

# Recipe for Recovery

## Necessary Ingredients for the Client's and Clinician's Success

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*Beth Hartman McGilley and Jacqueline K. Szablewski*

This chapter elucidates ingredients of two inextricably linked topics not well described in the clinical literature. First, despite a wide body of research now supporting the assertion that the quality of the therapeutic alliance is the best predictor of psychotherapy outcome (American Psychiatric Association, 2006), little rigorous attention has been paid to the qualities of the eating disorder (ED) therapist most conducive to a positive healing relationship. Second, even with close to 50 years of research, a comprehensive, comparable, consistent, and clinically meaningful definition of recovery has yet to be articulated and accepted in and across the ED treatment field.

To assist in bridging these gaps, we begin with a discussion of those therapist qualities associated with effective therapeutic alliance, followed by an exploration of what constitutes recovery. We hope to describe the mysterious mixture of textures, flavors, and hallmarks that indicate that the healing has indeed been done.

### THE EFFECTIVE CLINICIAN'S CUPBOARD

#### The Importance of Alliance

Both clinical experience and scientific rigor have borne out that the quality of the therapeutic relationship is essential for successful ED treatment (American Psychiatric Association, 2006; Beresin, Gordon & Herzog, 1989; Bunnell, 2009; Burket & Schramm, 1995; Costin, 2007a). In fact, it is regarded as a better indicator of positive outcome across ED diagnoses than any specific treatment technique (Costin, 2007a). The American Psychiatric Association (2006) names the importance of a therapeutic relationship as the first principle in their psychiatric management treatment guidelines. Eating disorder practitioners attest that solid therapeutic rapport results in less attrition, fewer premature treatment terminations, and more helpful therapy. It is through the relationship that we challenge the client's reliance

on their ED symptoms and engage them in developing alternative, adaptive skills in order to make effective changes in their physical, psychological, and psychosocial functioning.

Advances in neuropsychiatry and neuroscience have substantiated the relational claim, long suspected as true by practicing clinicians, and experienced as true by ED clients themselves (Beresin et al., 1989; Pettersen & Rosenvinge, 2002). For example, the discovery of mirror neurons has generated significant interest in the healing professions (Cozolino, 2002). Located in the premotor areas of the brain's frontal cortex, mirror neurons "fire in response to an observation of a highly specific relationship between an actor and some object, and also fire when the action is performed (mirrored) by the observer" (Cozolino, 2002, p. 184). The involved motor systems "in turn activate networks of emotions associated with such actions" (p. 186). In a number of ways "mirror neurons may bridge the gap between sender and receiver, helping us understand one another and enhance the possibility of empathic attunement" (p. 186). Thus, echoing early infant attachment studies, contemporary feminist thought, and the field of quantum physics, interpersonal impact is inevitable; so too, within the therapeutic relationship.

Previous chapters have addressed and explored approaches and modalities for treating ED. Effective ED clinicians must be adept in their approach and steeped in a variety of psychotherapeutic techniques. A basic body of knowledge, supervised specialty training in ED treatment interventions and techniques, clinical experience, and constant review constitute the staples of training programs for ED specialists (Andersen & Corson, 2001; Yager & Edelstein, 1987). Too often overlooked and harder to scientifically quantify are the qualities in the seasoned clinician that enliven the techniques and infuse the relationship so central to healing. Just as warmth and caring without technical skills do not suffice for sustained healing and recovery, neither do technical skills without an authentic therapeutic relationship.

## Alliance Ingredients

**Non-possessive warmth and unconditional positive regard.** "Non-possessive warmth" (Andersen & Corson, 2001, p. 356), stands akin to the "unconditional positive regard" espoused by Carl Rogers (1961, p. 47). Informed by the tenets of feminist relational theory, it provides the base for the therapeutic connection. Elements included are:

- Basic respect for the person who sits before us
- A desire to know who that person is no matter how textbook they may seem
- Care for whom we will discover them to be in the context of their lives
- Compassionate curiosity about how and what they make meaning of in life
- Communication that is honest and direct and not placating or patronizing
- Respectful kindness honoring boundaries on both sides
- Willingness to be wrong, own mistakes, and repair therapeutic impasses
- Room for conflict and confrontation to inform and deepen the connection.

These relational conditions create breathing space for clients amidst their skepticism, self-doubt, and panic (aka resistance). They help the client to dare to stay, trust, and risk often when not wanting to and sometimes without knowing why. To the clinician, these relational conditions offer an opportunity to meet the client. Impassioned by each of these, we have

a presence to offer and we begin our invitation for our clients to engage. If it is accepted, the work of recovery can proceed.

**Active and worthwhile engagement.** Since most clients exist within the perceived safety of the ED “atmosphere,” the invitation we extend needs to be engaging enough to reach through the atmospheric resistance. Davis (2009a) speaks poignantly about “the need [at the beginning of treatment] to grab the patient’s attention to wrench her away from her relationship with the ED symptoms and toward the other person [the therapist] in the room” (p. 40). He emphasizes nontraditional manners of behaving (less formal and aloof, more personal and collaborative), while being mindful of appropriate boundaries, in order, “to get the [person] thinking and wondering about you so that she starts to experience the therapist’s presence” (p. 40).

In my practice, this “active and worthwhile engagement” (Davis, 2009b, p. 6) takes many forms: a comment about another NFL team if the client shows up with a Pittsburgh Steelers cap on; a compliment about the scarf or pendant a client wears to session; or an exchange about what the client’s “patronas charm or dementors” would be if the client shows up reading *Harry Potter 3* (Rowling, 1999).

Such interchanges, marked by spontaneity, curiosity, and considered bits of self-disclosure, create opportunities. For a moment, the attention of the client is disarmed and moves away from the ED toward the therapist (Davis, 2009a, b). A new form of “molecular bonding,” a client-allowed-crack in the resistance occurs. Somehow, through the fissures in the resistance, impact can be felt and true contact has been made.

**Embodied authenticity and being real.** As stated by Zerbe, perhaps “first and foremost [our] ability to be real and human [helps our client] to feel that she, too, [has] a chance to be real and human herself” (1995, p. 162). Beresin et al. (1989) describe the task of becoming real as central to ED recovery and an area in which mentoring is necessary. How we deal with a faux pas, unintended empathic lapse, or a less than graceful moment goes a long way in modeling the survivability of human imperfection, and the resiliency of relationship in the face of conflict, disappointment, frustration, and anger. These are feelings the client may have sought to avoid through the “protection” of their ED symptoms.

These real, authentic experiences in relationship, of relationship, provide exposure to a different perspective of humanness. For example, upon successful completion of a 7-year treatment course for chronic bulimia nervosa (BN), incest and abuse, a former client thanked me for my “true humanness” in our relationship. She named it as central to her “becoming a real human being again.” Remarkably, this was a client whose initial grappling with the questions and meanings of humanness and perfection yielded her the insight that in her internal logic, “humanness” had defined her perpetrator, while “perfection” had attempted to separate her from abuse and the abuser. She would interpret a cookie with her lunch, an unsatisfying interaction with a co-worker, or an extra pound on the scale when she weighed herself for the fourteenth time that day, as “really messing up.” In the face of such “intolerable humanness” and perceived failing by self or other, she would turn to punishing and severely denigrating behaviors. A core component of her healing involved her challenging this template in the ways she related to her body and self, as well as in thought, spirit, and action. Eventually she was able to reclaim a broader definition of humanness characterized by the alternative relational experiences she had in therapy, and slowly but surely, in the other places of her life. Loosening her grip on both

the concept and practice of perfectionism made room for a healthy acceptance of the imperfections that make her authentically human and real.

In a similar vein, how we honor our own boundaries and expect others to do the same, like taking a vacation, or regularly breaking for lunch, demonstrates the permissibility of basic human needs and desires, and the process of navigating between “not abandoning self for other” and “abandoning self for fear the other will feel abandoned.” How and whether we deal with or ignore a burp, hiccup, coughing fit, or tummy growl can illustrate the naturalness of body function and the vital legitimacy of having a physical self that requires both acknowledgment and care. Especially in ED treatment, the therapist’s embodiment is a powerful example and teacher. “Carefully tended and appropriately nourished, the therapist’s embodied experience can be ... a useful tool in the efforts to help clients navigate recovery” (Costin, 2009, p. 191), teaching them to tend carefully, nourish well, and even enjoy their own embodiment.

**Empathy and trust.** For client and clinician alike, it can be tempting to avoid, dismiss, or numbly barrel through those life situations and challenges that threaten to expose our vulnerabilities and flaws. When finally we risk facing the challenge or developmental life task, we are also taking the tender and calculated risk of being seen, tolerated, even loved “as our worst selves” (Derenne, 2006, p. 339), in our worst light. Clinicians who have been clients, whether for ED recovery or other forms of personal growth, know both sides of this abyss. Taking that leap, believing our extension of trust will not be betrayed or belittled, is the essence of trust.

Empathy, including empathic memory of what we have learned from the client, about the client, is required to facilitate this kind of letting go. Derenne (2006) notes that remembering details, both large and small, is one of the most essential aspects of her role as a child psychiatrist and fosters her ability to connect with ED clients and their families. After many years of practice, I am still humbled by how a client can be touched and surprised by my memory of their best friend’s name, the date of a particular loss they’ve endured, or the adjectives they’ve used to describe an experience in their lives. Cousin to active listening and mindful attending, empathic memory and present empathy, void of triteness, provide evidence to clients that they matter. Being listened to—heard, understood, taken in, remembered, without being intruded upon—is a reflection of the process of introjection and empathy without the loss of self, abandonment of self-identity, or annihilation of other so many clients fear.

This level of trust, then, potentiates the possibility for the client that even their “worst selves” might be tolerated without retaliation (Beresin et al., 1989; Derenne, 2006; Zerbe, 1995). Such are particularly critical moments in the therapeutic process, repeating multiple times in different forms at different stages of the therapy. Depending on the manifestation of the client’s worst self, often impacted by comorbid conditions or characterological constellations, it can be more or less intense/activating for both client and clinician. As in Dante Alighieri’s classic poem, *The Divine Comedia 1: Inferno* (1939), the “pilgrim,” like our clients, must not be left alone in the deepest spirals of Hell. Just as Virgil, fortified by the guide Beatrice, “stays the course,” so must we as clinicians, thereby deepening the therapeutic relationship and the work of healing.

**Endurance and frustration tolerance.** A high frustration tolerance, and the ability to endure ambiguity and the often lengthy ED recovery process, are essential qualities for the effective ED therapist (Andersen & Corson, 2001; Bunnell, 2009; Davis, 2009a, b; Derenne, 2006; Zerbe, 1995). Often permeated with high levels of anxiety and angst, ED treatment is

more like a cross-country trek than a 50-yard dash. For the therapist, “staying the course” requires a stamina characterized by practiced mindfulness and compassionate curiosity toward personal experiences of counter-transference, counter-reaction, and the registering of visceral information. Without it, clinicians can run the risk of foregoing what may be clinically indicated and instead doing what might feel “easier,” like end treatment prematurely, or more commonly, elect to avoid or placate rather than confront the therapeutic challenge. With “mindsight” (Siegel, 2009), informed decisions about if, how, and to what extent the therapist overtly uses visceral information, are matters of skill largely influenced by theoretical approach and timing.

Staying the course does not mean a symbiotic or parasitic joining with the client that results in collusion with the ED symptomatology, coddling or “water pouring” (Kvidera, 2007) in the fires of ED Hell. Instead, it is doing what is clinically necessary (e.g., expanding the treatment team or utilizing a higher level of care) with a mix of humanness, sound clinical judgment, honest feedback, and respectful confrontation while enduring the however-long haul of the healing journey.

**Humbleness and transparency.** Finding balance between humble confidence in our clinical opinions (Derenne, 2006), and a non-investment in being right can be a challenge. Narcissistic tendencies, the need to control, and competition with the client are not compatible with effective treatment (Andersen & Corson, 2001), as they replicate the very interpersonal dynamics our patients guard against through their ED symptoms (Beresin et al., 1989). Power struggles typically derail the process and certainly distract from our clients making changes or confronting their barriers to doing so.

At its heart, humbleness is the recognition that, while we may do our best to provide sagacious guidance and work in collaboration with the client, we are not in charge of the client's healing pace or decisions. This is not a cop-out, or reason to do our jobs less well. Neither is it justification for failing to improve in those areas in which we are deficient. Ultimately, it is the client's recovery, not our own, and not ours to do for them. We are neither savior, nor white knight, nor recast of another in their family or social system. Our honesty and transparency with clients on this matter demonstrates the regard we hold for them as fellow human beings, our belief in their inherent redemptive capacities, and our respect for their rights to personal power. It allows clinicians to hold the hope for healing without unrealistic expectations.

**Ability to self-nurture.** The daily practice of treating people with ED requires adequate self-nurturance in addition to our “base” of clinical training (Andersen and Corson, 2001; Derenne, 2006; Warren, Crowley, Olivardia & Schoen, 2009; Zerbe, 1995). Its importance is at least three-pronged: (a) to connect us with a source, singular or conglomerate, of abundance from which to receive and replenish our stores of ingredients; (b) to insulate us from chronic and debilitating burnout (Rubel, 1986); and (c) to infuse and enliven us both personally and professionally. To be of best service to our clients and to ourselves, we must contemplate and honor how, what, and by whom we are fed, as well as how we best digest, metabolize, and utilize this nourishment.

Professional self-care includes clinical supervision, peer consultation and, when appropriate, personal therapy (Andersen & Corson, 2001; Yager & Edelstein, 1987). Zerbe (1995), among others, adds to the requisites what I refer to as “convening the lineage,” reading or rereading the works of forebearers in our fields of practice. This practice provides perspective, space to breathe, intellectual connection, and a means to understand our own

counter-transference, improving both our clinical endurance and frustration tolerance. Developing a regular practice of continuing education, or a sense of community at professional conferences, may also serve to reconnect us to our source.

Personal self-care, of course, influences us as professionals. Healthy, satisfying relationships with friends, family, and colleagues, as well as interests and passions aside from work can remind us we need not be enveloped by the flames of our clients' ED infernos. The world is bigger and broader than what occurs within the four walls of our offices, just as our clients' worlds extend beyond the immediate treatment experience. Active engagement in our lives can keep us from a narcissistic investment in overvaluing our clients' progress as a measure of our being "good enough" as people and as clinicians.

### Summary of the Clinician's Ingredients

With a connection to source, or the something-bigger, however personally defined, therapists are more able to calibrate the workings of their intuitive sensibilities. Coordinating these sensibilities with the blending of our basic clinical knowledge, accumulated experience, clinical training, and psychotherapeutic techniques, allows us to finely adjust and appropriately titrate therapeutic interventions according to the stage of treatment and the unique needs of our clients.

Spiced with courage and pinches of appropriate humor, levity, creativity, and adaptability, and folded into the therapeutic alliance, "non-possessive warmth" (Andersen & Corson, 2001, p. 356), "unconditional positive regard" (Rogers, 1961, p. 47), "active and worthwhile engagement" (Davis, 2009b, p. 6), embodied authenticity, being real, empathy, trust, endurance, high frustration tolerance, humbleness, transparency, and an ability to self nurture, heighten the likelihood of success in ED treatment. The question remains: If these are the essential ingredients for the clinician, what exactly are the fruits of our labor meant to help produce?

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## THE SUCCESSFUL CLIENT'S RECIPE

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### Product or Process: Averting Disaster in a Recipe for Recovery

Nowhere is the scientist/practitioner gap in the ED field more gaping than when it comes to answering this most elemental question: What is recovery? Fundamental to this inquiry is in whom, and by what processes, we invest the power to decide. Locating the sources of definitive authority (i.e., in the researcher, clinician, patient, and/or caregivers) determines the means by which we seek answers. Views from the ivory tower, and those from the therapy couch, provide dramatically different vantage points. The imperative to integrate these perspectives is where researchers, clinicians, and patients may ultimately find common and fertile ground.

The unfortunate divide in definitions of ED recovery parallels empirical design lines; exclusively quantitative or qualitative approaches yield vastly different results. Language is instructive in this discourse. Objective, static "outcomes" are typically the subject of quantitative research, whereas the subjective, process of "recovery" is the object of qualitative investigations. Kazdin (2009) suggests that qualitative research is a "natural way of bridging

research and practice," emphasizing the need for multiple methodologies as well as their complementarity (p. 277).

A fundamental criticism of traditional quantitative ED research involves the nearly exclusive focus on the physical parameters of recovery from what are clearly biopsychosocial illnesses. Examining only the overt symptoms (e.g., restoration of weight or menses) and grouping outcomes ignores the psychosocial and spiritual dimensions of ED recovery as well as the diverse and essential personhood of the individuals subject to their torment. Emphasizing the need for outcome research to include narrative, and qualitative reports, *Zerbe (2008)* succinctly states that the patient is always an "n of 1" and should be "considered as a human being first, not simply as a member of a diagnostic group" (p. 289).

The remainder of this chapter will review "reports" from both sides of the empirical design divide, provide suggestions for future investigative efforts, and conclude with a synthesis of what researchers, practitioners, *and* patients bring to bear on the definition of recovery and how it is best mediated.

### Outcome Literature: Coming in From the Outside

Fifty years of quantitative research devoted to ED outcomes has provided extensive data, despite failing to provide comparable, consistent, and clinically meaningful definitions of what recovery entails (*Berkman, Lohr & Bulik, 2007; Couturier & Lock, 2006; Jarman & Walsh, 1999; Steinhausen, 2008; Wonderlich, Gordon, Mitchell, Crosby & Engel, 2009*). Inconsistent definitions of successful outcome, as well as variations in design, measures, outcome ratings, dependent variables, populations, diagnostic categories and criteria, and the duration of follow-up, have generated an unwieldy body of literature with radical discrepancies. Indeed, given published ranges of recovery rates between 0–92% for anorexia nervosa (AN) (*Steinhausen, 2002*) and 13–69% for BN (*Herzog et al., 1993*), achieving recovery could be metaphorically construed as either a cakewalk or a death march. Additionally, these methodological inconsistencies compromise the practical interpretations and implications of the outcome data. For example, definitions of outcome applied to variable patient populations (e.g., inpatient vs. outpatient) generate different results with clinically meaningful relevance. Randomized, controlled therapeutic trials, limited mostly to tertiary care sites, are associated with high dropout rates and poorer outcomes, and their subjects may not be representative of the ED population typically seen in therapists' offices (*Johnson, Lund & Yates, 2003; Steinhausen, 2002; Zerbe, 2008*).

**Definitions of recovery in quantitative outcome research.** Despite *Morgan and Russell's (1975)* seminal efforts to establish and expand recovery criteria for AN to include the physical, psychological, and social aspects of functioning, subsequent research inconsistently assessed all these factors. The majority of succeeding AN outcome research relied solely on the physical parameters of weight, menses, and eating symptoms (*Steinhausen, 2002*). Similarly, researchers have narrowly equated a positive outcome for BN with cessation of bingeing and purging (*Jarman & Walsh, 1999*). These "outside" measures of recovery provide researchers and clinicians with static snapshots of behavioral control—momentary "product" analyses, which fail to inform us about the unfolding, multidimensional "process" of recovery.

A second common definition of recovery is simply "absence of diagnosis," meaning that the patient no longer meets the full diagnostic criteria of AN, BN or binge-eating disorder

(BED). It is not clear if these patients would otherwise meet criteria for Eating Disorders Not Otherwise Specified (EDNOS), the most frequent ED diagnosis, with comparable psychopathology to AN and BN (Fairburn et al., 2007). Moreover, patients may continue to be in psychiatric distress despite being considered subclinical or “recovered” from the gross physical and behavioral features of EDs (Jarman & Walsh, 1999). As Zerbe (2008) notes, “patients will not [achieve] life fulfillment if they still have poor social networks, feel badly about their self-image and personal well-being, lack a sense of belonging...or struggle with a lack of self-cohesion” (p. 288).

Insight is no more curative than behavioral control. What research equates with endpoints in treatment (symptom resolution), clinicians consider as starting points in recovery. From a clinical standpoint, until patients are nutritionally and physically stable, the real work cannot begin. In fact, research on AN recovery has demonstrated that *only* women who had, in addition to behavioral improvement, *also* achieved cognitive recovery, were “indistinguishable from female controls on self-report measures of body dissatisfaction...general symptomatology, endorsement of the thin ideal...drive for success, fear of failure, harm avoidance...perfectionism and self-esteem” (Bachner-Melman, Zohar & Ebstein, 2006, p. 700).

Thirdly, Steinhäusen (2002) describes ratings of global outcomes (good, fair, poor) as the most common form of AN recovery classification. This nondescript conceptualization of recovery is subject to the same criticism noted above, as freedom from overt, clinical symptomatology is not equivalent to eradication of the illness. Lastly, contemporary efforts to remedy the constrictive definitions of ED recovery in quantitative research have reincorporated measures of psychological and psychosocial functioning (e.g. Noordenbos & Seubring, 2006), such as reductions in fears and preoccupations about weight and food, and improved body image. Given that weight restoration tends to occur sooner and more often than psychological improvement in AN, outcome criteria must incorporate assessment of emotional and cognitive functioning (Couturier & Lock, 2006; Jarman & Walsh, 1999; Steinhäusen, 2002). Quantitative analyses of outcome are beginning to include quality of life measures (Adair et al., 2007), contributing timely and cogent insights into our understanding of recovery. Although still only “product” assessments, these efforts attempt to examine the full-bodied, robust and complex progression of recovery.

**Duration as a defining factor in recovery.** Empirical inconsistency in durations of asymptomatic status (from 8 weeks to 3 years) further obscures the outcome picture (Steinhäusen, 2008; Von Holle et al., 2008). In general, stricter definitions requiring longer durations of both weight and psychological improvement are associated with the lowest recovery rates for both AN and BN. Investigators have recently rallied to utilize empirically derived and tested consensus definitions that incorporate the full range of ED symptomatology evaluated over a sufficient period of time (Couturier & Lock, 2006; Frank, 2005; Keel, Mitchell, Davis, Fieselman & Crow, 2000; Kordy et al., 2002; Von Holle et al., 2008). These investigations clearly distinguish remissions (briefer periods of symptom absence) from recovery (maintenance of remission for a predetermined amount of time), but the duration criteria remain critically different.

Kordy et al. (2002) suggested a 1-year minimum duration of symptom abstinence, including psychological parameters of recovery. Strober, Freeman & Morrell (1997) indicated that it took nearly 5 years for physical symptoms of adolescent AN to fully recover and another 2 years for the psychological factors to normalize. Von Holle et al. (2008) utilized

a 3-year period of complete symptom abstinence to assess temporal patterns of outcome in a transdiagnostic sample. Their findings yielded sobering long-term outcomes. After 15 years, only 16% of those with AN, and 25% of those with BN, met recovery criteria. They concluded that 10 years post ED onset appears to be the critical juncture in which recovery either consolidates or the condition becomes chronic.

## Summary of Outcome Definitions

Methodological variability is the one consistent factor in ED outcome literature, generating data which suggest recovery is as possible as it is improbable. Patience and perseverance, previously noted as integral ingredients in the successful ED treatment provider, appear equally essential to the patient. Quantitatively derived definitions of recovery are limited by their inherent depiction of it as a static state: a product versus a process. Additionally, these approaches locate the source of definitive authority in the researchers, creating arbitrary and inconsistent determinants of outcome, and overlooking the nuances, voice, and perspectives of the patients and their caregivers. Finally, populations conspicuously overlooked in outcome research include children, males, EDNOS, BED, late onset EDs, minorities, and primary caregivers.

## Recovery Literature: Coming Out from the Inside

The shortcomings of quantitative clinical research are ubiquitous (Kazdin, 2009). The above synopsis is not meant as a wholesale indictment of research practices; indeed, data derived from quantitative inquiries provide invaluable information about group norms and variables. The relevant gap is less between science and practice as it is within scientific practices. As with most things, “the devil is in the details” and the preferential emphasis on quantitative approaches to characterize and assess ED recovery has undermined our efforts to both understand our patient’s torment and improve treatment.

What has been crucially missing are inquiries that move beyond efforts to *understand* recovery in favor of those that seek *innerstanding* (Kimura, 2004) from within the canvas of our patients’ lives.

Old paint on canvas, as it ages, sometimes becomes transparent. When that happens, it is possible, in some pictures, to see the original lines: a tree will show through a woman’s dress, a child makes way for a dog, a large boat is no longer on an open sea. This is called “pentimento” because the painter “repented,” changed his or her mind. Perhaps it would be as well to say that the old conception, replaced by a later choice, is a way of seeing and then seeing again. (Hellman, 1973, p. 3)

Recovery is like Hellman’s pentimento—a way of seeing and then seeing again. “Arguably, what patients know AN to be is even more important than what psychotherapists and other health professionals know” (Surgenor, Plumridge & Horn, 2003, p. 23). Professionals on both sides of the gap have failed to provide a clear, consistent, clinically meaningful definition of recovery that is process and diversity-oriented, *and* informed by those who have lived the experience. To reach innerstandings of recovery, we must get out of linear models of questioning derived from “experts” perspectives, and talk with the real experts—those who have experienced recovery.

In order to recover the definition of recovery from obscurity, we need to bring all of the relevant parties and perspectives to the proverbial table, and listen our way into the questions and answers rather than only assess answers to predetermined questions. Qualitative research is the ideal forum in which multiple voices and viewpoints can be distinguished and illuminated.

### Qualitative Research: Bridging the Tower and the Trenches

Following his tenure as president of the American Psychiatric Association, Kazdin (2009) underscored the priority of improving patient care by bridging science and practice through the use of qualitative research:

It includes an intense, detailed, and in-depth focus on individuals and their contexts...[It] can identify details of the experience; generate new theory, constructs, and measures....Traditional quantitative group research may not [be] able to reveal novel themes and processes of recovery in such an in-depth way (p. 277).

Zerbe (2008) eloquently echoed and articulated the imperative to consider ED patient's viewpoints in clinical research and practice. "Qualitative data speak to the humanity of the individual, they immerse themselves in those characteristics [patients]... include in constructing a life well lived...and with those specific skills and strengths that enable...[patients] to love...work [and] face down destructive symptoms" (p. 291). Maine (1985) was a forerunner in efforts to elucidate patients' voices in her phenomenological research regarding their understanding of the process of both their illness and recovery. Bruch's (1988) pioneering work, *Conversations with Anorexics*, and MacLeod's (1987) *The Art of Starvation* provided rich and compelling peeks into the inner sanctum of AN, while Beresin et al. (1989) offered an early empirical analysis of patients' views on recovery.

Fortunately, qualitative research regarding ED recovery is burgeoning. Some applications of these methods, such as feminist grounded theory approaches, have provided critical contributions to the recovery literature, fleshing out patients' perspectives well beyond restoration of weight and other physical parameters of improvement (Bowlby, 2008; Garrett, 1997; Jarman & Walsh, 1999; Keski-Rahkonen & Tozzi, 2005; Lamoureux & Botorff, 2005; Noordenbos & Seubring, 2006; Nordbo et al., 2008; Serpell, Treasure, Teasdale & Sullivan, 1999; Serpell & Treasure, 2002; Surgenor et al., 2003; Tozzi, Sullivan, Fear, McKenzie & Bulik, 2003; Weaver, Wuest & Ciliska, 2005). Paralleling the outcome literature, most studies have examined the phenomenology of AN and BN, while recovery perspectives from patients with BED, EDNOS, and late onset ED, as well as males and children, have been categorically overlooked. Unlike the outcome literature, however, the findings in the qualitative studies have yielded remarkable consistency with regard to how patients define, view, and experience recovery.

The most distinct difference between quantitative and qualitative definitions of recovery is that patients clearly view recovery not as an endpoint, but as a multidimensional process in which they are simultaneously and variously making progress *and* experiencing setbacks (Pettersen & Rosenvinge, 2002). Lamoureux and Botorff (2005) portrayed this experience as patients "inching away from anorexia," quoting one patient as saying, "*that's what characterized the struggle for me...the forward and the back*" (p. 175). This seeming incongruence is an ordinary occurrence in the clinical context: the same week a patient skipped her snacks, she risked conflict in connection, genuinely expressed and experienced disquieting feelings,

and/or made a decision without seeking another's approval. As improvements within the various dimensions of the recovery process do not occur in a linear, systematic fashion, the outcome literature has been of limited use to clinicians.

In their study of the journey of recovery from BN, [Peters & Fallon \(1994\)](#) described three main dimensions: denial to reality; alienation to connection; and passivity to personal power. [Platt \(1992\)](#) also conceptualized recovery from BN as a three-stage developmental process: (a) shifting the relationship to the ED from an ego-syntonic to ego-dystonic status; (b) learning to tolerate uncomfortable physical and psychological states without ED symptoms; and (c) improving self-care and self-esteem through adaptive coping skills. Consistent with other reports ([Lamoureux & Botorff, 2005](#); [Pettersen & Rosenvinge, 2002](#)), coming to view their illness as the problem rather than the solution, appears to be a fundamental necessity for patients. Beyond the initial "unleashing" of denial, patterns of progression with regard to their physical, emotional, relational, spiritual, and sociopolitical well-being are profoundly personal and unique. I wrote of this in my own recovery in 1980 (McGilley, personal diary):

If I extract myself to a different dimension, I'm aware of how tortured I am by my turbulent emotional inertia. I wonder, stoically and fearfully, if in like comparison, Sisyphus would have pursued his existential task of rolling his ill-fated rock up the hill had he seen his dilemma from afar? Faced solely with the rock, I too might persist, if only for the purpose of the struggle. But now, faced with both the rock and the weighty awareness of the "Big Picture," I find myself frantically paralyzed. In a frenzy of motionlessness. Falling with my feet stubbornly planted, gathering bruises that refuse to expel their ache. Even more frightening than the prospect of enlightenment, is that first real jolt of sentience, the piercing scream of nerves released from denial's hearty grip. Isn't there an internal gate-keeper, an emotional parachute that will ensure I don't reenter the realm of my senses free-fall and fragment into so many brittle pieces?

Across diagnoses, methods of assessment, and duration of illness, patients were unwavering in their experience that recovery entails something akin to the painter's repenting: some version of a reconciliation or reunion with one's self. Various described as "finding me" ([Weaver et al., 2005](#)), reclaiming oneself as "good enough" ([Lamoureux & Botorff, 2005](#)), or simply as "self-acceptance" ([Pettersen & Rosenvinge, 2002](#)), recovery demands a willingness to be "real *again*, vulnerable *again*, to the full range of human experience, all shades of gray included. Viewed from the anorexic 'shadowlands,' this invitation appears to be an absurd request, something like re-exiting the birth canal after achieving our full adult size" ([McGilley, 2000](#)). As a current patient, waxing and waning in the early stages of recovery defines it: "Recovery is a continuum of finding and [reconnecting] the part of 'you' that has been disconnected for so long, and...aligning this scared, shadowed self with a new, healthy self ready to make the transition into new life."

In one of the few qualitative analyses to include a mixed diagnostic sample, [Pettersen and Rosenvinge \(2002\)](#) used an open-ended interview process to assess what factors were helpful in recovery and what recovery meant to them. Patients were required to have received treatment and to have had an ED for at least 3 years. The majority of the sample had EDNOS, and the rest were nearly equally divided between AN, BN, and BED. The overarching motivation to recover was the desire for a better life. Participants' definitions of recovery were classified into seven general aspects: (a) accepting self and body; (b) ceasing to allow food to dominate life or be used to resolve problems; (c) finding a life purpose; (d) identifying and having the courage to express emotions; (e) diminishing anxiety and depression; (f) fulfilling one's

potential versus conforming to other's expectations; and (g) improving social functioning. Two other findings are noteworthy. Firstly, participants noted the capacity to "function sexually and emotionally in a relationship with a stable partner" as vital to their experience of recovery (p. 68). Issues related to sexuality are rarely mentioned in the recovery literature. Secondly, referring to the mixed blessings inherent to recovery, participants emphasized "[experiencing] life as rather difficult *without* their eating disorder" (p. 68). In direct contrast to outcome literature which necessitates symptom abstinence as defining in recovery, these patients "defined themselves as recovered despite the presence of symptoms of eating disorders, anxiety, and depression" (p. 68). The authors concluded that "symptom reduction may not stand out as a goal *per se*, but rather as a means to accomplish more functional interpersonal relations, thinking, and problem solving strategies" (p. 69).

Space limitations do not allow for a full rendering of the rich and nuanced aspects of recovery unveiled by qualitative research. However, a "recipe for recovery" derived by an inpatient group I once conducted, illustrates the concordant and enduring nature of recovery phenomenology (Box 12.1).

Whether EDs are curable or chronic, and/or whether a patient is viewed as recovered or recovering is distinctly debatable among professionals and patients (Root, 1990; Schaefer, 2009). Costin (2007b), a recovered therapist, is decisive in her view that recovery is fully obtainable. Once recovered, food and weight have been put into proper perspective and

### BOX 12.1

#### RECIPE FOR RECOVERY

1 strong dose of commitment  
 1 cup honesty  
 1 cup faith  
 ½ cup openness (assertiveness)  
 ½ cup positive attitude  
 ¼ cup group therapy  
 ¼ cup individual therapy  
 ¼ cup support from family and friends  
 1 heaping cup of sexuality  
 1½ cups self-esteem and identity  
 1 cup moderate exercise with a  
   good body image  
 1½ cups of love  
 1 cup of reckoning history  
 1½ cups sense of humor  
 1 cup food  
 Designated dose of medications

Start out with a strong dose of commitment. Mix in honesty and faith. Combine attitude with openness and add until thoroughly blended. In a separate bowl, mix group therapy, individual therapy, and family support. Beat well and *slowly* add sexuality. Peel identity down to the core and stir in self-esteem. Generously add love. Fold in food and humor, alternating with sifted history. Carefully combine the first bowl with the second. Pour into a well-greased body image. Bake at 350° as long as needed to become real and satisfied.

When cooled, top with 1 cup moderate exercise and medications as needed. Result: Healthy, happy, whole person who loves herself!

“what you weigh is not more important than who you are.... You will not compromise your health or betray your soul to look a certain way, wear a certain size or reach a certain number on a scale” (p. 164). A former patient, Claire, several years into alcohol and ED recovery, offers an alternative definition and perspective:

Recovery...cannot be measured. It is not tangible or visible. It lies within the individual and during the process manifests itself in, although subtle, outward signs. Recovery is finding the courage to tend toward things that bring benefit to health and spirit even when in some cases the individual tends to gravitate toward destructive or harmful behaviors. It is constantly evolving and changing. Therefore, I don't think we ever truly reach a 'recovered' state. We are spiritual beings in human vessels and we won't be fully restored until we are fully spirit.

Another patient, a group member and dear friend of Claire's, whose illness and recovery unfolded in a parallel fashion, respectfully disagrees:

Although I am on a continuum of self-improvement, I consider myself recovered. The switch from 'in recovery' to 'recovered' happened when I realized that no matter what—through illness, death, despair, and the darkness of depression—I would never go back to where I was. I still feel pain, I feel it quite often. The difference is that I have finally figured out that food or lack thereof will not ease the pain. I now cry it out, dance it out, talk it out, write it out, sleep it out, sing it out, and laugh it out. I might talk too much, move too much, cry too much and feel too much—but I will choose that 'too much' over the nothingness that the disorder gave me any day. I will never...starve it out again. It doesn't work, and that's one lesson I've learned that I just won't forget.

My model embraces both perspectives. Patients fundamentally recover from the active symptomatic aspects of their ED, what [Schaefer \(2009\)](#) describes as “Recovered (Period),” while remaining in a process of recovering from the underlying traumas, intrapsychic and interpersonal conflicts, emotional and temperamental vulnerabilities, and cultural stressors that co-conspired to culminate in the onset of their ED.

Spiritual issues have long been underscored in the recovery literature despite being more newly emphasized in academic forums. Somewhere within the recovery process, a spiritual shift occurs. It could be inspired by an AN patient's “first” plate of crispy fries, or by being reflected in the eyes of their beloved, but sooner or later, this dimension is tapped. [Beresin et al. \(1989\)](#) likened recovery to a psychological rebirth, while others have noted reconnecting with nature, finding purpose and making meaning of one's life ([Garrett, 1997](#)). In my own case, the existential leap recovery required had to do with living, loving, and losing in what had otherwise literally become an unbearable world: “Why live if loving hurts so much?” ([McGilley, 2000](#), p. 5). For many of us, finding our place in the world, a sense of belonging, or our “connection to source—or the something bigger,” is the redemptive blessing of recovery.

Two of the qualitative research contributions on ED recovery warrant further mention. The first provides a rare effort to elaborate a theory of the recovery process. Using a feminist grounded theory approach, [Weaver et al. \(2005\)](#) analyzed interviews of twelve women recovering from AN to discern “the central organizing process for how women recover” (p. 190). They constructed a theory of self-development, a dynamic helix, in which women move from “perilous self-soothing to informed self-care” (p. 191). In perilous self-soothing, patients wrestle with issues of identity and status in society. In this model, AN is understood as

a means of providing recognition and a contrived identity at the expense of compromised health and well-being. Through improved self-awareness, self-differentiation, and self-regulation, recovering patients reach a turning point labeled “finding me” in which they gradually move towards informed self-care. This stage involves developing a sense of one’s strengths and weaknesses, managing emotions, and maintaining intimate and meaningful relationships. Of greatest relevance is their comment regarding the social underpinnings of EDs and what I’ve referred to as the “innerstandings” of the recovery process. Emphasizing that recovery factors and their impact must be understood in context, they concluded that: “both perilous self-soothing and informed self-care arise from women’s interactions within social structure and not as individual intrapsychic processes, [underscoring] the inappropriateness of relying on personality characteristics, discreet behavioral responses, and single events to evaluate AN and its recovery” (p. 202).

Finally, [Jarman and Walsh \(1999\)](#) were prescient in their efforts to integrate the best of what we have learned about recovery from the research/practice fields. They offered four compelling suggestions: creating a comprehensive biopsychosocial model of recovery; using both qualitative and quantitative methodologies including client’s views; recognizing the limitations of different measures and methods; and connecting ED recovery research and other psychotherapy process and outcome research.

By 2009, we had achieved moderate success, at best, in applying these suggestions. Much remains to be done before we can confidently, consistently, and comprehensively evaluate and elucidate the experience of recovery from all informed perspectives.

## CONCLUSIONS: BRIDGING EXPERIENCE AND EMPIRICISM

Just as the client’s voice matters in the treatment process, so should it be included in efforts to define outcome. An integrated use of quantitative and qualitative research approaches would complement and expand traditionally derived empirical data. By bringing all the relevant parties to the table, “a combined methodological approach could also enable a multiple stakeholder (e.g. client, clinician, academic) perspective to be incorporated into the evaluation process” ([Jarman & Walsh, 1999](#), p. 784). Finally, the perspective of recovered therapists is just beginning to gain serious consideration in the field, lending another gap-bridging dimension to this important inquiry ([Bloomgarden, Gerstein & Moss, 2003](#); [Bowlby, 2008](#); [Costin, 2009](#); [McGilley, 2000](#)).

A change in language may also invite new perspectives. The word “integrity”, which means “the state of being whole, entire, or undiminished,” seems to better capture the essence of what we’ve been referring to as recovery. As [Hillman](#) describes (1994), integrity also has to do with a kind of wisdom, a way of “knowing together” and “accessing a more subtle kind of wisdom that depends on letting go of those old mental categories” (p. 86). If we were to conceptualize recovery as a return to a state of wholeness, and we were to go about assessing it with thinking hearts, what more could we learn about the harrowing world of EDs and the expansive world beyond its borders?

Fitting and timely, [Siegel \(2009\)](#) provides a compelling neurobiological basis for the concept of integration, and therapists’ roles as integrators. Emphasizing the relational capacity for changing brain structures through the sharing of “information flow,” [Siegel](#)

argues that specific clinical interventions can literally stimulate the integrative fibers of the patient's brain. Fostering this "vertical integration" restores or improves the patient's body/mind connection, so critically impaired in the ED population. "Health," in Siegel's conceptualization, is defined as integration. "Harmony" is the subjective experience of integration. Perhaps recovery is best likened to a process of seeking harmonic healing.

In sum, bridging the research/practice gap is going to require a fundamental shift in how we approach inquiry (from asking specific questions to inviting open dialog), the degree of control we exert over variables, and the kind of consistency we expect from the answers. Certain ambiguities must be tolerated and accepted; such is the nature of both science and human healing. "Science is not about control. It is about cultivating a perpetual condition of wonder in the face of something that forever grows one step richer and subtler than our latest theory about it. It is about reverence, not mastery" (Power, 1992, p. 411). Like those we treat, we succumb to the same alluring qualities of ease and concreteness in our efforts to evaluate the hard and fluid complexities of recovery. Clinically meaningful outcome research requires contextually and collaboratively considered concepts of recovery and its fostering agents. Only then can we begin to define a true recipe for success for those suffering with ED.

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