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BECOMING “WHOLE” AGAIN: A QUALITATIVE STUDY OF WOMEN’S VIEWS OF RECOVERING FROM ANOREXIA NERVOSA.

Abstract

Objectives: The study explored women’s perceptions of their recovery process and what recovery means to them in order to gain a better understanding of the predictors of recovery from anorexia nervosa (AN). **Method:** The data were analysed using Interpretative Phenomenological Analysis (IPA). Semi-structured telephone interviews were carried out with fifteen women who received a diagnosis of AN and defined themselves as recovered/in recovery. The women were recruited from **beat**. **Results:** The women described their experiences in terms of four broad areas; being anorexic; dissatisfaction with treatment; process of change; and being recovered. Whilst anorexic, women experienced a series of dichotomies. In particular, they described splits between mind and body, AN behaviour and cognitions and rational and irrational side. Recovery occurred when the above dichotomies became resolved. **Conclusion:** Recovery occurs only when an individual becomes “whole” again, which is a lengthy psychological process. Therefore, it is also essential that therapy is not discontinued after patients reach their target weight.

Keywords: anorexia nervosa, process of recovering, relationships, resolution of dichotomies

Previous research into recovering from AN has predominantly focused on defining the recovery from AN the patient perspective¹⁻⁶ and looked at predictors of recovery using quantitative criteria such as length of treatment and follow up or age at onset⁷⁻⁹ with mixed results.

Steinhausen⁷ reviewed 119 studies on recovery from EDs and concluded that “chronicity leads to poor outcome”. He also found that longer duration of the follow up and younger age at onset of the illness were associated with better outcome. However, a different study⁸ found that lower age at onset was predictive of readmission of patients within 12 months of completing their initial treatment. Contrary to these findings, another study⁹ found that age at onset was not a significant predictor of outcome.

Some authors suggested that comorbidity such as presence of depression and anxiety disorders leads to negative outcome in AN.^{7,10} It has been also argued that readiness for change is a significant predictor of treatment outcome in AN¹¹.

Despite longstanding research in this area, recovery from AN remains to be a controversial and not very well understood topic. Given the high mortality rate and the lack of understanding in terms of prognosis, enhancing an understanding of recovery has important clinical implications. Research has shown that recovery rates have not improved despite many developments in treatment and research on treatment effectiveness.¹²

Whilst some researchers argue that that recovery can be equated with symptom abatement^{13,14}, others contend that psychological factors should be factored in evaluating recovery.^{5,15} At present, there is no consensus as to how psychological factors should be assessed and comprehensive evaluation of recovery is rare, yet more clinically relevant.¹⁵ However, Couturier and Lock¹⁶ argued that to evaluate

comprehensive recovery is difficult for pragmatic reasons and therefore, using criteria for comprehensive recovery (including abatement of comorbidity) may not be feasible in clinical practice. After all, weight gain is easily quantifiable and therefore remains to be the primary factor in assessing recovery in eating disorders (EDs), followed by the presence/absence of disordered eating behaviours such as purging¹⁷.

However, there has been research to suggest that these behaviours are unable to significantly predict outcome in ED¹⁸.

Treasure and Schmidt¹⁹ argued that “*the outcome can be determined objectively*” (p.212) because patients’ treatment is effective when their weight loss is stopped and there is a reduction in anorexic behaviours. However, Fennig et al.²⁰ found that patients with AN who managed to recover their previous weight retained disturbed attitudes towards food and weight, continued to be depressed and obsessed about food and weight. This indicates that weight restoration does not constitute full recovery.

One qualitative study found that participants defined themselves as recovered whilst retaining some ED symptoms and disturbing eating patterns.⁶ This suggests that patients’ notion of recovery is different from that of clinicians who consider people to be recovered only when their symptoms are absent. They assert: “*symptom reduction may not stand out as a goal per se, but rather as a means to accomplish more functional personal relations, thinking, and problem solving strategies*” (p.69).

Fennig et al.²⁰ pointed out that an increasing number of patients with AN are discharged at below their target weight and this can explain poor prognosis and high relapse rates. They further contend that transition from inpatient to outpatient treatment is very difficult for AN sufferers because they lose structure and high levels of support. They concluded that patients need reassurance that their therapy will not be discontinued when their symptoms subside.

The literature review of previous qualitative research provides compelling evidence to suggest that subjective views on recovery differ from ‘objective’ views of recovery, according to which absent symptomology, healthy BMI (i.e. 18.5-24.9)²¹ and ‘giving up’ anorexic behaviours means that one is recovered. It is apparent that patients’ conceptualisation of recovery is more complex compared to what clinicians understand by recovery. It seems that patients perceive that clinical criteria for recovery underplay the importance of psychological factors such as self-acceptance and self-awareness² or feeling worthy and good enough.^{1,5} In addition, previous qualitative studies draw attention to recovery being a relational process that occurs in the context of close and supportive relationships¹⁻⁵ Some authors found that treatment did not facilitate recovery²⁻³, which indicates that processes outside therapy play an important part in recovery. Cognitive factors such as stopping obsessing about food and weight were also highlighted as important for recovery.^{1,22}

It has been also argued that recovery is “*a unique and subjective process*”²³, which entails integrating illness into one’s self-concept, learning to manage one’s self and reclaiming the self by taking control over one’s life. Therefore, to learn about predictors of recovery, it seems invaluable to explore what patients with AN regard as instrumental for their recovery.

Assessing psychological health by quantitative measures is difficult because it is a subjective construct. Therefore, this criterion had been neglected in research despite its importance for the recovery. In clinical practice, BMI and self- report questionnaires such as Beck’s Depression Inventory and Beck’s Anxiety Inventory are utilised in the assessment of psychological health. However, the author argues that using qualitative research methods is more appropriate for exploring the individual’s psychological recovery as well as their understanding of ‘outcome’.

The current study was concerned with tracking a process of recovery to gain an understanding of the mechanism of change and discover what are the predictors of recovery using qualitative research methods. Therefore, the present study aimed to explore women’s perceptions of their recovery process looking at the notion of recovery as a process rather than an outcome²⁴ and to explore what being recovered means to women. In the light of this, two research questions were examined: (1) How do women perceive their journey from AN to recovery? (2). What does recovery from AN means to women?

METHOD

Design

The study used a qualitative design with in depth semi-structured interviews.

Sample

Fifteen women over the age of 18, who received a diagnosis of AN, were treated for AN and defined themselves as recovered/in recovery were recruited for the study. Their profile characteristics are shown in Table 1 (at the end)

Procedure

Ethical approval was gained from the University of Surrey Ethics Committee. Participants were recruited from **beat** and the recruitment was twofold; the first, via beat’s research database, the second, via placing an advertisement on the beat’s web page. The following steps were undertaken in relation to the first recruitment route: A copy of the research protocol and evidence of the ethical approval from University of Surrey was sent to a research officer from **beat**. The research officer e-mailed an

invitation letter and information sheet to potential participants who fulfilled the research’s inclusion criteria. Those who were interested in taking part in the research contacted the researcher directly via e-mail. The researcher sent two consent forms to interested participants. One copy was for the respondent to keep and one was for the researcher. The researcher instructed the participants to sign and return one copy of the consent form in a pre-paid envelope. The researcher asked the participants to fill in a brief demographic questionnaire online. Once the researcher received the consent form and the questionnaire from each participant, she then contacted all participants via e-mail or telephone and arranged interview dates. In the second recruitment route, potential participants read the advertisement and the information sheet online and those who were interested to participate contacted the researcher via e-mail and thereafter, the same procedure as in the first recruitment route was followed. All interviews were conducted over the phone and lasted between 40-70 minutes.

The interview schedule

The interview schedule included open-ended questions such as: ‘Could you describe what did you find helpful/unhelpful in your treatment?’, ‘When (how) did you notice that your recovery has started?’, ‘What experiences were influential in your journey to recovery?’ ‘How did you know that you were recovered/in recovery?’, ‘What does it mean for you to be recovered/in recovery from anorexia?’

Data analysis

The data were analysed using IPA²⁵ because it focuses on the individual’s own accounts of their experiences and behaviours and locates these within the researcher’s own perspectives. The transcripts were read and re-read to ensure familiarity with the data.

For each interview a coding sheet was constructed. This sheet contained all possible themes and sub-themes for the interview. References to original material were recorded under each theme. From the individual summary sheets an overall list of themes was constructed. With continuous reference to the transcripts, shared themes and connections across the list of themes were made. All the verbatim transcripts were re-read to ensure that the themes were representative of the original material. Throughout the write-up process, themes and sub-themes were adjusted and illustrative quotes were identified.

RESULTS AND DISCUSSION

Women in this study described recovery from AN in terms of four broad areas; being anorexic; dissatisfaction with treatment; process of change and being recovered. These will be now considered.

Being anorexic

Anorexic behaviour: The women talked about “*dieting*”, “*restricting*” and “*controlling*” their food intake, which led to their considerable weight loss. The majority of women also used terms such as “*obsessive*” and “*secretive*” and described feeling compelled to continue their dieting behaviour despite losing a vast amount of weight. AN became an exclusive focus in women’s lives, “*consuming*” their energy.

Anorexic cognitions: The women talked about their reluctance to recognise that they had a problem. The majority of women described “*being in denial*”. Many women said that being anorexic was like having a “split personality”. Susan, for example, explained that she felt like two different people, the “*anorexic me and the other normal me.*” Whilst the normal part was rational, the other part was completely irrational. At

this stage, the irrational side was in charge as explained by Fiona: *“It is almost like your brain is split into two, you know that you should eat more and you shouldn’t do all that exercising but you are so driven by the other side”*.

Anorexic voice: Most women explained that the irrational side was dominated by an AN voice. Mary described the voice as: *“something else inside me that would overtake me...it drives you to do the most insane things”*. Being driven by the AN voice meant that women did not attend to their rational side, neglecting what their body needed (i.e. food) and thus split their mind from body. The body was firmly in charge, dictating to their mind not to eat. Chloe explained: *“you listen to that [AN side] and ignore what your body actually needs”*. The harsh AN voice thus condemned eating and told most women that when they eat, they *“should feel guilty (Paula)”*.

Anorexia as a means of communication Most women described that prior to developing AN, they felt *“unhappy”* and *“out of control”*. Many women talked about their quest for success and achievement and how they felt the pressure to *“perform”*, which was thwarted by their low self-esteem. Many talked about their perceived lack of control of their lives and how AN became a vehicle of control for coping with stresses and frustrations of everyday life. Other women developed AN whilst faced with transitional challenges. Two women talked about developing AN as a result of their childhood sexual abuse. They explained how they communicated distress via their bodies because using words was too painful. Thus, women in this study used AN as a maladaptive communication tool.

In previous research, participants also referred to being controlled by AN.⁵ It was apparent that whilst anorexic, the women used AN as a means of communicating their psychological distress. At this stage, their body/irrational side took priority over their mind/rational side. The women, however, were not able to verbalise their distress,

which is in line with previous research on alexithymia ²⁷ and hence, they used their body instead to communicate the distress. In other words, AN became a bodily expression of their psychological distress.

Dissatisfaction with treatment

Service related shortcomings: Many women described that gaining a diagnosis of AN was not straightforward. They talked about general practitioners’ (GPs’) lack of awareness about EDs and GPs’ condescending comments, which put the women off seeking further help. Several other women were frustrated about being placed on long waiting lists and not being able to access treatment earlier, which led to their health deterioration. Those who did not receive help from specialised ED services were disappointed by their therapists’ lack of expertise. Many described that their therapists did not know much about EDs or how to help them. Many women pursued private treatment because they felt unhappy about the quality of NHS care and the NHS staff’s lack of hope about their recovery. The standard of care was perceived by most women to be better in the private sector because as Sabrina put it “*private people were more positive and really wanted to help*”. Some felt they were not treated as unique individuals but rather as “*as a person with an eating disorder, as anorexic; there was no room for your personal circumstances or for your own personal recovery. It was like a machine like a conveyor belt...(Paula)*”.

Exclusive focus on weight: Many women also explained that clinicians believed they had recovered when they reached a target weight. However, all women felt that their weight restoration did not constitute recovery because they did not feel better about themselves and their cognitions about food did not shift. Some women, contrary to

clinicians’ views, perceived weight gain to be one of their “*lowest points*” on the journey to recovery. Diane explained:

“Oh my goodness I reached it [target weight] I think I put a lot of weight but a lot of mental things haven’t changed...It [treatment] was all very physical and they [doctors] didn’t look a mental side of things and although I did put on a lot of weight, they didn’t really take much into account what my mind was doing, they said, you look so much better, you must feel better, but inside I was like but I am not, I am really not!”

Therefore, Diane highlighted that mind and cognitions, not just body and behaviour has to be addressed by clinicians in treatment otherwise relapse may occur. Many women also explained that clinicians’ primary goal was increasing their weight and when this was achieved, clinicians had believed that the women were better. In contrast, most women expressed that reaching their target weight was only a starting point of recovery, which echoes contentions of Winston and Webster²⁶ who argued that psychotherapy needs to focus on underlying issues and “*attaining normal weight should not be seen as an endpoint*” (pp.361).

Process of change

Difficult journey: All women described how they gradually became better over time, which was perceived as a difficult journey. Many commented that their treatment was rushed, highlighting the importance of pacing the treatment to the individual’s needs and that clinicians should take a collaborative approach to treatment.

Using therapy/relationships: The majority of women described that they were not able to use treatment constructively until they became intrinsically motivated (i.e. wanting to change for themselves). Many talked about “*not feeling ready*”, and “*being*

resistant to treatment”. Relapse was attributed to the fact that they were extrinsically motivated to change (i.e. they entered treatment to please other people): “...*if somebody is just going through the motions, a/ they are not likely to get better and b/ if they do, they are going to relapse (Sabrina).*”

Therapy was described as helpful for acknowledging that AN was perilous. Many talked about feeling “*shocked*” when they had finally become aware of the “*damage*” they caused to their bodies. At this stage, therefore, they began to understand and gradually resolve their dichotomy between their mind and body and rational and irrational side. For example, Valerie explained:

“It was quite shocking as well to see the damage the starvation and restriction can have and how this affect not only your body but also your thought processes, so it was really interesting for me to see how it is closely intertwined...it was kind off strange because when I started to put on weight, my mood improved, my thinking improved, my general outlook improved...I was able to be a bit more rational...”

Many women commented that a shift from denial to acknowledging the problem led to change in their behaviour. However, they did not contemplate recovery until another dichotomy between AN behaviour and cognitions was resolved. For example, Stacey, similarly to Valerie, explained that when she put on weight, this helped her with counselling, however, it was until she understood the function of her AN behaviour, that she was able to connect with her cognitions and challenge her “*anorexic mindset*”, which subsequently led to the reduction of her obsessive behaviours. Many talked about the importance of understanding the causes for developing their AN. A further important facet of recovery that women commented on was having support from their families. Finding a boyfriend was also viewed by many women as very important for recovery. Having an intimate relationship in particular had helped women to feel better

about their bodies, increased their confidence and also fostered self-acceptance. It also allowed women to feel more hopeful about their recovery and helped them to connect with their emotions.

Managing emotions: Through treatment and supportive relationships, most women described they were able to connect with their emotions. In contrast, Valerie described that eating more was beneficial for labelling her emotions:

“Psychotherapy did start to change as well because I was what’s the word, more cogent, I could think more so rather than being in that oblige depressed state, I was able to be a bit more rational and logical...food intake helped me to identify emotions and connect with my emotions.”

Thus, for Valerie, managing her emotions had facilitated the resolution of the split between her irrational and rational side. Another woman, Jennifer described that whilst anorexic, she was detached from her emotions, however, finding a boyfriend enabled her to confide in him about her AN. This had helped her to connect with her emotions and she consequently became *“flooded with emotions”*. Other women commented that at this point of recovery process, they were able to acknowledge difficult emotions and openly discuss these. Thus, women used language as a communication tool as opposed to their body.

Acknowledging the consequences of AN: Many women also commented that AN led to many losses, such as a loss of academic life and friendships. Others acknowledged that AN prevented them reaching certain goals such as starting or finishing university, getting married and having children. Acknowledging the losses associated with AN led women to believe that they would be better off without AN. Many talked about *“being fed up”* and *“sick of anorexia”*.

Controlling the AN voice: The final stage of the women’s recovery process was controlling the AN voice. However, this was a gradual process, which varied among women. For example, Jennifer used yoga to counteract her voice, and Valerie externalised the voice of AN. The women commented that once they gained control over the voice, it had gradually begun to lose its power. Many associated controlled AN voice with recovery and controlling the voice with being in recovery. For example, Susan believed that one is recovered when: *it [anorexic voice] doesn’t control your life, when it doesn’t stop you doing things*. For Jennifer who has been recovered for seven years her “AN voice had disappeared”. For Chloe, who is in recovery, controlling the voice means getting “*to the point when I have that voice but I would not really listen to it*”. Controlling the AN voice is thus associated with the resolution of another dichotomy between the rational and irrational side.

Recovery was conceptualised as lengthy by all women, supporting previous research.²⁸ Many women also argued that recovery is complex which is in line with previous research.^{5,17} Women’s constructive use of treatment and relationships was clearly instrumental in their recovery because therapy and close relationships fostered trust and self-acceptance. This is in line with previous qualitative research.^{1,4} Receiving support from friends and family were also instrumental in recovery, which echoes previous findings.⁵⁻⁶

Being recovered

Ambivalence about recovery: Many believed, similarly to clinicians, that defining recovery is “tricky” and “difficult”. For those in recovery, the existence of AN voice and thoughts had made them question about whether one could fully recover. For

example, Ramila, in recovery, believed that *“you may never fully recover from AN, I think the voice is always there”*.

It was evident that women’s ambivalence was also linked to their internal struggles around weight gain. Indeed, all women said they found accepting weight gain difficult. This is because AN provided them with a sense of control and achievement: *“It [AN] was my way of feeling successful and different from other people, suddenly I felt huge...if you build your whole life about controlling what goes in your mouth and making sure that you don’t put on weight, it’s [weight gain] horrible, horrible (Susan).”* Despite the ambivalence, the women clearly appreciated that advantages of recovery outweighed the disadvantages of recovering and reflected on a multitude of benefits such as increased self-awareness, feeling stronger, more content and enjoying life.

Managing anorexic identity: The way women understood and managed their identity has also changed during the recovering process. Most women described that when anorexic, their identity was based on their appearance and AN defined them as a person. Many women explained that when they recovered, they started to acknowledge that other things apart from their body define them. However, giving up the AN identity was a difficult process for most women. For Jasmine who had AN for 7 years, giving up the AN identity was *“a huge risk because I was convinced I couldn’t be anything else”*. When she recovered after 9 years, she developed a new identity separate from AN:

“I have a new identity, I am a student, a friend, I have social life and I know that people I know now don’t see me as the anorexic, I might have a history of that but they see me as other things first (Jasmine).”

The way the women managed their new identity varied. Some described that AN had become incorporated into their new identity and acknowledged that although AN remained a part of their life, it did not define nor dominate them. However, for other women, recovery meant rejecting AN as a part of their new self-identity.

Description of full recovery: All women believed that a part of their full recovery was ending their obsession with food and weight and changing their AN mindset. They highlighted that changing AN cognitions is of vital importance for recovery and stated that psychological recovery does not automatically follow physical recovery, which can take several years to achieve. Many said that reaching target weight is only a starting point for full recovery. The majority of women believed that full recovery is possible, however, psychological recovery meant different things to different people. For Diane, understanding the connection between her body and mind facilitated her psychological recovery. Psychosocial adjustment was perceived to be important in recovery by several women. For example, Ethel described what full recovery means *...it is kind of enjoying life and a lot of things involve food, everyday things as well, going to work, because when I was ill I didn't want to do anything*. Ramila (in recovery) commented that although she still experienced symptoms of AN and did not reach target weight, she felt “*more comfortable*” within herself and felt she was “*clearly more healthy psychologically*”. In contrast, Barbara perceived she was still in recovery because AN was still “*captivating*” her thought processes despite reaching her target weight. Gillian, who suffered from AN for 15 years believed that recovery is “*not an end point*” and she would be “*always recovering*”. She explained that her doctor is however likely to believe that she is recovered because she has maintained her healthy weight for three years.

All women in this study firmly believed that they were not recovered until their obsession with food and weight had subsidised, which echoes the findings of previous research^{1,3}. The majority of women also clearly expressed that full recovery incorporates physical and psychological recovery and the latter does not follow the former spontaneously. Therefore, the results supports conclusions reached by previous research that psychological recovery must be incorporated in the definition of recovery from AN¹⁷ and that cognitive criteria must be also included in measuring recovery²².

CONCLUSION

The present study aimed to explore women’s perceptions of their recovery and what recovery means to them. The results show that women in this study describe AN in terms of four broad areas; being anorexic, dissatisfaction with treatment, the process of change and being recovered. Permeating all these areas was the notion of a series of dichotomies. In particular, the women described a dichotomy between mind and body, rational and irrational side, cognitions and behaviour and how these dichotomies are exacerbated by therapy, which focuses on one rather than both aspects of the divide. The women illustrated how recovery is characterised by these dichotomies being resolved. Whilst anorexic, the anorexic sees the body as taking precedence over the mind. AN is a bodily expression of psychological distress, i.e. the body expresses the distress which is exacerbated by therapy and therapists that focus on bodily classifications in terms of weight and diet. The dominant AN side is driven by the AN voice, which undermines a sense of self, allowing the body to be in charge. Full recovery occurs when the AN voice becomes muted via relationships boosting a sense of self, which includes a shift in power from body/AN side to mind/rational side so that

the mind/rational side can regain control and use language and relationships to express psychological distress.

It was apparent that the resolution of the dichotomies was achieved via supportive relationships, which ‘communicated’ to sufferers that they were worthwhile and their recovery was conceivable. In order to support people in their recovery journey, the therapist must address the patient’s cognitions and discuss alternative coping mechanisms after anorexic behaviour had been addressed. Many women reported that their weight gain was the most difficult time in their recovery process. Therefore, clinicians should not assume that patients are recovered on the basis of healthy BMI .

Arguably, the resolution of the dichotomies leading to psychological recovery is not an easy task and therefore it is also essential that therapy is ideally long-term. It is apparent that many women resented when psychological therapy was withheld after ‘physical recovery’ and many attributed relapse to withdrawing therapeutic support prematurely. The women also valued when clinicians recognized that recovery was very challenging for them and validated their resistance to change. They felt it was equally important that clinicians accepted their stage of change and they did not feel pressurised on their recovery journey. Some women felt that clinicians should be honest with patients that recovery is lengthy and advised clinicians that they must not rush this process. Some women highlighted that talking about expectations of recovery is invaluable as this enhances collaboration. It was apparent that most women resented being treated as a “textbook anorexic” emphasising the importance of the genuinely interested therapist who treats them as a “unique person”. Treatment should not therefore focus on anorexic behaviour at the expense of building a relationship and expressing authentic curiosity about the patient. Whilst all women emphasised that support from others was important, they primarily attributed their recovery to personal

responsibility and conscious effort, which was facilitated by supportive relationships and therapists that worked collaboratively with the patient to increase their responsibility for change.

The findings of this study illustrate that recovery is multidimensional and therefore that the evaluation of recovery should reflect this. One of the research implications would be to develop a standardised tool that could explore the client’s definition of recovery. This would inform the clinician whether his or her conceptualisation of recovery differs from that of patient and could serve as a potential tool for further exploration in therapy. Future research could focus on attempting to devise a recovery questionnaire that would incorporate questions on subjective recovery such as “When would you consider yourself recovered?, How do you define recovery from AN?” and incorporate more questions related to self-esteem and psychosocial adjustment rather than focusing predominantly on symptom abatement.

It could be argued that one of the weaknesses of this study concerned subjective definitions of recovery. The researcher did not affirm whether women were recovered with clinicians or relatives. A further weakness is that comorbidity such as depression and anxiety was not explicitly explored.

In conclusion, this study has added to the evidence base on recovery from the patient perspective. It is argued that the study makes two important contributions to current clinical and research literature. Firstly, the study illustrates that qualitative measures could be a useful tool for predicting the individual’s recovery. Secondly, recovery has multiple meanings and this impacts on a therapeutic process. Therefore, exploring the meaning and expectations of recovery should be incorporated in treatment of patients with AN. Women in this study described several predictors of recovery; such as feeling ready to engage in treatment and wanting to change, having an understanding of the

function of AN, finding a close relationship, stopping obsessing about food and weight and having a therapist who is knowledgeable about EDs. However, from women’s accounts, it emerged that the most important predictor of recovery is the resolution of splits between mind and body, AN behaviour and cognitions and the rational and irrational side. Therefore, clinicians should strive to guide anorexic sufferers to achieve the resolution of the above-mentioned dichotomies and treat patients with AN as multidimensional and “whole” beings to foster change.

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Table 1: Details of participants

Name	Age	Diagnosed (age of onset)	Treatment	Reached target weight?	Self-report recovery status
Susan	32	1993 (18)	Private counselling	Yes	Recovered (2000)
Jasmine	25	1997 (15)	CAHMS Inpatient EDU	Yes	Recovered (2006)
Paula	38	1988 (19)	Inpatient EDU*	Yes	Recovered (2003)
Jennifer	29	1996 (18)	Outpatient EDU*	Yes	Recovered (2002)
Sabrina	29	1996 (18)	Outpatient EDU*	Yes	Recovered (2002)
Diane	19	2003 (15)	Outpatient EDU*	Yes	Recovered (2005)
Gillian	35	1988 (16)	Inpatient, psych. ward	Yes	“Always recovering” (in recovery since 2004)
Valerie	30	2003 (26)	Outpatient *	Yes	Recovered (2006)
Fiona	49	1974 (16)	Inpatient EDU	Yes	Recovered (1986)
Ramila	28	2002 (23)	Private counselling	No	“Semi-recovered” (in recovery since 2005)
Ethel	23	2002 (16)	Inpatient EDU	Yes	In recovery since 2006
Barbara	25	2004 (22)	Inpatient EDU	No	In recovery since 2006
Chloe	23	2000 (16)	Inpatient EDU*	No	In recovery since 2006
Stacey	21	2004 (18)	Private counselling	Yes	In recovery since 2006
Mary	19	2004 (16)	Inpatient EDU	Yes	Recovered (2007)

EDU= eating disorder unit (NHS)

* = also received private treatment