ekeblad, E. R., Flores, A. T., ... & Keller, M. B. (1999). Recovery and relapse in anorexia and bulimia nervosa: a 7.5-year follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *38*(7), 829-837.

Herzog, D. B., Norman, D. K., Rigotti, N. A., & Pepose, M. (1986). Frequency of bulimic behaviors and associated social maladjustment in female graduate students. *Journal of psychiatric research*, *20*(4), 355-361.

Horowitz, L. M., Alden, L.E., Wiggins, J. S., & Pincus, A. L. (2003). *IIP 64 and 32: Inventory of interpersonal problems: Manual*. Menlo Park, CA: Mind Garden Inc.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: psychometric properties and clinical applications. *Journal of consulting and clinical psychology*, *56*(6), 885.

Hudson, J. I., Hiripi, E., Pope Jr, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological psychiatry*, *61*(3), 348-358.

Hyden, M. (2014). The teller-focused interview: Interviewing as a relational practice. *Qualitative Social Work, 13,* 795-812.

Ivanova, I. V., Tasca, G. A., Hammond, N., Balfour, L., Ritchie, K., Koszycki, D., & Bissada, H. (2015). Negative affect mediates the relationship between interpersonal problems and binge-eating disorder symptoms and psychopathology in a clinical sample: A test of the interpersonal model. *European Eating Disorders Review*, *23*(2), 133-138.

Ivanova, I. V., Tasca, G. A., Proulx, G., & Bissada, H. (2015). Does the interpersonal model apply across eating disorder diagnostic groups? A structural equation modeling approach. *Comprehensive psychiatry*, *63*, 80-87.

Johnson, J. G., Cohen, P., Kotler, L., Kasen, S., & Brook, J. S. (2002). Psychiatric disorders associated with risk for the development of eating disorders during adolescence and early adulthood. *Journal of Consulting and Clinical Psychology*, *70*(5), 1119.

Keel, P. K., Dorer, D. J., Franko, D. L., Jackson, S. C., & Herzog, D. B. (2005). Postremission predictors of relapse in women with eating disorders. *American Journal of Psychiatry*, *162*(12), 2263-2268.

Keski-Rahkonen, A., & Tozzi, F. (2005). The process of recovery in eating disorder sufferers' own words: An internet-based study. *International Journal of Eating Disorders*, *37*(S1), S80-S86.

Lee, N. F., & Rush, A. J. (1986). Cognitive-behavioral group therapy for bulimia. International Journal of Eating Disorders, 5(4), 599-615.

Levallius, J., Roberts, B. W., Clinton, D., & Norring, C. (2016). Take charge: Personality as predictor of recovery from eating disorder. *Psychiatry research*, *246*, 447-452.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Lindgren, B. M., Enmark, A., Bohman, A., & Lundström, M. (2015). A qualitative study of young women's experiences of recovery from Bulimia Nervosa. *Journal of advanced nursing*, *71*(4), 860-869.

Lub, V. (2015). Validity in qualitative evaluation: Linking purposes, paradigms, and perspectives. *International Journal of Qualitative Methods*, *14*(5), 1609406915621406.

Marshall, C., & Rossman, G. B. (1999). The "what" of the study: Building the conceptual framework. *Designing qualitative research*, *3*(3), 21-54.

Maxwell, H., Tasca, G. A., Ritchie, K., Balfour, L., & Bissada, H. (2014). Change in attachment insecurity is related to improved outcomes 1-year post group therapy in women with binge eating disorder. *Psychotherapy*, *51*(1), 57.

McFarlane, T., Olmsted, M. P., & Trottier, K. (2008). Timing and prediction of relapse in a transdiagnostic eating disorder sample. *International Journal of Eating Disorders*, *41*(7), 587-593.

McNarry, G., Allen-Collinson, J., & Evans, A. B. (2019). Reflexivity and bracketing in sociological phenomenological research: researching the competitive swimming lifeworld. *Qualitative Research in Sport, Exercise and Health*, *11*(1), 138-151.

Merriam, S.B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco: John Wiley and Sons.

Mitchell, J. E., Davis, L., & Goff, G. (1985). The process of relapse in patients with bulimia. *International Journal of Eating Disorders*, *4*(4), 457-463.

Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, *35*(2), 209-235.

Moustakas, C. E. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage Publications.

Neuendorf, K. A. (2002). *The content analysis guidebook.* Thousand Oaks, CA: Sage.

Novonen, L., & Broberg, A.G. (2005). A comparison of sequenced individual and group psychotherapy for eating disorders not otherwise specified. European Eating Disorders Review, 13, 29–37.

NVivo (Version 12) [Computer software]. (2019). QSR International Pty Ltd. Available from https://www.qsrinternational.com/nvivo/home

O'Neill, S. K. (2003). Black women and eating disturbances: A meta-analysis. *Journal of Black Psychology, 29,* 3–16.

Pettersen, G., & Rosenvinge, J. H. (2002). Improvement and recovery from eating disorders: A patient perspective. *Eating Disorders*, *10*(1), 61-71.

Rodgers, B. L., & Cowles, K. V. (2007). The qualitative research audit trail: A complex collection of documentation. Research in Nursing and Health, 16, 219-226.

Rorty, M., Yager, J., Buckwalter, J. G., & Rossotto, E. (1999). Social support, social adjustment, and recovery status in bulimia nervosa. *International journal of eating disorders*, *26*(1), 1-12.

Safer, D. L., Lively, T. J., Telch, C. F., & Agras, W. S. (2002). Predictors of relapse following successful dialectical behavior therapy for binge eating disorder. *International Journal of Eating Disorders*, *32*(2), 155-163.

Safer, D., Robinson, A., & Jo, B. (2010). Outcome from a randomized controlled trial of group therapy for BED: Comparing DBT adapted for binge eating to an active comparison group therapy. *Behavior Therapy*, *41*(1), 106-120.

Shaw, H., Ramirez, L., Trost, A., Randall, P., & Stice, E. (2004). Body image and eating disturbances across ethnic groups: More similarities than differences. *Psychology of Addictive Behaviors, 18,* 12–18.

Shiina, A., Nakazato, M., Mitsumori, M., Koizumi, H., Shimizu, E., Fujisaki, M., & Iyo, M. (2005). An open trial of outpatient group therapy for bulimic disorders: Combination program of cognitive behavioral therapy with assertive training and self-esteem enhancement. *Psychiatry and clinical neurosciences*, *59*(6), 690-696.

Sighinolfi, C., Norcini Pala, A., Chiri, L. R., Marchetti, I., & Sica, C. (2010). Difficulties in emotion regulation scale (DERS): the Italian translation and adaptation. *Psicoterapia Cognitiva Comportamentale*, *16*(2), 141-170.

Silva, J. (2013) Feminist research methodology. In: Ainsworth, J. (Ed.) *Sociology of education: An A-to-Z guide*, (pp. 282-84). New York: Sage. 282-84.

Silver, C., & Lewins, A. (2014). *Using software in qualitative research: A step-by-step guide (*2nd ed.). London: Sage.

Smink, F. R., van Hoeken, D., & Hoek, H. W. (2013). Epidemiology, course, and outcome of eating disorders. *Current opinion in psychiatry*, *26*(6), 543-548.

Striegel-Moore, R. H., & Bulik, C. M. (2007). Risk factors for eating disorders. *American Psychologist*, *62*(3), 181.

Striegel-Moore, R. H., Dohm, F. A., Kraemer, H. C., Taylor, C. B., Daniels, S., Crawford, P. B., et al. (2003). Eating disorders in White and Black women. *American Journal of Psychiatry, 160,* 1326–1331.

Tasca, G. A., Balfour, L., Presniak, M. D., & Bissada, H. (2012). Outcomes of specific interpersonal problems for binge eating disorder: Comparing group psychodynamic interpersonal psychotherapy and group cognitive behavioral therapy. *International journal of group psychotherapy*, *62*(2), 197-218.

Tasca, G. A., Mikail, S. F., & Hewitt, P. L. (2005). Group psychodynamic interpersonal psychotherapy: Summary of a treatment model and outcomes for depressive symptoms. In M. E. Abelian (Ed.), *Focus on psychotherapy research,* (pp. 159-188). Hauppauge, NY: Nova Science.

Toma, J. D. (2011). Approaching rigor in applied qualitative research. In C. F. Conrad & R. C. Serlin (Eds.), *The SAGE handbook for research in education: Pursuing ideas as the keystone of exemplary inquiry* (p. 263-280). Thousand Oaks, CA: Sage.

Tiller, J. M., Sloane, G., Schmidt, U., Troop, N., Power, M., & Treasure, J. L. (1997). Social support in patients with anorexia nervosa and bulimia nervosa. *International journal of eating disorders*, *21*(1), 31-38.

Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of general psychiatry*, *33*(9), 1111-1115.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). Comprehensive guide to interpersonal psychotherapy. New York, NY: Basic.

Wilfley, D., Welch, R., Stein, R., Spurrell, E., Cohen, L., Saelens, B., ... & Matt, G. (2002). A randomized comparison of group cognitive-behavioral therapy and group interpersonal psychotherapy for the treatment of overweight individuals with binge-eating disorder. Archives of general psychiatry, 59(8), 713-721.

Williams, C. J., Power, K. G., Millar, H. R., Freeman, C. P., Yellowlees, A., Dowds, T., ... & Jackson, M. A. (1993). Comparison of eating disorders and other dietary/weight groups on measures of perceived control, assertiveness, self-esteem, and self-directed hostility. *International Journal of Eating Disorders*, *14*(1), 27-32.

Wnuk, S. M., Greenberg, L., & Dolhanty, J. (2015). Emotion-focused group therapy for women with symptoms of bulimia nervosa. *Eating disorders*, *23*(3), 253-261.

Yager, J., Devlin, M. J., Halmi, K. A., Herzog, D. B., Mitchell, J. E., Powers, P. S., & Zerbe, K. J. (2005). Guideline watch: Practice guideline for the treatment of patients with eating disorders. *Focus*, *3*(4), 546-551.

## APPENDIX A: EMAIL TO FACEBOOK EATING DISORDER SUPPORT GROUPS AND LISTSERVS

Dear Site Moderators,

I am a doctoral student in Counseling Psychology at the University of Denver and I am currently seeking help with recruiting participants for my dissertation, under the supervision of Dr. Maria Riva. My dissertation is a qualitative study aimed at understanding the experiences of women who experienced relapse in their process toward recovery from bulimia nervosa or binge eating disorder. Participants can earn up to $50 in electronic Amazon gift cards for their participation.
Would you be willing to share the included request with the members of your group please? If you have any questions, please let me know. Thank you in advance for your help with my research.

Thank you,
Britney Tibbits, M.A.
Counseling Psychology Ph.D. Candidate
University of Denver

APPENDIX B: RECRUITMENT POSTING OR EMAIL FOR EATING DISORDER SUPPORT GROUPS AND LISTSERVS

Hello,
My name is Britney Tibbits and I am a doctoral student in Counseling Psychology at the University of Denver. I am seeking participants for my dissertation, which is a qualitative study looking at the experiences of women who experienced relapse in their process toward recovery from bulimia nervosa (BN) or binge eating disorder (BED).

I am seeking women who

a) identify as being recovered from BN or BED for **at least 6 months** and
b) have experienced relapse as part of their process toward recovery **within the last 3 years**.

Participation in the study will include one audio-recorded Zoom interview in which the participant will describe their experiences of relapse and recovery. Zoom is a web-based video conferencing tool. Participants will also be asked to complete one 64 question survey that takes about 10 minutes and asks about social and interpersonal functioning. I also ask that participants review the transcript of their interview that I provide via email and participate in one follow-up Zoom meeting to ensure accuracy of their stories. Participants will be eligible to receive up to $50 in the form of electronic Amazon gift cards for their participation in the study.

For those qualified and interested in taking part in this study, please follow the survey link below or copy and paste it in your browser. The information you provide will allow me to learn more about you and your fit for this study, as well as how best to reach you to further discuss the details of the study.

**Link: https://udenver.qualtrics.com/jfe/form/SV_3UVPegWSsUpZHH7**

If you have any further questions about the study, please do not hesitate to contact me at Britney.Tibbits@du.edu.

Thank you for your time and interest in my study,

Britney Tibbits, M.A.
Counseling Psychology Ph.D. Candidate
University of Denver

## APPENDIX C: SCREENING SURVEY AND RESOURCES, HOTLINES AND TREATMENT OPTIONS

The Screening Survey Link is below:
https://udenver.qualtrics.com/jfe/form/SV_3UVPegWSsUpZHH7

Thank you for your interest in this qualitative research study examining the experiences of women who identify as recovered from bulimia nervosa (BN) or binge eating disorder (BED) but also experienced relapse in their process.

Please fill in the information below to assess your fit for the study. The brief survey should take less than 5 minutes to complete.

By providing the information below, you are not agreeing to participate in the study, but consenting for me to contact you to learn more about the study. Participation in this study will include one interview in which you will describe your experience of relapse and recovery from BN or BED, a 10 minute survey about interpersonal functioning, a review of you interview transcript, that will be emailed to you by the researcher, and one brief follow-up Zoom meeting where you are invited to share any additional thoughts. Participants can earn up to $50 in electronic Amazon gift cards for their participation. Participants will receive $25 following the hour-long interview and the remaining $25 following completion of the survey, review of transcript and follow-up Zoom meeting.

All information you provide below will be kept confidential and will solely be used to contact you and learn more about you and your fit for this study.

Although the expected risk of participating in this survey is minimal, if you experience emotional distress, a list of various resources providing more information about eating disorders, how to get connected to care or speak to someone immediately is provided at the end of this survey.

Please provide your name and contact information.
Name: _____
E-mail:_____
Phone Number: _____

Please provide information related to your experience with an eating disorder.

Do you identify as a woman?
- Yes
- No

What type of eating disorder did you experience?
- Bulimia

- Binge Eating Disorder
- Anorexia
- Other

If you answered other, please say what eating disorder you most recently experienced?

_____

How old were you when you developed an eating disorder?

_____

Do you identify as being recovered or in recovery?
- Yes
- No

How long have you been recovered or in recovery?
- Less than 6 months
- 6 months to 1 year
- 1 to 5 years ago
- 5 or more years ago

Did you experience relapse on your journey toward recovery?
- Yes
- No

If so, how long ago was your most recent relapse?
- Less than 6 months ago
- 6 months to 1 year ago
- 1 year or more years ago
- NA, did not relapse

Did you receive treatment for your eating disorder?
- Yes
- No

If so, what type of treatment(s) did you receive? (Select all that apply).
- Individual psychotherapy
- Medication
- Group psychotherapy
- Family or couples psychotherapy
- Other

In what settings did you receive therapy? (Circle all that apply).

- Outpatient
- Intensive outpatient
- Partial Hospitalization
- Inpatient hospitalization program
- Other: _____

Do you **currently** have an of the following (Select all that apply):

- Untreated depression
- A current substance use disorder
- Current suicide ideation
- Recent suicide attempts
- A schizophrenia spectrum disorder
- Untreated bipolar disorder

Are you **currently** receiving treatment for your eating disorder?

- Yes
- No

If so, what type of treatment(s) are you **currently** receiving (Select all that apply).

- Individual psychotherapy
- Medication
- Group psychotherapy
- Family or couples psychotherapy
- Other

In what settings are you receiving treatment **currently**? (Circle all that apply).

- Outpatient
- Intensive outpatient
- Partial Hospitalization
- Inpatient hospitalization program
- Other: _____

This research aims to examine how the experience of relapse and recovery may be related to various social/interpersonal variables. In order for me to learn more about you and your identities as they relate to these variables, please provide your demographic information.

Please self-identify in the text boxes below:
How old are you currently?: _____
How do you identify in terms of your race and/or ethnicity?: _____
What is your relationship status?: _____
What other identities are important to you, if any? _____

Thank you for completing this survey! I will reach out to you within the next week to follow-up, discuss the study with you in further depth, and review the consent form if you are interested in participating. If you need to reach me before then, feel free to contact me, Britney Tibbits at Britney.Tibbits@du.edu.

**Resources, Hotlines and Treatment Options (Presented at End of Screening Survey)**

**National Eating Disorders Association Helpline: 1-800-931-2237**
This helpline offers support Monday–Thursday from 9 a.m.–9 p.m. EST, and Friday from 9 a.m.–5 p.m. EST. You can expect to receive support, information, referrals, and guidance about treatment options for either you or your loved one. You can also contact this helpline through its online chat function, available on its website. Additionally, there is an option to send a text message if you are in crisis by texting NEDA to 741741; a trained volunteer from the Crisis Text Line will get in touch with you.

**Something Fishy: 1-866-418-1207**
This eating disorders helpline offers treatment referrals nationwide. Its website also provides a wealth of information and resources about eating disorders and eating disorder treatment. Through its website, you can join an online chat group where you can speak to others in your shoes to gain support, advice, and hope.

**Hopeline Network: 1-800-442-4673**
This is a hotline dedicated to serving anyone in crisis. Sometimes, people with eating disorders might feel so full of shame or self-hatred that they contemplate hurting themselves. If this is true for you, this hotline offers nationwide assistance and support from volunteers specifically trained in crisis intervention. You can talk to someone day or night about anything that's troubling you, even if it's not related to an eating disorder. You can also call if you need referrals to eating disorder treatment centers.

**National Association of Anorexia Nervosa and Associated Disorders: 1-630-577-1330**
Currently serving people in the United States, the hotline operates Monday–Friday from 9 a.m.–5 p.m. CST, with plans for a 24/7 hotline coming soon. Trained hotline volunteers offer encouragement to those having problems around eating or bingeing, support for those who "need help getting through a meal," and assistance to family members who have concerns that their loved one might have an eating disorder.

**American Psychological Association Division 12 Treatment Guide**
APA's Society of Clinical Psychology provides information about effective treatments for psychological diagnoses, including bulimia nervosa and binge eating disorder. Descriptions are provided for each psychological diagnosis and treatment.

**National Suicide Prevention Hotline**
The Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals.

**Crisis Text Line**
Text HOME to 741741
Text from anywhere in the USA to text with a trained Crisis Counselor.
Every texter is connected with a Crisis Counselor, a real-life human being trained to bring texters from a hot moment to a cool calm through active listening and collaborative problem solving. All of Crisis Text Line's Crisis Counselors are volunteers, donating their time to helping people in crisis.

## APPENDIX D: E-MAIL TO CO-RESEARCHERS

Dear [insert name],

Thank you for your interest in my dissertation research on experiences of women who experienced relapse in their process toward recovery from bulimia nervosa or binge eating disorder. I am writing to invite you to participate in the next steps of the study after reviewing your online survey. I am excited about the possibility of your participation and hearing about your experiences. The purpose of this e-mail is to inform you of your rights within this study and to provide you with an informed consent for you to sign if you agree to participate. I will provide details on how to return the consent form below.

I am conducting a qualitative study whose aim is to understand a unique phenomenon and provide descriptive detail and understanding of the experience of relapse in the process of recovery from bulimia or binge eating disorder. My main research question is ": "How do women who relapse from bulimia or binge eating disorder perceive what factors led to relapse?" The goal of this research is to explore the variables related to relapse and bring additional understanding to the recovery process. I will be requesting that you complete one semi-structured interview with me through Zoom, a web-based video conferencing tool, that will last about one hour, complete a 10 minute survey online about aspects of your interpersonal functioning, review our interview transcript that I provide and participate in one follow-up Zoom meeting to provide additional feedback. As compensation for your time you can earn up to $50 in electronic Amazon gift cards, $25 following the interview and the additional $25 following the completion of the survey, review of your transcript and follow-up meeting.

I will ask you to share about your experiences before, during, and after your relapse and how this relates to social and interpersonal variables and your eventual path toward recovery. I am seeking vivid and comprehensive portrayals of what these experiences were like for you, which may include your thoughts, feelings, and behaviors, as well as situations, events, places, and people connected with your experience. My goal for this study is to make this a collaborative process and will follow-up with you at times to make sure I accurately capture your experience as I begin to analyze data. If you have additional thoughts or ideas beyond our interviews, I encourage you to contact me so I can fully capture your experience. You can also decide at any point in this study to withdraw your consent and participation.

If you agree with all of the material in the attached consent form, please sign it and let me know it is complete. Once you have signed the consent form, I will send a file request for you to upload and return it via an encrypted transfer system. Once you have returned the consent form, please also send me dates and times that you are available for our first interview. During the interview I will introduce myself and the study, review the consent form with you, and will ask questions about your experience.

I appreciate your interest and the time and energy that it will take to be a part of this study. This study is completely voluntary which means you can choose to be in the study or not. If you have any further questions before signing the consent form attached, please feel free to reach out to me via e-mail (Britney.Tibbits@du.edu) or telephone (301-221-4423).

Thank you,
Britney Tibbits

## APPENDIX E: EMAIL TO INELIGIBLE SUBJECTS

Dear [insert name],

Thank you for your interest in my dissertation research on experiences of women who experienced relapse in their process toward recovery from bulimia nervosa or binge eating disorder. While I value your journey and experience with an eating disorder, I am writing to let you know that you do not currently meet the requirements to be part of the study. Thank you so much for your time.

Britney Tibbits

APPENDIX F: CONSENT FORM

**Consent to Participate in Research**

**Study Title:** *Exploring the Role of Relapse for Women in Recovery from an Eating Disorder*

**IRBNet #: 1442352-1**

**Principal Investigator:** *Britney Tibbits, MA*

**Faculty Sponsor:** *Maria T. Riva, PhD*

**Study Site:** *Zoom interview (a web-based video conferencing tool), and online survey*

**You are being asked to participate in a research study.** Your participation in this research study is voluntary and you do not have to participate. This document contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to ask questions via email or phone before making your decision whether or not to participate.

The purpose of this form is to provide you information that may affect your decision as to whether or not you may want to participate in this research study. The person performing the research will describe the study to you and answer all of your questions via email or phone. Please read the information below and ask any questions you might have via email or phone before deciding whether or not to give your permission to take part. If you decide to be involved in this study, this form will be used to record your permission.

**Purpose**

The purpose of this study is to learn about the experiences of women who experienced relapse in their process toward recovery from bulimia nervosa or binge eating disorder and deepen the understanding of this phenomenon. If you agree to be a part of the research study, you will be asked to complete one semi-structured interview, lasting around one hour, in which you will share your experiences of relapse and recovery as it relates to social and interpersonal variables. The interview will take place over Zoom, a web-based video conferencing tool. The interview will be audio-recorded and will be scheduled at times that are most convenient to you. Following your interview, you will be asked to complete a 64-question survey about your interpersonal functioning as well. A typed transcription of your interview will be provided to you within 1 week and you will be asked to review the transcript to assess for accuracy and make changes as you see fit. Once you have reviewed your transcript, you will be asked to participate in one brief audio recorded follow-up Zoom meeting to make any additional comments or provide feedback. You will be given the final study analysis to review and provide feedback if you would like. You may refuse to answer any interview questions or survey items. Any identifying information will not be published, but solely used for data analysis.

**Risks or Discomforts**

While the potential risk for this study is minimal there are potential risks related to confidentiality and emotional distress. There is a risk that confidentiality could be compromised in that the experiences you share may be recognizable to others. However, in order to protect your confidentiality, you will be given a pseudonym and I will provide minimal demographic information including your race/ethnicity and age when writing up study findings.

There is also the risk of loss of confidentiality due to data breach. The researcher will send secure emails and files via an encrypted data transfer system only. All audio-recordings and study related documents will be saved in password-protected files on an encrypted drive. Online platforms utilized for this study utilize encryption to help minimize risk of data breach.

There is the possibility that discussing certain issues about your experience may be upsetting. I have provided a list of resources related to eating disorders that can help you find more information about getting connected to care at the end of the screening survey and can send this again if needed. If you are struggling to find support, I am happy to assist you in finding some. I have experience working with people with current and historical eating disorders so I have chosen interview questions thoughtfully to avoid triggering subjects. If you are experiencing distress, remember you may withdraw from the study at any time and have your data (personal information & interviews) destroyed at any time.

**Benefits**

Sharing your experiences of relapse and recovery may have benefits for participants in feeling empowered by telling their story aloud or providing cathartic relief. It also may be validating to hear about other women's experiences when you review my final product.

**Confidentiality of Information**

In order to protect your confidentiality, you will be given a pseudonym and I will provide minimal demographic information including your race/ethnicity and age when writing up study findings. The list connecting your actual name to this pseudonym will be kept in a password protected file on an encrypted drive. Only the research team will have access to the file. When the study is completed and the data have been analyzed, the list will be destroyed. Your name will not be used in any report. Identifiable research data will be encrypted and password protected. The researcher will send secure emails and files via an encrypted data transfer system only. All audio-recordings and study related documents will be saved in password-protected files on an encrypted drive. Online platforms utilized for this study utilize encryption to help minimize risk of data breach.

Only the Faculty Advisor, Dr. Maria T. Riva, and the Principal Investigator, Britney Tibbits, will have access to the raw data. Confidential information will not be shared with anyone outside of the dissertation committee.

The Principal Investigator will conduct Zoom interviews in their private home using their secure and password-protected Internet connection. You can take steps to ensure your Internet connection is secure by utilizing a WPA (Wi-Fi Protected Access) protection instead of a WEP (Wired Equivalent Privacy) and ensuring you have a strong Internet password. When using Zoom for the interviews, please be mindful to respond in a private setting and through a secured Internet connection for your privacy. You are encouraged to monitor your surroundings during your interview to ensure your privacy and if your privacy becomes compromised, you are welcome to ask the researcher to pause or discontinue your interview until you can continue privately. Your confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

All of the information you provide will be confidential. However, if we learn that you intend to harm yourself or others, we must report that to the authorities as required by law.

Before you begin the online survey portion of this research study, please note that the data you provide may be collected and used by *Mind Garden's Transform™ System* as per its privacy agreement. This research is only for U.S. residents over the age of 18.

With your permission, I would like to audiotape this interview so that I can make an accurate transcript. Once I have made the transcript, I will erase the recordings. Your name will not be in the transcript or my notes.

Information collected about you will not be used or shared for future research studies.

The information that you provide in the study will be handled confidentially. However, there may be circumstances where this information must be released or shared as required by law. Representatives from the University of Denver may also review the research records for monitoring purposes.

Government or university staff sometimes review studies such as this one to make sure they are being done safely and legally. If a review of this study takes place, your records may be examined. The reviewers will protect your privacy. The study records will not be used to put you at legal risk of harm.

**Incentives to participate**

You will receive up to $50 in the form of Amazon gift cards for participating in this research project, $25 following the interview and the additional $25 following the completion of the survey, review of your transcript and follow-up meeting.

**Consent to audio recording**

This study involves audio recording, If you do not agree to be recorded, you CANNOT take part in the study.

_____ YES, I agree to be video/audio recorded/photographed.

_____ NO, I do not agree to be video/audio recorded/photographed.

**Questions**

If you have any questions about this project or your participation, please feel free to ask questions now or contact Britney Tibbits at 301-221-4423 or Britney.Tibbits@du.edu. You can also contact the Faculty Advisor of this project, Dr. Maria Riva, PhD, at Maria.Riva@du.edu.

If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the University of Denver (DU) Institutional Review Board to speak to someone independent of the research team at (303)-871-2121 or email at IRBAdmin@du.edu.

**Please take all the time you need to read through this document and decide whether you would like to participate in this research study**

I have read (or someone has read to me) this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

Once you have signed the consent form, please notify the researcher, who will then send a file request for you to upload and return it via an encrypted transfer system.

I am not giving up any legal rights by signing this form. I will be given a copy of this form**.**

| | | |
|---|---|---|
| **Printed name of subject** | **Signature of subject** | **Date** |

## APPENDIX G: INTERVIEW PROTOCOL INTRODUCTION

- Thank participant for taking time to interview

- Share general format for first interview
    - I will share about myself & study
    - Review consent form together
    - Discuss interview format and will begin interview questions

- Feel free to interrupt at any point with questions
- Introduce myself and share about background
    - Doctoral student in Counseling Psychology at DU
    - Became interested in this topic after personal experience and clinical experience
    - Purpose of dissertation is to explore the interpersonal variables related to relapse and bring additional understanding to the recovery process and inform treatment. My main research question is ": "How do women who relapse from bulimia or binge eating disorder perceive what factors led to relapse?"
- 
- Briefly review consent form & method
    - I'm viewing you as the expert on this topic and want this to be a collaborative process
        - Please feel free to add comments or questions I may not directly ask.
        - After our interview, I will transcribe it and send it to you. I will ask you to review interview transcript and you can remove, add or edit statements as you see fit
        - Once you have been able to review our transcript, we will have a brief follow-up meeting to provide a space for additional comments or feedback.
        - I will provide you with my final analysis that you are able to review if desired or not.
    - I will protect your confidentiality in this study by assigning you a pseudonym and only using vague identifying information (race, age, relationship status). You will be welcome to review everything before I publish
    - You've agreed for me to audio tape, all of these are saved on my encrypted drive with your ID code, password protected and will be deleted after transcribed.

    - I am hoping this experience can be cathartic and empowering for you and other women; if you feel distressed by this experience, please let me know and I would be happy to help you find professional mental health care.
    - After this interview, you will receive a $25 Amazon gift card, however, you are of course allowed to drop out at any time if you so desire.

    - After completing the survey, transcript review and follow-up meeting, you will receive the next $25 gift card.

- Discuss interview approach
    - Feminist approach to study, hope for conversational style.
    - You have the power to steer the interview in the direction that is most salient to you.
    - I conducted a pilot interview with a woman I know in recovery to refine these questions and get her input/feedback on what's important to ask

    - All are open-ended questions and I encourage you to answer as feel comfortable
- Any questions?

## APPENDIX H: INTERVIEW PROTOCOL

I am going to start by asking you about variables that might be related to your most recent relapse and then I will ask you about these variables in recovery.

1. Tell me about your most recent relapse, what was going on with you at the time?

2. Where they any significant events that occurred in your life around the time of your most recent relapse?

I am in interested in learning about various aspects of your social life and social interactions at the time of your relapse so the next three questions will be about these aspects of your experience.

3. How would you describe your social support at the time of your relapse?

4. How would describe the way you interacted with people at the time of your relapse?

I am also interested in how you would describe your relationship with your self at the time of your most recent relapse. The next three questions will be about intrapersonal variables.

5. How would you describe your ability to express your emotions around the time you most recently relapsed?

6. How would you describe your self-esteem around the time you most recently relapsed?

7. How would you describe your "self-care" at the time of your most recent relapse?

I will ask you the same 7 questions again, but this time I will be asking about how you experienced these variables when you entered recovery and moving forward.

8. Tell me about your recovery, what is going on in your life when you entered recovery?

9. Were there any significant events that occurred in your life around the time you entered recovery?

10. How would you describe your social support when you entered recovery? How about now?

11. How would describe the way you interacted with people when you entered recovery? How about now? Friends? Family? Partners?

12. How would you describe your ability to express your emotions when you entered recovery? How about now?

13. How would you describe your self-esteem when you entered recovery? Now?

14. How would you describe your "self-care" when you entered recovery? Now?

Wrapping up…

15. What challenges do you still face in maintaining your recovery and how do you manage them? What else? Are their aspects of relationships that are challenging in recovery
16. What is easier in recovery?

17. Is there anything else you would like me to know about your experience relapse and then recovery from bulimia or binge eating disorder?

APPENDIX I: INTERVIEW PROTOCOL RESEARCH

| Research Question | Literature Support | Source |
|---|---|---|
| 1. Tell me about your most recent relapse, what was going on with you at the time? | Interviews should begin in an open-ended way to allow space to share experiences openly. | Hyden (2014) |
| 2. How would you describe your social support at the time of your relapse? | People with eating disorder psychopathology display specific deficits in assertiveness, social skills, social adjustment, and social support. These individuals also experience less emotional and practical social support, where practical support refers to concrete aspects of support such as financial assistance. | Arcelus, Haslam, Farrow, & Meyer (2013)<br>Grissett & Norvell (1992)<br>Tiller at al. (1997) |
| 3. How would describe the way you interacted with people at the time of your relapse? | People with eating disorder psychopathology display specific deficits in assertiveness, social skills, social adjustment, and social support. People with eating disorders perceive themselves as less socially competent/socially effective, and others from their peer group perceive them this way as well. Research shows, across various eating disorder diagnoses, women are more submissive and excessively affiliative. | Arcelus, Haslam, Farrow, & Meyer (2013)<br>Grissett & Norvell (1992)<br>Constantino & Smith-Hansen (2008) |
| 4. Where they any significant events that occurred in your life around the time of your most recent relapse? | These individuals also experience less emotional and practical social support, where practical support refers to concrete aspects of support such as financial assistance | Mitchell et al. (1985)<br>Grissett & Norvell (1992)<br>Tiller at al. (1997) |

| | | |
|---|---|---|
| 5. How would you describe your ability to express your emotions around the time you most recently relapsed? | Research has found these individuals have difficulties expressing feelings. | Duchesne et al. (2012) |
| 6. How would you describe your self-esteem around the time you most recently relapsed? | Qualitative research found themes of building self-esteem, accepting and learning to love oneself, and finding the right tools to manage emotions as essential to achieving and maintaining health. | Lingren et al. (2015) |
| 7. How would you describe your "self-care" at the time of your most recent relapse? | Qualitative research found themes of building self-esteem, accepting and learning to love oneself, and finding the right tools to manage emotions as essential to achieving and maintaining health. | Lingren et al. (2015) |
| 8. Tell me about your recovery, what is going on in your life when you entered recovery? | Since the interview is shifting to an different topic, it is important to start this section in an open-ended way to allow space to share experiences openly. | Hyden (2014) |
| 9. How would you describe your social support when you entered recovery? How about now? | People with eating disorder psychopathology display specific deficits in assertiveness, social skills, social adjustment, and social support. These individuals also experience less emotional and practical social support, where practical support refers to concrete aspects of support such as financial assistance. Qualitative research has shown that developing meaningful relationships was important in the recovery process. | (Arcelus, Haslam, Farrow, & Meyer, 2013). (Grissett & Norvell, 1992; Tiller at al., 1997), (Bowlby at al., 2015). |

| | | |
|---|---|---|
| 10. How would describe the way you interacted with people when you entered recovery? How about now? | People with eating disorder psychopathology display specific deficits in assertiveness, social skills, social adjustment, and social support. People with eating disorders perceive themselves as less socially competent/socially effective, and others from their peer group perceive them this way as well. Research shows, across various eating disorder diagnoses, women are more submissive and excessively affiliative. | (Arcelus, Haslam, Farrow, & Meyer, 2013) (Grissett & Norvell, 1992) (Constantino & Smith-Hansen, 2008), |
| 11. Were there any significant events that occurred in your life around the time you entered recovery? | These individuals also experience less emotional and practical social support, where practical support refers to concrete aspects of support such as financial assistance | Mitchell et al. (1985) (Grissett & Norvell, 1992; Tiller at al., 1997), |
| 12. How would you describe your ability to express your emotions when you entered recovery? How about now? | Research has found these individuals have difficulties expressing feelings. | (Duchesne et al., 2012) |
| 13. How would you describe your self-esteem when you entered recovery? Now? | Qualitative research found themes of building self-esteem, accepting and learning to love oneself, and finding the right tools to manage emotions as essential to achieving and maintaining health. | Lingren et al. (2015) |

| | | |
|---|---|---|
| 14. How would you describe your "self-care" when you entered recovery? Now? | Qualitative research found themes of building self-esteem, accepting and learning to love oneself, and finding the right tools to manage emotions as essential to achieving and maintaining health. | Lingren et al. (2015) |
| 15. What challenges do you still face in maintaining your recovery and how do you manage them? | As many as one third of those affected relapse after full recovery. | Arcelus, Mitchell, Wales, & Nielsen (2011)<br>Herzog et al. (1999) |
| 16. Is there anything else you would like me to know about your experience relapse and then recovery from BN or BED? | | |

# APPENDIX J: IRB APPROVAL LETTER

UNIVERSITY of DENVER

OFFICE OF RESEARCH & SPONSORED PROGRAMS
Research Integrity & Education

| | |
|---|---|
| DATE: | August 6, 2019 |
| TO: | Britney Tibbits, MA |
| FROM: | University of Denver (DU) IRB |
| PROJECT TITLE: | [1442352-1] Exploring the Role of Relapse for Women in Recovery from an Eating Disorder |
| SUBMISSION TYPE: | **EXPEDITED NEW PROJECT** |
| APPROVAL DATE: | August 6, 2019 |
| NEXT REPORT DATE: | August 5, 2021 |
| RISK LEVEL: | Minimal Risk |
| REVIEW TYPE: | Expedited Review |
| ACTION: | **Approved** |
| REVIEW CATEGORY: | Expedited Category # 7<br>**Category 7:** *Research on group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.* |

Thank you for your submission of the **New Project** materials for this project. The University of Denver Institutional Review Board (IRB) has granted Full Approval for your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission. The IRB determined that the criteria for IRB approval of research, per 45 CFR 46.111, has been met.

This submission has received an Expedited Review based on applicable federal regulations. This project has been determined to be a Minimal Risk project. Please note that the following documents were included in the review and approval of this study:

- Advertisement - Recruitment Posting or Email for Eating Disorder Support Groups and Listservs.docx (UPDATED: 08/5/2019)
- Advertisement - Email to Participants.docx (UPDATED: 08/5/2019)
- Advertisement - Email to Facebook Eating Disorder Support Groups and Listservs.docx

(UPDATED: 08/5/2019)

- Application Form - Tibbits PART I 8.5.19.docx (UPDATED: 08/5/2019)
- Consent Form - Tibbits Expedited Consent Form.docx (UPDATED: 08/5/2019)
- DU - IRB Application Form - DU - IRB Application Form (UPDATED:06/26/2019)
- Letter - Email to Ineligible Subjects.docx (UPDATED: 08/5/2019)
- Other - Resources, Hotlines and Treatment Options.docx (UPDATED: 08/5/2019)
- Other - Use of Internet Appendix Tibbits.pdf (UPDATED: 08/5/2019)
- Other - Tibbits Appendix A.docx (UPDATED: 08/5/2019)
- Protocol - Interview Protocol.docx (UPDATED: 06/26/2019)
- Questionnaire/Survey - Screening Survey.docx (UPDATED: 08/5/2019)

**Informed Consent Process**

Please remember that informed consent is a process beginning with a description of the project and the assurance of participants understanding. Informed consent must continue throughout the project via a dialogue between the researcher and the research participant. Federal regulations require that each participant receive a copy of the consent document.

*Please note, a* **Waiver of Informed Consent**, per 45 CFR 46.116(d), has been granted for the initial screening of potential subjects, based on the following criteria:

1. The research involves no more than minimal risk to the subjects;
2. The waiver or alteration will not adversely affect the rights and welfare of the subjects;
3. The research could not practicably be carried out without the waiver or alteration; and
4. Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

**Implementation of Changes to Previously Approved Research**

Prior to the implementation of any changes in the approved research, the investigator must submit any modifications to the IRB through completing an amendment form and await approval before implementing the changes, unless the change is being made to ensure the safety and welfare of the subjects enrolled in the research. If such occurs, a Reportable New Information (RNI) Form should be submitted, via the IRBNet system, within five days of the occurrence indicating what safety measures were taken and provide an updated protocol and/or consent, if applicable.

**Unanticipated Problems Involving Risks to Subjects or Others (UPIRTSOs)**

Any incident, experience or outcome which has been associated with an unexpected event(s), related or possibly related to participation in the research, and suggests that the research places subjects or others at a greater risk of harm than was previously known or suspected must be reported to the IRB. UPIRTSOs may or may not require suspension of the research. Each incident is evaluated on a case by case basis to make this determination. The IRB may require remedial action or education as deemed necessary for the investigator or any other key personnel. The investigator is responsible for reporting UPIRTSOs to the IRB within 5 working days after becoming aware of the unexpected event. Use the Reportable New Information (RNI) form within the IRBNet system to report any UPIRTSOs.

All NON- COMPLIANCE issues or COMPLAINTS regarding this project must also be reported.

**Continuation Review Requirements**

Based on the current regulatory requirements, this expedited project does **not** require continuing review. However, this project has been assigned a **two-year review period** requiring communication to the IRB at the end of this review period to either close the study or request an extension for another two years. The two-year review period will be posted in the Next Report Due section on the Submission Details page in IRBNet. During this two-year period, a staff member from the Office of Research Integrity and Education (ORIE) may also conduct a Post Approval Monitoring visit to evaluate the progress of this research project.

**PLEASE NOTE: This project will be administratively closed at the end of a two-year period unless a request is received from the Principal Investigator to extend the project.** Please contact the DU HRPP/IRB if the study is completed before the two-year time period or if you are no longer affiliated with the University of Denver through submitting a Final Report to the DU IRB via the IRBNet system. If you are no longer affiliated with DU and wish to transfer your project to another institution please contact the DU IRB for assistance.

**Study Completion and Final Report**

A Final Report must be submitted to the IRB, via the IRBNet system, when this study has been completed or if you are no longer affiliated with the University of Denver. The DU HRPP/IRB will retain a copy of
the project document within our records for three years after the closure of the study. The Principal Investigator is also responsible for retaining all study documents associated with this study for at least three years after the project is completed.

If you have any questions, please contact the Institutional Review Board at (303) 871-2121 or through IRBAdmin@du.edu. Please include your project title and IRBNet number in all correspondence with the IRB.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within the University of Denver (DU) IRB's records.