Recovery from Bulimia: What Helps in Healing

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

There is an astonishing presence of eating disorders in American culture today, affecting upwards of 11 million individuals, and the treatment for these disorders is becoming increasingly comprehensive. Bulimia nervosa is one of the most common eating disorders, involving episodes of binge eating followed by compensatory behaviors to rid the body of food for fear of weight gain. Using a holistic and procovery-based framework, the present study focused on the perspectives of individuals who described themselves as being in recovery from bulimia and their stories of what helped in the healing process. This researcher created a mixed-method online survey to examine the types of treatment accessed by those who had recovered from bulimia, their attitudes about recovery, and their descriptions of what changed with their relationships to food, body, self, and others during recovery. Descriptive statistics were run on the quantitative data collected, and content analysis was used to describe the responses to the qualitative questions.

Participants strongly believed that recovery from bulimia was possible, but achieving it involved significant input from professional, non-professional, and spiritual realms. Professional services were found to be the most important aspect of the recovery process. Spirituality was also a powerful source of strength in healing from bulimia for many participants, though it was not a resource used by the majority. Social workers can use the anecdotal results from this study to provide a realistic, yet hopeful, vision of healing from bulimia to clients who still struggle with the disorder.
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Recovery from Bulimia: What Helps in Healing

The prevalence of eating disorders in America is a persistent and growing problem, with as many as 10 million women and 1 million men struggling with anorexia or bulimia nervosa at any given time (NEDA, 2008). There are many more millions of people who struggle with binge eating disorder and sub-clinical levels of body dissatisfaction and disordered eating attitudes (Shisslak, Crago, & Estes, 1995; NEDA, 2008). The age at which disordered eating behaviors and attitudes begin is shockingly young, with 81% of ten year olds afraid of being fat (McNutt, Hu, Schreiber, Crawford, Obarzanek, & Mellin, 1997) and 42% of seven to ten year old girls desiring to be thinner (Collins, 1991). While anorexia nervosa has the highest mortality rate of any mental disorder at 4.0%, bulimia nervosa comes in a close second at 3.9% mortality rate due to medical complications from the illness, co-morbid psychiatric conditions, or suicide (Arcelus, Mitchell, Wales, & Nielsen, 2011; Crow, et al, 2009; Marques, 2011). There are eating disorders present in every ethnicity, age, gender, sexual orientation, and socioeconomic circumstance (Marques, 2011; NEDA, 2008; Nielsen, 2001). With so many people struggling with inappropriate food intake and unhealthy body-obsessions in America, the need for effective intervention strategies is clear.

Bulimic symptoms of bingeing and purging have been present in medical literature since ancient times, but new concerns about weight and body shape make bulimia nervosa a distinctly modern phenomenon that has increased since the 1960’s and more than tripled since 1988 (Habermas, 1989; Hoek & van Hoeken, 2003; Zerbe, 1995). Clinical diagnoses of bulimia are particularly common among young women 20-24 years old, with a prevalence of 83 cases per 100,000 in comparison to 12 per 100,000 for the general
population (Hoek & van Hoeken, 2003). Estimates of the actual incidence of bulimia in young women, however, are much higher in community populations, closer to 1,500 per 100,000 women who either have the full diagnosis or subclinical levels of disordered eating (Hoek & van Hoeken, 2003). The physical complications of the bulimic behavior can cause changes in brain chemistry, depression, anxiety, dizziness, heart complications (irregular beat, weakened muscle, and possible failure), dehydration, kidney problems, irregular menstruation, fatigue, irritated or ruptured esophagus, and sore throat (Fursland, et al., 2010; Lamb, 2006). The mental and emotional distress caused by bulimia include the aforementioned anxiety and depression, as well as obsessive thoughts about food, eating, and body shape, that cause immeasurable anguish that impairs social and role functioning for those who suffer from the disorder (Abraham & Beaumont, 1982; Hudson, et al., 2007). Treatments that can effectively address both the physical and mental complications of bulimia are needed to reduce the suffering of many young women and restore them to healthy life pursuits.

However, treatment for eating disorders is challenging and complex. Each person who enters the process of healing from an eating disorder has a unique life story that necessitates a comprehensive, personal treatment plan (Emily Program, 2009; Richards, Hardman, & Berrett, 2007; Zerbe, 1995). Research supports a multi-dimensional approach that may include a combination of the following components: individual psychotherapy, group therapy, nutrition counseling, psychopharmacology, integrative therapies, inpatient hospitalization, outpatient therapy, and relapse prevention groups (Lamb, 2006; Richards, Hardman, & Berrett, 2007; Zerbe, 1995). It is increasingly challenging to find this personalized treatment in America's insurance-driven mental and physical health care
system, despite evidence that treatment for eating disorders is not an unending source of insurance costs and that the majority (72%) of those who receive timely, evidence-based treatment significantly improve or fully recover from bulimia (Crow, et al., 2009; Steinhausen, 2009). Social stigma against treatment, lack of insurance coverage, and strong shameful feelings surrounding disordered eating have resulted in less than 6% of those with clinical levels of bulimia receiving treatment (Hoek & van Hoeken, 2003; Joy Project, 2011). Delivering effective, affordable, and personalized treatment is a challenge for social workers and providers of eating disorder treatment that deserves attention to reduce the suffering of many who live under the control of crippling eating disorders.

The need for effective treatment for eating disorders cannot be overstated given the millions of Americans who suffer from these disorders. The road to recovery from eating disorders, and bulimia in particular, is often a curvilinear path involving periods of improvement, relapse, treatment, and movement towards a healthy relationship with food and one’s body; but there is most certainly hope for recovery and relief from eating disorder symptoms for those who pursue it (Steinhausen, 2009; Kaye, 2008). The purpose of this study is to identify the most helpful elements in healing bulimia from the perspective of people who consider themselves to be in recovery from this eating disorder.

**Literature Review**

**Eating Disorders Defined**

The most prominent eating disorders, as outlined by the American Psychiatric Association, are Anorexia Nervosa (AN) and Bulimia Nervosa (BN) (APA, 2000). There is also a separate category for the Eating Disorders Not Otherwise Specified (EDNOS) to describe disorders that are of clinical severity but do not meet the full criteria for either AN
or BN. The fifth revision of the *Diagnostic and Statistical Manual of Mental Disorders* is anticipated to have an additional eating disorder category entitled Binge Eating Disorder (BED) (APA, 2011; Keel, et al., 2011). Anorexia (AN) is characterized by the restriction of food intake to achieve a thin body shape, failure to maintain an adequate body weight for one’s height and age, intense fear of gaining weight, and a deeply distorted image of one’s own body (APA, 2000; Emily Program, 2009). Bulimia (BN) is characterized by a cycle of compulsive consumption of large quantities of food, followed by frantic efforts to rid the body of the food and calories through vomiting, fasting, exercise, or laxatives (APA, 2000; Lamb, 2006; NEDA, 2008). There is also an intense fear of gaining weight, obsession with food, and distorted sense of one’s own body image in bulimia (APA, 2000; Lamb, 2006). EDNOS are characterized by any combination of anorexic or bulimic symptoms, as well other clinically significant unlisted symptoms unique to the individual (APA, 2000). BED is characterized by the consumption of large quantities of food, often for the purpose of avoiding or escaping from unpleasant emotions or circumstances, without any purging behaviors (APA, 2011). All of the clinical eating disorders share the commonality of an abnormal relationship to food and one’s body, albeit with different expressions of this abnormality. Since it is beyond the scope of this study to evaluate the recovery process for all of the eating disorder categories, this project shall focus solely on recovery from bulimia nervosa (BN).

**Risk Factors for Bulimia**

The factors that contribute to the development of bulimia nervosa (BN) range from the personal to the environmental. There is a basic, biological component to BN in the serotonin pathways (called 5-HTC) in the brain that regulate emotions and eating behavior,
which may be passed down genetically (Broft, et al., 2011; Lamb, 2006). Family history of eating disorders, mental illness, or substance abuse also predicts the later development of BN (Fairburn, Cooper, & Shafran, 2003). There are also pre-morbid experiences that influence the development of BN, including being obese in childhood and having traumatic experiences at a young age, which may directly relate to the development of low self-esteem which is a significant predictive factor in BN (Fairburn & Harrison, 2003). Thus, there seems to be an interaction of numerous genetic and environmental factors that create the context in which the disordered eating of bulimia can develop.

There are several distinct personality characteristics and qualities that can contribute to the development of BN, including elevated perfectionism, low self-efficacy, impulsivity, and novelty-seeking behavior (Bardone-Cone, et al., 2008; Cassin & von Ranson, 2005). Perfectionism contributes to the development of disordered eating when there is a discrepancy between high personal standards and actual attainment, particularly in relationship to body shape and eating behavior (Bardone-Cone, et al., 2008). Many women with bulimia have a low sense of self-efficacy, which means they have a negative cognitive appraisal of their abilities, are easily daunted or discouraged by life challenges, and have a low sense of personal worth. These negative self-perceptions contribute to the negative affect that precedes a binge-eating episode and perpetuates purging behaviors (Bardone-Cone, et al., 2008). The character trait of impulsivity is associated with bulimic symptoms in those who struggle to control behavior, words, thoughts, or decisions may also struggle with making impulsive choices to overeat, regardless of the consequential weight gain or subsequent emotional distress (Cassin & von Ranson, 2005). Persons who are continually seeking out new experiences or situations to achieve elevated emotional
sensations or thrills may also struggle with the sense of relief or emotional satisfaction that comes during binge eating. There are clearly personality traits and characteristics that predispose a person to the development of bulimia as the stages of life progress.

Cultural folklore has indicated that there is a connection between personality disorders and the development of eating disorders; however, current research does not support this relationship. It was previously estimated that 27-93% of individuals with eating disorders had co-existing personality disorders, which was a gross over-estimation based on incorrect self-reporting (Cassin & von Ranson, 2005, Lilenfeld, et al., 2006). While there are traits of Avoidant and Borderline Personality Disorders present in those with bulimia, research does not support a causal relationship between these variables (Cassin & von Ranson, 2005). For instance, individuals with eating disorders tend to be overly concerned with acceptance and approval and fear rejection or criticism, which is a characteristic of Avoidant Personality Disorder, but does not mean they meet full qualifications for a personality disorder diagnosis (APA, 2000; Narduzzi & Jackson, 2000, as cited in Cassin & von Ranson, 2005). Borderline Personality Disorder is characterized by instability and impulsivity, two elements that contribute to the binge-purge cycle (Cassin & von Ranson, 2005). Previous self-report measurements were incorrectly used and inflated the supposed percentage of eating disorder clients with co-morbid personality disorders, but there remains a connection between some pathological personality traits and the development of bulimia.

The risk for a chronic course of the BN increases with the presence of certain indicators in early life, which impact treatment success, and likelihood of relapse. Obesity in childhood is strongly linked to a chronic course of bulimia and continual struggle with
weight (Cooper & Fairburn, 2011; Fairburn & Harrison, 2003). The degree of over-
evaluation of body weight and shape, along with the degree of low self-esteem, present in a
sufferer significantly increases the likelihood of a chronic course of the illness (Cooper &
Fairburn, 2011; Fairburn & Harrison, 2003). Clients who have these aforementioned
characteristics have a higher likelihood of relapse, nearly three times greater, than others
with the disorder (Keel & Mitchell, 1997). For the entire population of those who suffer
from bulimia, research has found that nearly 50% of sufferers recovered without any
residual symptoms, 27% improved considerably since diagnosis, and between 23-30%
continued to have clinical levels of symptoms five to ten years post diagnosis and treatment
(Keel & Mitchell, 2007; Steinhausen, 2009). Clinicians should be aware of the key
indicators for chronicity (low self-esteem, low body-evaluation, and childhood obesity) so
as to be able to convey the seriousness of the illness to clients, while also instilling hope for
recovery despite many challenges.

**Cognitive Behavioral Model of Bulimia Nervosa**

The Cognitive-Behavioral Model of Bulimia Nervosa (CB-BN) was developed to
explain the elements that maintained the cycle of the disorder and provide a framework for
clinical interventions (Fairburn & Wilson, 1993). In the CB-BN there is a central
dysfunctional system of self-evaluation that bases self-worth on body weight, shape, and
eating behaviors. These thoughts then lead to behavior designed to improve personal
appearance, often by dietary restriction, for weight loss purposes. The psychological and
physical sense of self-deprivation that comes from dieting then contributes to uncontrolled
binge eating episodes. These binge episodes are then followed by tremendous fear of
gaining weight and sense of shame over the loss of control during the binge, which
contributes to the purging behavior aimed at removing the consequences of overeating. The clinical implementation of cognitive behavioral therapy can occur at any place in this model to adjust incorrect assumptions about the self, body, stress, coping, and food (Fairburn & Wilson, 1993).

Fairburn, Cooper and Shafran revised the original CB-BN model in 2003 to further elaborate upon the connections between various elements of BN. The revised CB-BN model postulated, for instance, that low self-esteem encourages striving for an ideal body weight or shape, and perfectionism can lead to negative self-evaluation or disordered eating behavior in response to failing to meet high self standards (Fairburn, Cooper, & Shafran, 2003). Mood intolerance, or the inability to handle adverse mood states, was thought to encourage participation in the binge-purge cycle to order to alleviate these intense emotions. Interpersonal problems were also thought to contribute to the maintenance of BN by magnifying concerns about weight or shape, triggering binge eating through conflict, and worsening self-esteem problems (Fairburn, Cooper, & Shafran, 2003). The elements of low self-esteem, clinical perfectionism, mood intolerance, and interpersonal problems enhanced the original CB-BN model by providing greater insight into the maintenance factors of BN.

The validity of the revised CB-BN model was evaluated in a comprehensive study conducted by Lampard, et al. (2011). For the study, 162 women diagnosed with full or slightly sub-clinical bulimia used self-report questionnaires and the Eating Disorder Examination scale to test the validity of the CB-BN model (Lampard, et al., 2011). The revised CB-BN model was found to be a good overall fit for the data and the accounted for more variance in dietary restriction and bingeing behavior than the original CB-BN model.
Lampard, et al., supported the connections between low self-esteem and over-evaluation of body weight and shape, which subsequently influence dietary restriction and increase binge-eating episodes, and these, in turn, spur purging episodes and interpersonal problems, such as deception, isolation, and conflict (2011). However, significant elements of the revised CB-BN model were not supported by this study. Mood intolerance was not found to maintain the binge-purge cycle, as the CB-BN model outlines, rather, increased levels of mood intolerance were associated with decreased binge eating (Lampard, et al., 2011). This contrasted with early descriptive reports of bulimia that indicated a significant increase in anxiety and tension prior to bingeing, and a tremendous decrease in these intense emotions post-purging (Abraham & Beaumont, 1982). The relationship between dietary restriction and binge eating (one of the core tenants of the CB-BN model) was found to be weak and insignificant, and the personality trait of perfectionism was also not shown to be significantly related to over-evaluation of body weight and shape, as predicted by CB-BN (Fairburn, Cooper, & Shafran, 2003; Lampard, et al., 2011). This research indicates that while some elements of the CB-BN model are valid, it may need further development to accurately explain the full spectrum of bulimia and should be used only tentatively in understanding the maintenance factors of BN for clients (Lampard, et al., 2011).

**Affect Regulation Model**

Research into the efficacy of another maintenance model of bulimia, the Affect-Regulation Model, also has important implications for the validity of the CB-BN model. The Affect Regulation Model of binge eating suggests that binge episodes occur as a way to reduce negative affect or emotional states and bring about a more positive or peaceful affective state (Haedt-Matt & Keel, 2011). A meta-analysis of 36 studies on the role of affect
in modulating binge eating did not support the core assumption of the Affect Regulation Model, that negative affect is reduced by bingeing (Haedt-Matt & Keel, 2011). Instead, it was found that negative affect does increase prior to a binge, but rather than decreasing, negative affect actually increases further after a binge. This supports descriptive findings of Abraham and Beaumont’s 1982 study on bulimic behavior that found negative self-evaluations and negative affect to increase after a binge (Haedt-Matt & Keel, 2011). The desire to regulate or alleviate unpleasant mood states is postulated to maintain the binge-purge cycle by the CB-BN model; however, the results of this meta-analysis indicate that this is not an empirically supported claim (Haedt-Matt & Keel, 2011). The relationship between binge eating and affect regulation needs to be further clarified by research to determine its continued inclusion in the CB-BN model and other theoretical frameworks used to understand bulimia. It is important for clinicians to know the tentative nature of the relationship between affect regulation and bulimic symptoms presented in literature so that they provide truthful psycho-education to clients.

**Treatment for Bulimia**

There are a variety of treatment methods currently used to treat bulimia nervosa, including, among many others, Cognitive Behavioral Therapy, interpersonal therapy, and theistic treatment. These three treatment types were chosen for elaboration herein because of the multitude of research supporting their efficacy and because of the design of this study, which includes an investigation into the spiritual component of treating BN.

**Cognitive Behavioral Therapy.** The most-widely accepted and empirically proven treatment for bulimia is Cognitive Behavioral Therapy or CBT (Crow & Peterson, 2009; Fairburn & Harrison, 2003; Wilson, Grilo, & Vitousek, 2007). The manual-based CBT
treatment addresses the mechanisms proposed by the CB-BN model to maintain bulimic symptoms, including negative concern about body shape and dysfunctional dieting behavior (Wilson, Grilo, & Vitousek, 2007; Vocks, 2011). Originally created by Aaron Beck, later refined by his daughter Judith Beck, CBT attempts to address inaccurate thought patterns that generate unpleasant emotions, which lead to undesired behavior, such as anxiety, depression, or disordered eating (Beck, 1995). CBT treatment for bulimia typically consists of 16-20 sessions over the course of 4-5 months (Wilson, Grilo, & Vitousek, 2007). Research has shown success with CBT interventions that target either the elements of the bulimic cycle or broader life challenges (Crow & Peterson, 2009; Fairburn & Harrison, 2003). It is likely that what is most impactful in both scenarios is the focus on correcting pathological errors in thinking and developing healthier patterns of relating to the world, which is applicable to a wide range scenarios beyond the eating disorder.

**Interpersonal Therapy.** Another talk therapy treatment that has proven to be extremely effective for treating bulimia is interpersonal therapy (Fairburn, et al., 1995; Wilson, et al., 2007). The interpersonal therapy model focuses on identifying and modifying interpersonal problems that help maintain the bulimic cycle (Wilson, Grilo, & Vitousek, 2007). Interpersonal therapy is more time-consuming initially, creating complications with insurance limits for some patients, and the improvement occurs more gradually than in CBT (Wilson, Grilo, & Vitousek, 2007). However, long-term studies of outcome (4-8 years post-treatment) have found comparable, and even slightly greater, improvement rates for interpersonal therapy over CBT (72% and 68%, respectively) (Fairburn, et al., 1995). Combining CBT with interpersonal therapy diminishes the impact of each treatment modality on symptoms of bulimia (Wilson, Grilo, & Vitousek, 2007).
However, when used separately or in conjunction with other professional services besides CBT, interpersonal therapy can be another valuable treatment option for those with bulimia.

**Theistic Treatment.** A theistic or spiritual approach to eating disorders is another valuable framework to consider during treatment, in addition to the widely used CBT and interpersonal therapy. Richards, Hardman, and Berrett describe a model of treatment that inserts an ecumenical role of God into the healing process (2007). This model encourages a continuation of the multi-dimensional approach to standard treatment of eating disorders, including medical, psychological, pharmacological, dietary, and cognitive components (Richards, Harman, & Berrett, 2007). Theistic treatment, however, adds an additional element of spirituality to the process of healing. This modality begins with a belief that God can intervene in the lives of humans and that therapists can work as conduits to the relationship between client and his/her God or belief system (Richards, Harman, & Berrett, 2007). Therapists must walk a careful line to not impose their own beliefs on clients, but instead encourage clients to examine their lives and live congruently with their values (Richards, Harman, & Berrett, 2007). By encouraging moral living and providing spiritual insight into problems, therapists help to reconnect clients with their spiritual side and harness this power for transformation during the process of eating disorder recovery (Richards, Harman, & Berrett, 2007). The incorporation of spirituality into the existing treatment of eating disorders may provide an important source of strength for clients and improve recovery rates of all treatment modalities.
Clients’ Perspectives on Recovery

Understanding of what it means to be in recovery from bulimia can only come through the personal perspectives and stories of those who have come through the illness and consider themselves to be in recovery. Former sufferers have described for previous researchers the circuitous nature of the recovery process, and highlighted the multitude of professional, non-professional, and spiritual resources used during their journey.

Recovery Process. Recovery, or release from control of bulimic symptoms, is an ongoing process that former sufferers believe is possible to fully achieve. Rorty, Yager, and Rossotto found that nearly 70% of those diagnosed with bulimia were optimistic about a full recovery from the disorder (1993). Former patients describe recovery as a subjective, ongoing process that is uniquely defined by each person with the disorder (Bjork & Ahlstrom, 2008; Pettersen & Rosenvinge, 2002). Recovery is not about being “supernormal,” according to those who have recovered, but rather about identifying as a “healthy” person who no longer has an eating disorder as part of his or her core identity (Bjork & Ahlstrom, 2008; Pettersen & Rosenvinge, 2002). Former patients have described the experience of recovery as feeling able to handle thoughts and emotions without resorting automatically to bulimic behavior, but it is not necessarily important to have a complete remission of symptoms for people to consider themselves to be in the recovery process (Bjork & Ahlstrom, 2008; Pettersen & Rosenvinge, 2002). Recovery from bulimia, it seems, may be less about symptom reduction and more about developing healthy coping strategies for life stressors, problem-solving skills, and better emotional regulation.

Former bulimic patients describe recovery as changing the way they relate to food, their body, themselves, and their social environment (Bjork & Ahlstrom, 2008). Recovery
was not about giving anything up, according to former patients, but rather the gaining of a richer, more satisfying life experience (Pettersen & Rosenvinge, 2002; Rorty, Yager, & Rossotto, 1993). Accepting of one’s body as “good enough,” putting less importance on weight, and valuing the body as strong, healthy, and functional are all key to restoring the relationship with one’s body (Bjork & Ahlstrom, 2008). The relationship with food for former bulimic patients must also adjust to be more relaxed (eating many kinds of food in a variety of situations, with the ability to decline food invitations as well) so that thoughts about food no longer dominate thinking (Bjork & Ahlstrom, 2008). There is also an improvement in self-esteem that comes in recovery through accepting oneself as good enough, being kind and caring towards oneself, enjoying life experiences, setting limits and boundaries with others, and feeling like life has a purpose (Bjork & Ahlstrom, 2008; Pettersen & Rosenvinge, 2002). Former patients cite improvement in emotional stability as key in recovery, particularly the ability to deal with unpleasant emotions without blame or self-destruction (Bjork & Ahlstrom, 2008). Having better emotional regulation also reduces some of the anxiety and depression symptoms that are often co-morbid with bulimia (APA, 2000; Lamb, 2006; Pettersen & Rosenvinge, 2002). Improved social interactions were also significantly important to patients in recovery, particularly the ability to create a social life, to recognize the value of relationships, and to make people a priority without fears of abandonment (Bjork & Ahlstrom, 2008). Altering the pathological relationships to body, food, self, and others is key to the bulimia recovery process.

**Professional Services.** Professional eating disorder services were the most widely used form of treatment for those who suffered from bulimia. Nearly 71% of people in recovery from BN used professional mental health services as part of their healing process.
(Rorty, Yager, & Rossotto, 1993). The effectiveness of this professional intervention was largely determined by the timing of treatment: starting the process before a person had reached rock bottom and truly desired change in symptoms was often counterproductive (Pettersen & Rosenvinge, 2002). The quality of the therapeutic relationship was also extremely important to former patients, particularly the therapist’s ability to see the person behind the symptoms (Bjork & Ahlstrom, 2008; Rorty, Yager, & Rossotto, 1993). Having a therapist that was available, engaged, and able to deal with issues underlying the external bulimic symptoms was seen as critically important by former patients (Pettersen & Rosenvinge, 2002). While knowledge of eating disorders and their symptoms were preferable in a therapist, former bulimia sufferers found that the quality of empathy and caring found in a therapist was of even greater importance (Pettersen & Rosenvinge, 2002). Learning from professionals about their eating disorder, normal eating, and healthy coping mechanisms were also important to former patients (Rorty, Yager, & Rossotto, 1993). Professional care was a cornerstone in recovery from bulimia.

**Non-Professional Elements.** Non-professional support and treatment were also found to be significantly important in the process of healing from bulimia. Receiving immediate, practical, and emotional support from family members, spouses, significant others, friends, and others with bulimia were all particularly important for former patients to implement the gains made in professional treatment (Pettersen & Rosenvinge, 2002; Rorty, Yager, & Rossotto, 1993). Positive life changes often involved social supports and were key to recovery; these often included finding a life partner, having kids, starting a new job, or continuing in education (Pettersen & Rosenvinge, 2002). Other identified forms of non-professional support in healing included support groups for those with eating
disorders, self-help books, Internet chat rooms, and physical exercise (Pettersen & Rosenvinge, 2002). These less-formalized sources of treatment often supplemented or continued the healing process after professional treatment was completed, particularly if insurance coverage was a barrier to receiving treatment (Rorty, Yager, & Rossotto, 1993). These non-professional sources provided an important social, emotional, and physical connection that was often lost during the isolation of full-scale bulimia and provided additional support that continued after the formal therapeutic relationship terminated.

**Spiritual Resources.** People who have recovered from bulimia also identified spiritual and/or religious connections as sources of strength, encouragement, and hope during recovery (Jacobs-Pilipski, et al., 2005; Richards, Harman, & Berrett, 2007; Rorty, Yager, & Rossotto, 1993). According to one study, spirituality was not a universally accessed resource, with up to 53% of eating disorder clients reporting that spiritual/religious practices were not important to them; but for those who did choose to access spirituality and religion, it was a significant form of coping with and alleviating the distress associated the eating disorder (Jacobs-Pilipski, et al., 2005). Prayer was found to be the most frequently used and effective means of spiritual coping among eating disorder participants (Jacobs-Pilipski, et al., 2005). Another researcher posited that common religious issues among eating disorder patients are linked to the strength of eating disorder pathology in clients, particularly, feelings of shame, spiritual unworthiness, fear of abandonment by God, and distorted God images (Richards, Harman, & Berrett, 2007). From this perspective, individuals can heal from their eating disorder by resolving the aforementioned spiritual questions, rediscovering their own sense of spirituality, placing trust in a Higher Power, and regaining confidence in the love and support of others.
Research into the role of spirituality in eating disorder treatment and prevention efforts is still in the nascent stages, but current research suggests spiritual and religious beliefs may be a significantly underutilized resource in the journey to recovery (Jacobs-Pilipski, et al., 2005; Richards, Harman, & Berrett, 2007).

The process of recovery from bulimia is a consuming, long-term process often involving professional treatment, non-professional supports, and sometimes, a spiritual component. The purpose of this study is to confirm the professional and non-professional elements found by previous research to be instrumental in the recovery process from the perspective of persons who formerly had bulimia. The element of spirituality will also be further examined in this study to elucidate the relationship between spiritual growth and the process of healing from bulimia. The purpose is to gain a thorough picture of what recovery from bulimia looks like from the point of view of those who have made the journey to better inform the practice of social workers and other professionals who treat this disorder. Therefore, the research questions for this study are: what are the professional, non-professional, and spiritual elements that are important to recovering from bulimia? And what does recovery look like from the perspective of those who have had the disorder?

**Conceptual Framework**

**Procovery Model**

The first conceptual framework that informed the direction and focus of this research project is known as the Procovery Model, which differs significantly from traditional medical focus on return to complete health, as in before illness. Recovery is often seen as the goal in mental and physical illnesses alike - a sort of recapturing of health,
wellness, and balance that once existed in life. However, recovery may actually be a faulty term to use for those with eating disorders in that the possibility of “recovering” or recapturing a sense of health and normalcy in relationship to self, body, and food can be a very difficult, if not impossible task, after so many years of disordered patterns. The concept of procovery, in contrast, is an empowering, forward-looking approach to healing from mental illness that is strongly applicable to healing from eating disorders. Kathleen Crowley wrote the inaugural book, *The Power of Procovery in Healing Mental Illness*, about the concept of procovery, but the tenets within are rooted in common sense and other therapeutic modalities, such as the strengths-based social work perspective (Crowley, 2000; Saleebey, 2006). There is a strong emphasis in this framework on the strengths that already exist within a person and using those to create a healthy future for each person.

Procovery involves moving forward in life once mental illness has entered life and made it difficult and undesirable to move backward; it is a practical approach grounded in every-day steps and hope for future change. The procovery model views mental illness as an experience to be integrated into one’s life story, not as something to be shamefully excised from it (Crowley, 2000). Healing from eating disorders, such as bulimia, then, can be seen as something that sufferers must incorporate into their life experience in order to move into a new future characterized by health, wellness, and forward motion.

The central tenets of procovery generate hope for a better future and belief in the power of the individual to change disordered eating patterns. Crowley laid out the following favorable conditions required for procovery: believing that it is possible to overcome the mental illness; recognizing the power of the individual to create change; focusing forward on life, not illness; starting anywhere to effect change; accepting
backsliding as part of the process; and keeping hope alive (2000). Therapists and social workers with a procovery mindset can transmit this mode of positive, forward-change-thinking to clients with bulimia, encouraging them to utilize the model in a personalized manner.

**Holistic Model**

The second theoretical framework that informed this study is the holistic model of mental health that is taken from the tenets of integrative medicine practice and includes all aspects of life - social, emotional, mental, physical, and spiritual. From this perspective, illness (including mental illness) is seen from a broad perspective that identifies multiple causes, ranging from the internal to the external, and offers multiple avenues for healing (Brown, 2001). Like the procovery model, the holistic mindset focuses on *healing* from mental illness rather than curing it, as is often promoted by modern medicine. There is a distinctly individual emphasis in holistic health that focuses on adjusting lifestyle, transforming the person and using natural remedies to alleviate the illness (Brown, 2001). The multi-systemic focus of holistic health coincides with the treatment recommendations for eating disorders and thus opens the door for a broad, individualized approach to healing from bulimia (Richards, et al., 2007). Since the literature is not definitive about the factors that alleviate bulimia, and even the model for explaining its development and maintenance is not fully understood, the holistic approach allows for other explanations for development, maintenance, and treatment the literature that have not yet been examined.

Together, the holistic and procovery models provide a solid framework for this study by laying out the multi-dimensional, individualized, and pro-active approach to
healing from eating disorders taken by this researcher. The belief in the possibility for individuals to achieve change in their bulimic symptoms is firmly rooted in these two conceptual models. Healing from bulimia is a journey that needs to address all facets of life and evidence asserts it can be attained through a process directed by the individual. Thus, the research questions for this study remain: what are the necessary professional, non-professional, and spiritual elements used in the process of healing from bulimia? And what does recovery look like from the perspective of those who have healed from bulimia?

**Methods**

**Research Design**

The research design for this study was a cross-sectional, mixed-method design for the purpose of examining how individuals recover from bulimia. This researcher created an online survey to assess the recovery process, based on prior research findings about what helps individuals with bulimia recover, and what professional services, non-professional elements, and spiritual resources were used by former sufferers. Both qualitative and quantitative forms of measurement were used to yield concrete yet descriptive results.

**Sample**

Participants were recruited for this study using a combination of availability sampling, snowball sampling, and purposive sampling. There were four main requirements for subjects in this study: 1) self-identify as being in recovery from bulimia, 2) be 18 years of age or older to give consent, 3) have had a diagnosis of bulimia in the past, and 4) not be in current full-time treatment. Subjects were recruited from a survey link posted at the Joy Project’s website (an online discussion board for those recovering from
eating disorders) and two postings in the University of St. Thomas online Bulletin newsletter. Two personal contacts of this researcher also sent email invitations to their personal contacts and participants from a local eating disorder support group to participate in this study. In addition, a page was created on Facebook by this researcher as a means of recruiting more participants. All participation in this study was voluntary and there was no compensation of subjects.

**Protection of Human Subjects**

Since the participants of this study were asked highly personal questions about their history of bulimia, there were several measures taken to ensure the protection of subjects during this project. To start, subjects in this study were required to be 18 years of age or older, ensuring that they were of age to give consent for their responses. Participants were thoroughly informed through a consent form about the nature, purpose, and duration of the study prior to taking the survey. Contact information for this researcher and the IRB at St. Thomas was provided to subjects if any questions or concerns arose during the survey. Participation in this study was entirely voluntary. Subjects were allowed to stop at any point during the survey and skip questions they did not wish to answer. A list of local eating disorder resources and treatment information was provided at the end of the survey, should the questions have provoked any unexpected feelings in participants or stirred up questions about their own recovery. See Appendix A for a copy of the informed consent document.

The risks to the subjects in this study were minimal, though the topic was sensitive and highly personal to respondents. The responses to questions were untraceable to any specific participant, assuring anonymity to subjects. The survey was conducted online,
which hopefully allowed participants to be more honest and upfront with responses due to the cyber barrier between themselves and this researcher. The questions asked of subjects were also framed in a positive and recovery-focused manner, which may have helped participants to focus on the improvements they have already made towards healing rather than perseverating on the symptoms and difficulties of their experience with bulimia. A full review and approval of this study was made by the Institutional Review Board (IRB) at the University of St. Thomas to ensure further protection of subjects.

**Data Collection**

On the basis of findings from four key studies, this researcher created a survey entitled “Healing Bulimia” for this project. The work of Pettersen and Rosenvinge (2002) informed the survey questions concerning professional services utilized by participants, as well as their definition of what it means to be in recovery. Rorty, Yager, and Rossotto (1993) did extensive research on non-professional services that were helpful in recovery from bulimia, and thus, their results informed the list of non-professional services used by subjects, as well as the question about what initiated the healing process for participants and if it is possible to fully recover from bulimia. The research conducted by Jacobs-Pilipski, et al., (2005) informed the list of spiritual services and activities utilized by subjects to heal from bulimia. Bjork and Ahlstrom (2008) contributed four key areas to recovery literature (relationship with food, body, self, and others) that sparked four of the open-ended questions on the survey. This researcher also included demographic questions to gather descriptive information on participants.

The “Healing Bulimia” survey contained a total of 32 questions, including a combination of closed and open-ended questions, and was created online using Qualtrics.
Participants were required to read a consent form and to give their consent by answering yes or no before continuing. The first survey questions concerned the subjects’ current recovery status and if he/she believed it is possible to recover from bulimia, to verify findings by Rorty, Yager, and Rossotto (1993). The subsequent three sections required participants to identify which professional, non-professional, and spiritual resources were used in their own healing process. Participants were then asked to rank the importance the above three categories in their overall recovery. The survey section concluded with open-ended questions about how subjects’ relationships with food, body, self, and others changed during the healing process. Participants were also asked to describe what it means to be in recovery, as well as what initiated their recovery process. The survey concluded with simple demographic questions and additional resources for eating disorder support, if needed. See Appendix B for a full list of survey questions.

This researcher then downloaded data collected from survey participants through the Qualtrics software onto her personal computer and the information was stored on a password-protected file on this researcher's computer for data analysis. There was no destruction of data at the end of this project, as all information collected was anonymous and untraceable back to participants. The findings will be kept for potential future research projects.

**Data Analysis**

Quantitative data analysis techniques were used to interpret participant responses to numerous survey questions (3, 4, 6, 8, 9, 11, 12, 14, 15) and demographic questions (23-30). Descriptive statistics were collected by the survey software Qualtrics and used to create basic reports of categories (i.e. types of services or resources used; extent of
personal recovery), and rankings of the value of recovery processes. Descriptive statistics were also found for the questions concerning the types of treatment utilized, the helpfulness and importance of each treatment type, the question about key elements of recovery, and if it is possible to fully recover from bulimia. This researcher manually entered survey data from the aforementioned quantitative questions into Microsoft Excel in order to generate graphs to pictorially depict the results. These statistics were generated to indicate the importance and value placed on the different realms of treatment and to either confirm or disconfirm results from previous studies concerning key elements of recovery and the belief of whether or not healing is possible.

The open-ended questions on the survey were evaluated using the qualitative data analysis method known as content analysis (Berg, 2007). This researcher compiled the responses to each question and looked for key themes. This researcher looked for overlapping themes and patterns in responses to examine the changes in subjects’ relationship to food, body, self, and others. The responses were then evaluated a second time by this researcher to critically examine themes found in the first review. The number of corresponding (and non-corresponding) responses were then tallied and entered into the SPSS program for descriptive statistics purposes. The combination of qualitative and quantitative analysis techniques yielded rich sources of information for this study.

**Findings**

This research aimed to understand participants’ experiences and beliefs about recovery from bulimia nervosa, including their own recovery as well as the recovery of others. It also looked into the types of services used in the healing process, from professional to non-professional and spiritual, and invited participants to describe what
was most helpful in each of these categories. The research also inquired into what had changed for participants in their relationships with their bodies, food, others, and themselves in recovery.

Participants

There were 31 people who opened the Healing Bulimia survey link online, 25 people who partially completed the survey questions, and 18 people who completed the entire survey. The partially completed survey responses were included in the statistical reports of this study, as there was no way to separate the responses of partially and fully completed surveys. The average age of participants was 25 years old, with a range from 18 to 39 years. The majority of respondents were female (89%), but two men also participated (11%), giving the study more gender variability. Occupationally, the majority of respondents were students (61%), 40% of the entire sample worked full-time, another 28% worked part-time, and 17% were unemployed at the time of the survey, with many participants fitting into multiple occupational categories. In describing their spiritual/religious affiliation, a third of participants described themselves as “spiritual but not religious,” another third as Catholic and Christian, and the last third as having no religious affiliation or other. Two-thirds of participants subscribed to spiritual beliefs and/or practice, which was significant in examining the role of spirituality in healing bulimia in this study.

The eating disorder pathology of participants indicated that 84% had an official diagnosis of bulimia nervosa, 26% anorexia nervosa, 21% eating disorder not otherwise specified (EDNOS), and 11% other diagnosis (both bulimia and anorexia, as well as a person who was never officially diagnosed but had bulimic symptoms). Individuals could
have more than one eating disorder diagnosis, which is why the percentages exceed 100% in the diagnostic category. The majority of participants (78%) had another mental health diagnosis simultaneously with their eating disorder, predominately depression or anxiety disorders. The average age of onset for subjects’ eating disorder was 15 years old, with a range of onset from 10 to 23 years. Participants had clinical eating disorder symptoms for an average of nine years, but there was a wide range in years of suffering, ranging from one to 25 years. The majority of survey respondents struggled with their eating disorder symptoms at least five years prior to beginning to treatment, but some also struggled for significantly longer. Participants typically entered professional treatment around 19 to 20 years old, but this ranged from 14 to 35 years of age. The average amount of time participants had spent in recovery prior to completing the survey was four years, with a broad range of experience in recovery stretching from one month to seven years.

Participants reflected the intended research demographic of those in recovery from bulimia nervosa and reflected a wide spectrum of experience with recovery; however, there was also some crossover into other diagnostic categories of eating disorders and mental health diagnosis that was not anticipated among participants.

Recovery

**Possibility of Recovery.** The majority of participants considered themselves to be in recovery from bulimia (85%), but a minority described themselves as “not in recovery” (15%). When asked to rank the extent to which they considered themselves to be in recovery, nearly three-fourths of participants considered themselves to be mostly or fully recovered (Figure 1). Participants described their level of recovery in terms of binge/purge symptoms, the presence or absence of eating disorder related thoughts and
emotions, as well as the length of time in recovery. One respondent articulately stated, “I no longer struggle with symptom use but in times of stress the thoughts are quite pronounced. Most of the time I don’t think about food or weight and my life doesn’t revolve around when or what I eat or how I will get rid of it.” Thinking about food and weight, and the correlated emotions, were also key markers of recovery for participants: “I feel like to fully recover you do not get the urge or the need to binge and purge, and for me that feeling has not gone away, although I do not partake in it like I used to.” Subjects stated clearly defined time limits on their recovery, often framed in terms of when they last self-induced vomiting: “I have not purged for about 10 years” or “two months” or “I have not made myself vomit in two years.” It was clear from many participants that some level of recovery had been achieved, but that most still struggled with some residual symptoms or felt there was more recovery yet to come.

Figure 1. Participants’ Rating of Personal Recovery Level.

Defining Recovery. When participants were asked if they believed full “recovery” from bulimia was possible, 48% said yes, it is possible, 28% said they were unsure, and
24% said that no, full recovery is not possible. Survey participants expressed four key sentiments about their beliefs in full recovery from bulimia: it never goes away; it takes time; it is a choice; and it requires inspiration from others. The large majority of responses indicated that they felt they would “always have some disordered eating habits stored in the back of their mind” and that there would “always be an urge” to use bulimic symptoms. In reference to the urges to binge and purge, one person succinctly said, “the voices never stop.” Others felt that the feelings or desires to use bulimia may never go away, but that one can get stronger and more able to handle the negative thoughts that trigger symptoms. Participants consistently expressed that they felt “a portion of food battles/thoughts [would] always be there” and that they needed to constantly be aware of potential triggers in their personal lives. There was an overwhelming sense from participants that a life free from all bulimic-related thoughts and actions was not quite achievable (or at least not conceivable at this point in recovery). However, being free from the control of constant urges to binge and purge was something that participants felt was very achievable.

**Time and Choice.** Recovery was also defined and deemed possible by participants in terms of time and choice. The refrain “it takes time... and more time... and still more time” to get to a place of healing was echoed repeatedly by subjects. There was a solid recognition that recovery is a “long process,” while also acknowledging “as time goes on it takes less effort [to be in recovery] as more healthy habits are established.” A handful of participants also described their recovery as a choice or decision they made. Sentiments such as “my recovery was a choice,” “I choose to be in recovery,” and “one makes the decision to stop purging for themselves” were expressed to voice this view of recovery based on willful intention.
Inspiration from Others. Other participants said that they knew recovery from bulimia was possible based on inspiration from others. Because they had met someone or heard stories of someone who had recovered from the disorder, participants had hope for full recovery. Respondents said that they had “seen it and heard of it [recovery]” and this gave them hope for their own recovery. One participant said it beautifully, “The way I see it, I never thought there would be a day that I would stop using symptoms, and there was, so I figure there must be a day that I can truly recover from bulimia. And if I can do it, others sure as hell can!” Inspiration from others clearly motivated subjects along their personal path to recovery from bulimia, however long their journey might be and however they decided to get on the path.

Professional Services

There was a broad spectrum of professional services utilized by participants to recover from bulimia, reflecting the wide array of treatment options available to individuals. The most commonly used professional services were individual mental health therapy, nutrition counseling, and medication management through psychiatry. See Figure 2 for a full list of services used by survey participants.
Subjects further indicated that the most important professional services to their recovery were as follows: individual mental health therapy, then intensive outpatient, day treatment, medical services, medication management, nutrition counseling, and other services. While the specific ranking of services varied from most important to less important but still crucial, the aforementioned services were all consistently seen as crucial components to the recovery process. These rankings support the comprehensive, multi-disciplinary team approach to treating eating disorders that has been adopted by well-known programs such as the Emily Program and Melrose Institute in the Minneapolis area. See Figure 3 for a breakdown of ratings from participants.
Figure 3. Ranking of the Importance of Professional Services in the Recovery Process. Note: On a scale of 1-3 with 1 being most important and 3 being less important but still key to recovery.

Subjects provided some qualitative feedback as to what was so helpful about the professional services they utilized during the recovery process. Individual therapy was helpful because it "helped with...straightening out my disordered thoughts" and it gave me "someone to process life with." Therapy was a place that individuals sorted through past issues, thoughts, and emotions that had contributed to bulimia, and a place where they learned something new about themselves. Several people reported that inpatient hospitalizations "saved [their] life numerous times" but went on to say that this was not where their primary recovery took place; it merely broke the cycle of the eating disorder to make the rest of healing possible. Having the right combination of psychotropic medications was extremely helpful to several subjects, who emphasized that medication was what “pushed me onto the ‘recovery’ path.” Nutrition therapy was helpful in changing participants perceptions of food and redefining what “healthy eating” was for “normal” eaters. Learning how food was important for the body and health was another key
component of nutritional counseling. Group therapy sessions were supportive to recovery for respondents because it “allowed me to stop feeling so isolated and ashamed.” This professional service allowed individuals to learn that they were not alone in their suffering and that there were others who understood their struggles. Each of these professional services provided healing benefits to respondents when combined with the others. As one subject clearly stated, “Having a full spectrum of services and a highly trained team for an extended period of time was absolutely essential for me [in recovery].”

**Non-professional Elements**

There were four main non-professional elements that subjects utilized the most in their recovery process. These included: friend support, physical exercise, family support, and extracurricular activities. The “other” category of non-professional elements encompassed making jewelry, recovery meetings, pets, spirituality, and sleeping. Subjects indicated that these alternative non-professional elements were used frequently and were critical to their recovery process. See Figure 4 for a full list of non-professional elements used by participants.

![Bar chart](image-url)

*Note: subjects may select more than one element.*
Figure 4. Non-Professional Elements Used by Participants. Note. The “other” category included making jewelry, recovery meetings, pets, spirituality, and sleeping.

The most important non-professional elements used by subjects to help in their recovery were family and friend support. Physical exercise and other activities (such as the aforementioned jewelry making, pets, recovery meetings, and sleeping) were also significant to the recovery process. It was clear from participants the relationships with supportive others were critically important to recovering from bulimia, but that other activities supplemented the process as well.

Figure 5. Ranking of Importance of Non-Professional Elements to the Recovery Process. Note: On a scale of 1-3 with 1 being most important and 3 being less important but still key to recovery.

Subjects elaborated significantly about what was so helpful about these non-professional elements in their recovery process. Family and friend support was crucial to recovery; husbands, parents, brothers, sisters, and best friends were all listed as central to recovering. These important people provided honesty to subjects, they spoke candidly to subjects about their concerns regarding bulimia, they never gave up during the recovery
process, and they provided motivation to heal. One subject said “my family, mainly my mom and dad, never gave up on me - even when I did” and another said that “family members [were] really important to me because I was worried that they would judge, and knowing once it was all in the open and receiving only positive and loving reactions really helped [my recovery].” Physical exercise was necessary for individuals to “relieve anxiety that would otherwise snowball into unhealthy coping mechanisms.” Exercise helped them to reconnect with their bodies and learn that their “body is something to be loved and cared for, not something to hate.” It also helped to improve participants’ mood and allowed for clear thinking, which was critical in weeding out confusing and conflicting messages of the eating disorder. All participants displayed evidence of a healthy relationship with exercise in recovery, as something done in moderation for the improvement of health, rather than compulsively as during the eating disorder.

Hobbies and extracurricular activities (sports, music, theatre, etc.) were also important to get subjects’ minds off of food and weight, to allow for the recovery and healing taking place. One subject said, “Making jewelry allowed me to focus on something other than my weight... my weight had become my hobby. I need to be good at something other than being skinny. In addition to giving me a creative outlet, it also allowed me to channel my perfectionism into a productive path.” Self-help books were seen as a source of support and information; one participant said that self-help books were “the first place where I started to understand what was wrong with me, that it had a name, and that there were others who knew what I was going through.” There was one negative reaction to books with the subject saying that “self-help books often functioned more as a how-to-guide... meaning, how to trick people, purge better, be sneakier.” Overall, however, these
non-professional elements were important for providing participants with a sense of belonging, support, encouragement, and distraction from their eating disorder - all of which contributed as significantly as professional services to subjects’ recovery from bulimia.

**Spiritual Resources**

Two-thirds of survey participants reported having some spiritual or religious affiliation (66%) and, accordingly, there was significant use of spiritual tools in the process of recovering from bulimia. The most highly used spiritual resource was prayer (60% of subjects used some form of prayer in recovery), followed by reading religious writings, attending religious services, and support from their faith community. However, nearly a third of respondents indicated that no spiritual resources were used whatsoever during their recovery process. Spiritual resources appear to be an important source of strength and encouragement for many people during recovery, but are not essential for everyone. See Figure 6 for a full listing of spiritual resources used by survey participants.

![Figure 6. Spiritual Resources Used by Participants During Recovery.](chart)

*Note: subjects may have selected more than one element.*
Note: The “other” category included forgiving self and others, finding own faith and spirituality, recovery meetings, and spiritual advising.

Subjects were then asked to rank how important these spiritual sources of support were to them in the recovery process. Prayer and support from a faith community were consistently ranked as the most important forms of spiritual encouragement to participants. Meditation was important to a number of participants as well. There was a significant sub-section of respondents who did not see any spiritual resources as important to recovery from bulimia. See Figure 7 for a ranking of the importance of spiritual resources.

![Figure 7. Ranking Importance of Spiritual Resources During Recovery.](image)

Figure 7. Ranking Importance of Spiritual Resources During Recovery. Note: Scale ranged from 1-3 with 1 being most important and 3 being less important, but still key to recovery.

When subjects were asked to illuminate what was so helpful about the spiritual resources, only a few chose to elaborate on this question, and those who did either had extremely positive or negative comments to share. Subjects who found spirituality to be helpful in their recovery shared that attending religious services and support from faith
community were essential to “helping me connect to God [and others].” One young subject said that the “support from my youth group and the prayers from the [church] community as a whole really gave me the faith that I could make it through the journey of recovery.” Prayer, both directed to God and received from others, was essential to recovery. Several participants said “spirituality was a key thing which helped me recover” and “my spiritual faith was a huge reason I decided to seek help in the first place and it is the reason I continue to maintain my strength in the Lord and my belief that he will help me fully recover.” Spirituality development was also linked to the sense of self. As one subject clearly articulated, “finding my own spirituality helped with finding out who I was,” thereby linking her spirituality development to her sense of self. Having faith in God or another spiritual higher power, was clearly central to the recovery of the majority of participants. Thus, spirituality may be an important, though perhaps supplemental, factor for mental health professionals to delicately explore in the treatment process.

Subjects who responded in the negative to questions about use of spiritual resources in recovery had both strong and wistful statements to make about this aspect of their lives. “Spirituality was key for many of my friends in their recovery, but not for mine,” said one survey respondent, clearly separating herself from any type of spirituality. Several other participants simply stated “none” or were careful to state that they had no religious or spiritual affiliation. Still others expressed ambivalence over their spirituality saying, “I am still battling to find some sort of spirituality somewhere hidden in me” and “I wish I used these [spiritual resources] more but I’m kind of in a non-spiritual phase… I think that prayer/meditation combined with a community atmosphere would help me a lot. I just am unsure where to find it.” One person acknowledged that things such as “prayer, meditation,
and [community] support can be extremely helpful [for others]” in recovery, but then went on to say, “I think faith is unreliable, even if it helps sometimes.” This sort of ambivalence about spirituality predominated nearly half of subjects’ responses to these questions. Thus, for some individuals in recovery, exploration of new ways to access spiritual resources or removal of barriers to some form of spirituality may be important to connect individuals with the sustaining and energizing power felt by those who readily embrace spiritual experiences.

**Importance Rating of Professional, Non-professional, and Spiritual Components**

Subjects were asked one final question about the professional, non-professional, and spiritual resources they used during their recovery. They were asked to rank on a scale of 1 to 3 (1 being the most important and 3 being the least important) the importance of the aforementioned resource areas in their recovery. Professional services (individual mental health therapy, medication management, and nutrition counseling) and spiritual resources (prayer, reading religious texts, support from the faith community, and attending services) were both seen as the *most important* aspect of recovery to an equal number of participants. The second most important resource was overwhelmingly non-professional elements (family and friend support, physical exercise, and extracurricular activities) for the majority of survey subjects. The least important source of recovery was spirituality for many participants (likely, those who indicated in the survey that spiritual-related things were not for them), but others found professional and non-professional elements to be least important (likely, those who did not access professional services at all and/or those who found spiritual resources to be the most important aspect of recovery). The value and importance placed on aspects of treatment and recovery varied by individual, thus, this
finding supports the current clinical model involving many different types of services in the treatment process. See Figure 8 for a graphical presentation of the rankings of recovery resources.

![Figure 8. Subjects’ Importance Ranking of Resources Used in Recovery. Note: Figure shows number of participants who chose that area of treatment as the most important, important, and least important to recovery.](image)

**Relationship with Food**

The majority of survey subjects reported that their relationship with food had changed for the positive through recovery from bulimia. There was a new understanding of hunger that emerged for several participants, including one person who quoted an unknown source as saying, “There’s always another meal. Hunger always comes back so you can feed it enjoyably rather than forcefully.” Others reported a decrease in how often they thought about food, “I don’t think about food unless I’m hungry” and a more balanced perception of hunger “I eat when I’m hungry and stop when I’m full.” A new understanding of the essence and definition of food also emerged from participants’ comments. People reported enjoying food more in recovery, as evidenced by the following comments: “I try to
enjoy food without going to excess,” “I enjoy food but don’t live for it,” and “I look forward to eating so I can enjoy the food and nourish my body and mind, rather than eating to feel emotionally detached.” Several participants said that having a new appreciation for the purpose of food was also important for recovery: “I try to think about food more as healthy energy rather than a pleasure to be abused and then feel ashamed about,” and “I see food as a source of nutrition to keep my body functioning, not as a means of stress relief or control.” Eating a wide range of foods (and not restricting types of food eaten) was key to recovery, as one subject stated, “I no longer have safe or nonsafe foods, and no longer binge and purge because I allow myself to eat a wide range of foods.” It was important for subjects to re-evaluate the meaning and purpose of food in their lives, as well as how to discern appropriate hunger cues, in their recovery process.

A portion of survey respondents indicated ongoing triggers and struggles with food consumption even though they considered themselves “mostly” or “partially” in recovery from bulimia. There was an ongoing vigilance in food consumption required to maintain a life free of binge/purge symptoms. One female reported occasionally feeling self-conscious about what she eats and how others perceive her but said, “through the recovery process I’ve learned a few tricks that help me to get over those feelings and to remain healthy.” Others reported increased self awareness of the triggers for binge behavior, saying: “I can feel it when I start to binge,” and “I know I have some trigger foods that set me up for a binge and those are sugar, carbs, and ice cream. I’m also able to stop myself before I get so far into a binge that I can’t stand to hold the food in.” Making healthy food choices throughout the day helped participants stay “even throughout the day and not anxious” and helped them to remain free of bulimic symptoms. A minority of subjects indicated
significant, ongoing difficulties in their relationship with food: “I still hate food but I am working on my relationship with it” and “I still have a horrific relationship with food; the only difference now is that I have stopped binging and purging and I have stopped counting calories.” Individuals who expressed significant ongoing conflict with food, while not engaging in active binge/purge behaviors, may need to process more of their underlying beliefs and attitudes towards food that contribute to these continued struggles. The term recovery, then, can be seen as reflecting a spectrum of levels of healing that varies from person to person in relationship to food.

**Relationship with Body**

When asked about how their relationship with their body has changed in recovery, subjects noted a renewed appreciation for their bodies, but many admitted to still working through residual appearance and body issues from when their eating disorder was most severe. Appreciation for their bodies was the overwhelming sentiment of those in recovery. Subjects said, “I appreciate my body [now] for what it does for me and realize how miraculous it can be,” “[I view my body] with more acceptance than before,” and “I don’t hate my body as much. I am more content with it than I used to be.” Recognizing the value and worth of their bodies was important to recovery: “Now I try to look at my body as something to be loved and cared for and I am much happier living in it [now],” and “my body has other purposes than to be (in my eyes) aesthetically pleasing.” Letting go of the unrealistic body shape expectations inherent in bulimia allowed subjects to realize that “healthy people don’t look like supermodels.” Acceptance of their bodies was a central component to recovery for subjects in this study, and thus, should be an integral component to clinical work with those with bulimia.
Even while full acceptance of the body was commonplace among those in recovery, there was still another undercurrent of body dissatisfaction among some participants. Some people expressed ambivalence over their body saying: “I don’t always love my body” but I appreciate it for what it does for me; “I’m judgmental of my body” but I’m taking steps to regain confidence in my body [paraphrased]; “I still have body issues” but I have more realistic expectations of myself and I recognize that it takes time to work through these issues [paraphrased]; and, “It’s a big issue for me... but I’m not constantly thinking about what I look like any more.” These quoted participants recognized their dissatisfaction with their body as residual influences from their eating disorder and were actively seeking to dissolve these remaining negative feelings.

There was also a small subsection of participants who were no longer bingeing or purging (physical manifestations of the eating disorder) but still had significant loathing for their bodies (a mental manifestation of the disorder). These subjects made comments such as: “I detest the way I look and don’t think I can ever fully recover until I am able to be comfortable with how I look;” “I still view my body with a lot of hatred;” and “[I] still put more of my attention on the number on the scale than I do on what I look like.” Comments reflecting such inner hostility toward the body point to the continued presence of significant eating disorder symptoms in clients, possibility laying the foundation for future relapse into the disorder.

**Relationship with Others**

Relationships with others were described as more honest, open, close, and strong, now that participants considered themselves to be in recovery from bulimia. Not having to hide the disorder or lie about symptom use was central to the change in interpersonal
relationships. One woman reported, “my marriage is SO much better now that there is no
deception of the eating disorder and no tension around meals or if I used symptoms that
day.” Numerous subjects reported feeling more honest with their families now that their
eating disorder was out in the open with comments such as: “I am more honest now - I can
look people in the eye,” and “I feel more honest with my family now because I’m not hiding
what’s really going on in my life.” There was an oft-repeated concept of “being more open”
in relationships with others that seemed to characterize these post eating disorder
relationships.

Subjects reported feeling closer to others, having more time for relationships, and
feeling more present with other important people in their lives (such as mother, father,
brother, sister, friends) now that they are in recovery. One participant stated, “I've gotten
closer to people because of my disorder.” Having more time for other people in recovery
was also important to making these relationships stronger; as one subject said, “I am able
to devote myself better to relationships [because] not all my thoughts and energy are about
food anymore. I can give to another.” Other respondents said that they had more time for
people and relationships now that they were not having to hide symptom use or worry if
others would “catch on” to their eating disorder. Several people reported being able to be
more “present” with others now that they were in recovery, whereas in the midst of the
disorder their mind continually returned to food, eating, bingeing, and purging. Overall,
there was a strong positive impact on relationships with others when subjects were honest
about their eating disorder struggles and no longer had to hide parts of their lives from
others.
However, there was also a minority of respondents that indicated their relationships with others were still strained, dishonest, and unsupportive even though they were in recovery. One woman said, “my relationship with my sister is worse because she was not supportive when I told her I had bulimia.” Another said that “as for my close friends, I haven’t even told many of them that I’ve struggled with [bulimia]” because she felt that some of them wouldn’t be able to handle the news about her eating disorder. There was an element of fear that pervaded these negative reports about relationship quality in recovery, which may be an area to explore in individual mental health therapy.

**Relationship with Self**

Recovery from bulimia had a very positive impact on participants’ view of themselves; it caused them to feel stronger, more in-control, and less at the mercy of negative self-thoughts. As one person said poignantly, “the pain that led me to become bulimic has transformed to make me a really strong person.” Another said, “I am a much stronger person [now] than I ever was when my [bulimic] symptoms were most intense.” There was a sense of being more “in-control” that emerged from responses such as, “I am more in-control, ironically enough, by letting myself eat what I want in moderation.” Other subjects reported, “I am more self-assured and I feel more in-control of myself [now that I’m in recovery],” and “I don’t feel out of control or insecure the way I used to [when my bulimic symptoms were most intense]. I am learning to trust myself again.” These responses reflect a realization that subjects were not helpless to change the symptoms of their eating disorder and were, instead, powerful enough to move beyond the disorder.

Participants also reported new positive perceptions and new ways of thinking about the self in recovery. There was a sense of appreciation for themselves that emerged from
comments such as, “I like me as a friend [now],” and “I can accept and even like who I am.” Some participants were even able to compliment themselves, saying “I see myself as prettier [in recovery] because I am more confident,” and “I am more mature.” One subject reflected that her sense of worth and value had broadened in recovery: “I see myself as a healthy weight now and as having more important characteristics than physical appearance.” Other subjects reported changing the way they thought about themselves in recovery by saying, “I’m not as critical of my self or my past now. I’m gentle with myself and my feelings” and “I’m not where I’d like to be [in my perception of self]... but I recognize mentally that I was most unhappy when I looked like that.” There was a sense of continual growth and development in subjects’ responses, as evidenced by the comment, “I am learning to trust myself again.” The change in sense of self in recovery was epitomized by the response of one young lady: “I used to call myself ‘crazy slasher throwup girl’ (cutting was also a big problem for me)... but now, I’m just me, who should probably eat more vegetables and watch less trash tv, but who also does some pretty cool things too.” These responses demonstrate that adjusting misguided thoughts and beliefs about personal identity and sense of self are important in recovering from bulimia.

**Most Important Recovery Factor**

Participants identified four primary categories of factors that were most important to recovery from bulimia: family, support from others, personal realizations, and other. The most frequent and important factor to beginning recovery, according to subjects, was their family. For some individuals, their family discovered their disorder and helped them seek treatment. For others, it was the realization of “how much what I was doing hurt my family and friends” and the value that family held in their lives that caused them to pursue
healing from bulimia. One woman reported that becoming a mother herself was the most significant factor in her recovery. Many respondents also said that it took the support of others (outside of their family) to really be able to heal and recover from bulimia. For some, this support from others meant that it took “everyone telling me I truly needed help [for my eating disorder]” or “finding others to support me [as I left an abusive husband and dealt with my bulimia issues].” Whether from family, friends or recovery meetings, it was essential to have support from others for most people to recover from bulimia.

Personal realizations about self, life, illness, and body were critically important factors in recovery for many survey participants. Some realizations included, “realizing that I could die and that I was damaging my body,” and recognizing that “I was either going to die from my eating disorder or I was going to find a way out.” As another participant said, “it’s now or never” in terms of starting recovery. There was a sense of culminating tension that led up to the beginning of seeking recovery for many participants. One subject said, “I only sought recovery when I felt that enough was enough and I needed help.” A minority of respondents identified very specific, unique factors that were key to recovery. These other factors encompassed spiritual pursuits like prayer, meditation, and personal connection with God; the prescription medication Topamax; cognitive behavioral therapy; and exposure therapy. Every survey respondent had one specific factor or moment that led to his/her recovery and healing, whether specific therapies, prescription medications, spiritual pursuits, personal realizations, or relational support. There were many factors and trigger events that brought individuals in this study to the point of seeking healing from bulimia. The journey to recovery can indeed start from many places.
Discussion

This research sought to understand participants’ experiences and beliefs about recovery from bulimia nervosa. It also looked into the types of services used in the process of healing, from professional to non-professional and spiritual, and invited participants to describe what was most helpful in each of these categories. This research also inquired into what had changed for participants in their relationships with their bodies, food, others, and themselves in recovery for the purpose of gaining a more comprehensive understanding of what it means to recover from bulimia.

Observations about Recovery

There was a strong sense of hope for healing from bulimia in this study, with the majority of participants in this study labeling themselves as in recovery. When reflecting on their own status in recovery, 75% of survey respondents stated that they considered themselves to be fully or mostly in recovery for an average of four years. These findings are consistent with previous research showing that 50% of former bulimia patients were in full recovery 5-10 years post treatment, 27% were significantly improved, and 23-30% continued to struggle with symptom use (Keel & Mitchell, 1997; Steinhausen, 2009). The level of recovery that participants chose for themselves in the current study was based on the frequency of eating disorder related thoughts and behaviors, time since last binge/purge episode, and emotions/desires to use symptoms. Recovery was subjectively defined by participants in this study and did not require a full remission of symptoms, similar to findings from prior research (Bjork & Ahlstrom, 2008; Pettersen & Rosenvinge, 2002). Clinicians working with patients with bulimia should be aware of the breadth of the
recovery spectrum described by people who have had bulimia and allow their clients to define their own recovery standards.

On a broader scale, recovery from bulimia is something that most former sufferers believe is possible for most people, according to the present study. Nearly half of participants (48%) said that they believed it was possible for someone to fully recover from bulimia, while a nearly a third (28%) said they were unsure if it was possible, and a fourth (24%) said that it was not possible at all. These findings contrast with previous research that found 70-72% of subjects believed recovery from bulimia was possible (Crow, et al., 2009; Rorty, Yaeger, & Rossotto1993; Steinhausen, 2009). This discrepancy can perhaps be attributed to different definitions of what it means to be in recovery and to the allowance for greater subjectivity in defining recovery in the current study. However, the optimistic outlook for recovery held by most people who have had bulimia is something that clinicians can convey to clients during treatment to instill hope.

Participants in this study also made several specific observations about the healing process that clinicians can pass along to clients as they begin their journey towards recovery from bulimia. Participants had four key insights about recovery: it takes time, some thoughts might never fully go away, it’s a choice to continue to recover, and inspiration from others is critically important. There are several potential implications for clinical practice that come from these observations. To increase inspiration and hope for healing, social workers might recommend biographies of individuals who have overcome bulimia or they might suggest involvement in a support group. Social workers should also work to empower clients to feel as though they have the power to choose their own recovery and that they are not at the mercy of the eating disorder. Social workers should
also work to cultivate realistic expectations about the recovery process, acknowledging for clients that some struggles may always remain and that it takes a long time to fully heal. These insights are critically important for social workers and other mental health professionals to convey to clients, as they provide a realistic yet hopeful picture of the healing process (Zerbe, 1995).

While healing and recovery seem to be achievable for the majority of those who have had bulimia, there is a subset of patients who continue to struggle with symptoms even with treatment. This minority is evidenced by the third of participants who stated in this study that they are only partially in recovery or not at all in true recovery. Past research has found a similar proportion of former bulimia patients still struggling with symptom use and disordered thoughts after treatment (Steinhausen, 2009). The respondents in the current study who described themselves as not in recovery gave some insight into why they were struggling in the open-ended questions: these individuals were still struggling to relate to their body, to food, and to themselves in an accepting, non-judgmental way. In the same way that a person’s character style influences his or her response to traumatic events, the presence or absence of certain personality traits might well contribute to the resilience and recovery of some individuals and not others (Spiers, 2001). The characteristics that predispose young women to develop bulimia, including perfectionism, impulsivity, and a desire for novelty, may be stronger in some individuals than others, thus making recovery more of a challenge for these individuals (Bardone-Cone, et al., 2008; Cassin & von Rasson, 2005). Having more difficulties in recovery may stem from powerful and influential biological factors at work in these individuals, or from their more dysfunctional families of origin (Broft, et al., 2011; Fairburn, Cooper, & Shafran,
Further research is needed to examine the variables that may be at work in the significant subsection of clients who continue to struggle with symptom use even after participating in treatment.

**Professional Services**

Survey respondents used a variety of professional services during their treatment and healing process from bulimia, reflecting the multi-disciplinary approach to eating disorder treatment currently used by major treatment facilities and supported by existing research (Petersen & Rosenvinge, 2010; Richards, Hardman, & Berret, 2007; Zerbe, 1995). The most commonly used professional services for this study were individual mental health therapy, medication management (psychiatry), and nutrition counseling, which are cornerstones of multi-disciplinary treatment for eating disorders (Zerbe, 1995). The high percentage of participants who said that individual therapy was the most helpful component within professional services reflects the success rate of personal therapy (72% for Cognitive Behavioral Therapy and 68% for interpersonal therapy) in treating bulimia (Fairburn, et al., 1993). When asked to describe what was most helpful about the individual therapy, participants said that it was important to “have someone to process life with” and someone to “help straighten out my [disordered] thoughts.” Participants also highlighted the relationship with the therapist, as well as the information learned through therapy about the diagnosis and what normal eating really was, as the more important aspects of professional services. The continued use of a multi-disciplinary approach for eating disorder treatment, with an emphasis on individual therapy, can be advocated for based on the findings of this study.
Non-Professional Elements

Family support, physical exercise, friend support, and extracurricular activities were the most frequently used and most important sources of non-professional support in recovery from bulimia. Prior research had also shown the importance of friend and family support in the process of healing from bulimia, buttressing the significance of this social support to participants’ wellbeing and recovery (Rorty, Yaeger, & Rossotto, 1993). The support from others (family, friends, support groups, etc.) was particularly helpful to survey respondents because it helped to ground them emotionally and give them hope for healing. Survey participants also stated that physical exercise was important because it provided an outlet for tension that might otherwise lead to detrimental coping mechanisms, and it helped them reconnect with their bodies in a healthy manner. The importance of extracurricular activities and hobbies in the healing process was found in their ability to distract and give participants something else to focus on besides the eating disorder. Clinicians should encourage the development of a healthy support network and cultivation of personal interests and hobbies for clients, as these were found to be important sources of hope, strength, and positive distraction for participants in this research. These non-professional elements, moreover, are more enduring in nature and more readily available as sources of support during recovery after professional treatment has ended (Bjork & Ahlstrom, 2008).

Spiritual Resources

The use of spiritual resources in the recovery process varied greatly among survey participants, even though two-thirds of respondents (66%) identified with some form of spirituality or faith. For some respondents, faith and spirituality were the most significant
components to their recovery process; these individuals reported faith to be a major source of strength, encouragement, and hope. Yet for others, spirituality played little or no role in healing; these individuals politely said faith was for other people but not them. Previous research and theorists have found spirituality to be a critical element in recovering from an eating disorder, so the wide range of value attributed to spirituality was surprising in this study (Jacobs-Pilipski, et al., 2005; Richards, Hardman & Berrett, 2007; Rorty, Yaeger & Rossotto, 1993). The ambivalence expressed by participants about spirituality may reflect an understanding of spirituality restricted to religious or institutional values; thus, clinicians might explore the value system that the client does use to navigate life (i.e. a sort of unlabeled spirituality). For non-spiritual clients suffering from bulimia, awakening spirituality (on whatever level, in whatever form) could unveil a previously unknown source of strength, encouragement, and hope that is frequently used by those who more readily embrace the spiritual dimension.

There are several important caveats to be made, however, with regards to the incorporation of spirituality into the therapeutic experience. Richards, Hardman, and Barrett (2007) adamantly maintain that social workers should work within clients’ existing worldview and value system, maintaining respect for the individual to determine his or her own beliefs. Social workers should also maintain clear professional boundaries with clients so that the role between therapist and clergy member/religious office is not blurred. Social workers should act as conduits to further exploration of the spiritual component of their clients, particularly those who are recovering from eating disorders, while being careful not to impose their own views onto the client. Most importantly, social workers should respect any decision by clients to not explore spirituality or not involve it in the therapeutic
environment. Spirituality may indeed be an untapped source of strength and support during recovery for some individuals, but results from this study indicate that a significant portion of individuals can recover without using spirituality.

**Important Recovery Components**

Professional and spiritual elements were listed as the “most important” aspect of the recovery process by an equal and significant number of respondents, indicating that they are both critical to healing from bulimia. The importance placed on professional and spiritual components by those who have recovered is significant in that spirituality is often overlooked or not addressed directly by current multi-disciplinary teams that focus on offering professional services to the client (Richards, Hardman, & Berrett, 2007). The second most important element to the recovery process was the non-professional aspect of support from family and friends, physical exercise, other activities, etc. These elements were secondary in importance to spiritual and professional services in recovering from bulimia, but they provide the crucial role of involving all aspects of a client’s life in the recovery process. The significance and importance placed on all aspects of healing (professional, spiritual, and non-professional) by participants in the current study provides support for the multi-disciplinary approach advocated for in existing research (Richards, Hardman, & Barrett, 2007; Zerbe, 1995). The significance attached to spirituality in recovery, however, is unique to the present study and may point to a need to incorporate more spiritual elements into the healing process from bulimia.

**Changed Relationships**

**Food.** Participants in the current study found that their relationship with food changed significantly for the better through the healing process. They reported a new
understanding of what hunger truly was (a physical urge not a means of satiating emotional pain). There was a new definition of food that emerged for participants in recovery as something healthy, enjoyable, and necessary for giving energy to live life. Food and eating no longer dominated the thinking of participants in recovery, and they were able to eat a wide variety of foods without guilt or need for compensatory behaviors. Bjork and Ahlstrom found a similar redefinition of food emerge from their study as well, further underscoring significance of findings in this present study (2008). Clinicians should note the change in relationship to food when discussing the recovery process with clients, making the connection between pathological understandings of food and bulimic symptoms, and providing hope for changing these understandings based on the stories of other survivors.

**Body.** Participants in the current study expressed a newfound appreciation for their body in recovery that was not present during the course of the eating disorder. Respondents said that they appreciated the body for what it does for them and spoke of it with acceptance in recovery. They described a letting go of unrealistic expectations for their body shape and size, which allowed them to embrace and appreciate their body for what it was (and not what it "should" be). Participants also described how they loved and cared for their body in recovery, instead of abusing and punishing it as they did during their eating disorder. This was a critical change in perception of the body that occurred with treatment and recovery in this study as in previous research (Bjork & Ahlstrom, 2008). Clinicians should include the change in perception of the body when describing what recovery and healing will entail to those seeking treatment for bulimia. Moreover, this should be something that is addressed directly during treatment, either by challenging
automatic negative thoughts about the body or by encouraging connection to body through methods such as yoga, bodywork, or physical exercise.

Others. Participants in the present study described a new openness in their relationship with others once in recovery that was not there when they were in active symptom use of bulimia. Respondents said that people were a priority for them in recovery and they valued their connections with others much more than when their eating disorder was controlling their lives. They also described their relationships as being more honest, especially since they no longer had to hide symptom use or struggles from those important to them. Although some participants reported an increase in tension or difficulty in their relationships, the majority of respondents in this study felt that their relationships improved in recovery, similarly to prior research (Bjork & Ahlstrom, 2008). Those who indicated continued difficulty in their interpersonal relationships spoke of fear of rejection from others and concern over not being accepted if they were honest about their eating struggles; these individuals are at increased risk for relapse into their eating disorder (Narduzzi & Jackson, 2000, as cited in Cassin & von Ranson, 2005). Clinicians should help clients work through the difficulties inherent in sharing about their eating struggles with important people in their lives, keeping in mind the knowledge that those who fail to fully disclose their eating disorder with others are at greater likelihood of relapse. The work that clinicians do to create a safe and caring relationship with the client may also help to reduce the sting of any uncaring responses from others.

Self. There was a significant change in participants’ perception of themselves from when their bulimia symptoms were severe to when they were in recovery. Participants described themselves as stronger people and more in control of their lives than when they
were constantly driven by desires to binge and purge. They were able to trust themselves more and had better thoughts about themselves when the eating disorder was no longer in control. One respondent succinctly stated, “I like me now [that I’m in recovery],” which was more than she could say before treatment. These positive changes in self-conception were found to be significant to maintaining recovery by prior studies (Bjork & Ahlstrom, 2008; Narduzzi & Jackson, 2000, as cited in Cassin & von Ranson, 2005). The results of the present study indicate then that there should be a focus on developing a strong, positive personal identity and a coherent sense of self during the course of individual therapies, such as CBT, to help clients maintain a recovery lifestyle.

**Beginning Recovery**

There were several repeated themes that emerged from participants of this study as to how the recovery or healing process started for them. Family was cited as a frequent reason for seeking treatment, either because their family discovered their disorder or because their family relationships motivated them to deal with their eating disorder. Others found that a change in life role, such as marriage or motherhood, was significant to beginning the process of recovering from bulimia, similar to previous research (Pettersen & Rosenvinge, 2002). Yet others emphasized the decision aspect of beginning recovery with statements such as, “I just decided that enough was enough. I was either going to find a way out [from my eating disorder] or I was going to die.” There was no one right way to begin the recovery process, according to respondents from the present study. The important thing was just to begin from wherever point possible. The road to healing and recovering from bulimia, then, can start from many different places. Clinicians can
emphasize the multitude of paths than can be taken towards recovery as a way of reassuring clients as they begin their journey away from bulimia.

**Implications for Social Work Practice**

There are several important messages about recovery that come from this study that social workers should be aware of when treating individuals with bulimia. The first is that those who have come through the healing process do believe that recovery from bulimia is possible, which is an important message of hope for clinicians to convey to clients as they begin treatment. Another message is that recovery is something that is subjectively defined by each individual, so there is no gold standard that clients must achieve to regain mastery over their lives. This knowledge should hopefully free clients from the pressure to live up to certain expectations and allow them to be easier on themselves in the recovery process. Social workers can also help clients set realistic, personal expectations for their healing by providing them with stories from others who have been in their position with the eating disorder and healed from it. Since survey participants noted the vital importance of having support and inspiration from others during the recovery process, social workers can facilitate this connection to others by recommending biographies of those who have recovered, encouraging participation in group therapy, or perhaps even arranging a mentoring program between someone further along in the healing process and a new client.

Other messages of importance that emerged from this study are that recovery starts from many places and that it is a long process, not an overnight fix. Using a procovery framework of constructing a better future from present circumstances, social workers can emphasize to clients that the path to recovery is unique for each client and it starts from
many different points. Recovering from bulimia is a long journey that involves both setbacks and forward motion, according to the current study. This realistic and compassionate outlook on the process acknowledges the very real possibility of relapse, while also empowering clients to move beyond those setbacks and continue their progress towards a healthy life. Social workers can also convey the message that recovery is a choice clients must make repeatedly throughout the healing process, which is something those who have recovered from bulimia found to be important to their healing. Interweaving these anecdotal pieces of information found through this study may be helpful in creating hope, crafting recovery expectations, and inspiring clients as they begin the recovery process.

Social workers should also be aware of the multitude of resources that individuals draw upon during the process of healing from bulimia, from professional to non-professional to spiritual. The multi-disciplinary approach adopted by social workers and medical professionals was supported by responses from this survey. Individual mental health therapy, medication management, and dietary counseling were the most important professional services in healing, according to former clients, so social workers should emphasize the importance and value of (at least) these three professional elements in the process. Social workers may need to be a broker and advocate for clients with their insurance providers to help them obtain access to these needed professional resources.

The importance that survey respondents placed on non-professional aspects of the recovery, such as family and friend support, physical exercise, and hobbies, should also be acknowledged by social workers and encouraged for clients. Clients who fostered the development of these relationships and activities found themselves better able to maintain
the gains made during treatment (Bjork & Ahlstrom, 2008). Social workers can draw upon some of these anecdotal research findings to support clients in developing a healthy, honest support system, a regular exercise routine, and a greater involvement with activities of interest.

Social workers can also be advocates for clients to explore their spiritual side during the process of healing from bulimia. Spirituality and faith connections were found to be as important as professional services in recovery for some participants in the current study, while a strong minority also said that spiritual resources were of no assistance to them in recovering. Social workers, however, should encourage clients to explore their spiritual/religious beliefs as they pertain to their eating disorder, as this was anecdotally found to be a significant source of strength for some people in the recovery process. Yet, social workers should also be sensitive and respectful of clients who decline to explore or utilize spiritual resources in their recovery, as many individuals in the present study also recovered without accessing these resources. Social workers can utilize knowledge of common components of the healing process to help clients see recovery through a holistic framework that encompasses every area of life.

Social workers should also be informed about what changes during the recovery process in relationship to food, body, others, and self in order address these four areas directly in treatment. Individuals who have recovered from bulimia reported a positive, healthy change in their understanding of food, hunger, and appetite through treatment. Social workers should be sure to put clients in touch with a dietician who can provide some dietary counseling and should also educate themselves about what normal eating is to provide additional psycho-education to clients. Social workers should also pay attention to
disordered thoughts related to body shape, size, and appearance in clients, and work to foster acceptance, care, and appreciation for the body instead. Social workers can be advocates, educators, and encouragers for clients as they work to develop healthy and honest relationships with important others in their lives to support their recovery from bulimia. Participants in this study also noted the importance of developing a strong sense of self and personal identity during recovery, thus social workers can use CBT and other individual therapy techniques to address flawed thinking about the self and encourage the development of a positive personal identity. If social workers can be cognizant of the importance of these four areas in the treatment process, clients will have at least begun to look at their relationships with their body, self, food, and other people, as these are important areas for healing from bulimia.

**Strengths and Limitations of This Research**

This research design was strengthened by its foundation on previous peer-reviewed studies of recovery from bulimia, and the use of both quantitative and qualitative methodologies. Drawing on existing knowledge of healing from bulimia, this researcher created a survey instrument that yielded information about previous results from qualitative studies, through quantitative means. The variety of subject pools tapped by this research project (online support groups, personal connections, and university students) added depth to this project by reaching a broader range of participants; however, there was no place for subjects to indicate how they heard about the survey, so the actual breakdown of sources for participants is unknown. The online format of this study, ideally, also made participation in the survey more possible to a greater number of people. Finally,
the qualitative questions allowed the respondents to introduce new influences on their recovery from bulimia that were not addressed elsewhere in the survey.

There were several limitations to the present study that affected the ability to generalize the findings about recovery to the broader population of those who have bulimia. The participants in this study were fairly homogenous in terms of educational background, race, and gender, which left out the opinions of those with bulimia from other backgrounds. Therefore, the ability to generalize these responses to other cultural groups, including adolescents and immigrants, is limited in the present study. The sample size of the current study also did not allow for results to be descriptive of the recovery process for all individuals, even though there were a variety of routes and methods of recovery described by participants in this study. Although it was useful to have both qualitative and quantitative questions in the survey designed by this researcher, the dual approach may have weakened the strength of findings from both methodologies. The responses to the qualitative questions may have been shorter because participants were already tired from completing numerous quantitative questions. There were also not as many quantitative questions in the survey, due to the inclusion of more descriptive questions, which limited the ability to correlate results and make tentative suggestions as to the relationship between variables in the healing process.

Several respondents to this survey indicated that they also had other diagnoses of eating disorders and mental health struggles that may have influenced the findings of the study. The co-occurrence of mental health and eating related struggles is common, but the way in which the multitude of diagnoses influenced the treatment methods used by individuals to heal from bulimia is uncertain in this present study. There were also several
individuals who indicated that they were not in recovery from bulimia, which was a pre-requisite to participating in the study, but there was no way to separate out their responses from other participants in the present study, which may have impacted the results of quantitative questions. These limitations should be addressed directly in future research.

**Suggestions for Future Research**

Future research in the area of recovery from bulimia could look more in depth into some of the findings from this study. There are clearly many factors that play a role in healing from bulimia, but future studies could examine the specifics about one area, such as non-professional services, and perform a qualitative analysis of how these components helped with healing. The role of spirituality in the healing process should certainly be explored in greater depth with future research, since results from the present study provided only preliminary information on how spirituality is incorporated (or not incorporated) into the recovery process. Since there were numerous individuals who began the survey for this study, but did not complete it, future researchers should make every effort to ensure full participation of potential subjects, perhaps through material incentives or through a shorter survey format. Future studies should also seek to broaden the recruitment base to more treatment facilities, eating disorder support organizations, educational institutions, or other unlisted sources to gain more participants. The survey instrument created by this researcher should also be revised, and the use of both the quantitative and qualitative questions should be re-considered, per limitations listed above, in any future research. Addressing the role of culture on the development, maintenance, and recovery of an eating disorder in future studies could expand the multi-
cultural application of results and the further understanding of eating disorders across social groups.

Conclusion

The findings of this study reinforce the results of previous research supporting multi-disciplinary, multi-modal treatment guidelines for those with bulimia nervosa. Professional services, particularly individual therapy, were the most significant factors in the healing process according to those who are in recovery. Spirituality was also the primary motivating factor for a sub-segment of participants, but it was not the key to recovery for everyone. Non-professional elements play an important contributory role to the healing of bulimia, but are not the primary means by which individuals become well. Participants in this study highlighted the significance of changing their beliefs about food, body, self, and others in moving towards healing. There was not a universal starting point for the process of becoming healthy from bulimia, but rather, individuals began their journey towards healing when “enough was enough” and something needed to change. Healing from bulimia required changing many things, but recovery was something that those who have made the journey firmly believe to be possible. Recovering from bulimia is a journey forward that starts from many different places, but for the social worker, it always begins where the client is.
References


Appendix A

Consent Form

General Study Information:
This is a MSW graduate student research project about what helps in the process of recovery from bulimia.

Invitation to Participate:
You are invited to participate in this research because you self identify as being in the recovery process from bulimia and are no longer in the acute phase of illness or actively in full-time treatment. You must also be 18 years of age or older.

Purpose of this Study:
Research has shown that recovery from bulimia is possible and that it often comes through a variety of treatment sources. The goal of this study is to better understand what types of treatment you used in your recovery process, what has changed for you since you were in the active stages of bulimia, and your thoughts about the recovery process.

Participation Process:
If you agree to be in this study, you will be asked to answer a series of questions about your views on recovery, your recovery status, types of treatment you used, and other demographic questions. This survey should take you about 15-25 minutes to complete.

Risks and Benefits of the Study:
It is possible that answering the questions on this survey may stir up memories and emotions related to your eating disorder. A list of resources and support services will be provided at the end of the survey.

There are no direct benefits to participating in this study. There is no compensation or other reward for your participation.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntarily. You are free to withdraw from this study at any time or skip any questions that may be asked. Your decision to participate in this study or not will not affect your relationship with the University of St. Thomas or any other affiliated agencies both now and in the future.

Confidentiality:
The information collected in this study will be completely anonymous. There will be no way to determine your identity or that of other participants. The only identifying information collected will be the general demographic information you disclose in the survey.

Therefore, given the anonymous nature of the data, all information collected from you and other participants will be kept indefinitely in locked, password protected Excel and Word
documents on the principal investigator’s personal computer for use in future research. The only persons who will have access to these anonymous survey responses are the principal investigator, Erin Reynen, and the chair of the research, Dr. Jessica Toft.

Contacts and Questions:
You may contact any of the following persons or agencies with questions or concerns about the research.

Principal Researcher’s Name: Erin Reynen
Contact Info: roff3601@stthomas.edu or (651) 226-6128

Research Advisor’s Name: Dr. Jessica Toft
Contact Info: jetoft@stthomas.edu or (651) 962-5803

University of St. Thomas Institutional Review Board
Contact Info: (651) 962-5341

Statement of Consent:
I give my consent to participate in this study. I have read the above information and understand what is being asked of me in this survey. I confirm that I am at least 18 years of age and consider myself to be in recovery from bulimia (i.e. not in acute phase of illness or in active, full-time treatment).

I give my full consent to participate in this study by clicking the YES button below.

___ Yes

___ No
Appendix B

Healing from Bulimia Survey

Do you consider yourself to be in recovery from bulimia?
___ Yes
___ No

To what extent do you consider yourself to be in recovery? (Please select only one).
___ Partially
___ Mostly
___ Fully

Explain why you feel you are at this stage or level of recovery

Do you believe it is possible to fully “recover” or heal from bulimia? (Please select only one).
___ Yes
___ No
___ Unsure

Why? Why not? ____________________________________________________________

-----------------------------------------------------------------------------

The following section allows you to share more about what paths you took to recover from bulimia: professional services, nonprofessional elements, and spiritual resources.

Please select the following professional services you used during your recovery process. [Check all that apply]
___ Intensive Outpatient
___ Day Treatment
___ Inpatient Hospitalization
___ Residential Treatment
___ Group Therapy
___ Medical Services
___ Medication Management (Psychiatry)
___ Individual Mental Health Therapy
___ Family Counseling
___ Nutritional Counseling
___ None
___ Other (please specify): ____________________________________________

Please rank the top three most important professional services in your recovery process.
(1=Most important, 3=Least important)
___ Intensive Outpatient
___ Day Treatment
___ Inpatient Hospitalization
___ Residential Treatment
___ Group Therapy
___ Medical Services
___ Medication Management (Psychiatry)
___ Individual Mental Health Therapy
___ Family Counseling
___ Nutritional Counseling
___ None
___ Other (please specify): ________________________________

What about these top three most important professional services was most helpful to your recovery? (i.e. what did you learn or how did they help).

Please select which of the following non-professional services you accessed during your recovery process:
___ Family support
___ Friends
___ Significant other (spouse, partner, boyfriend/girlfriend)
___ Bulimia or eating disorder support group
___ Exercise
___ Yoga
___ Alternative medicine
___ Self-help books
___ Art/music therapy
___ Extra curricular activities (sports, music, drama, etc)
___ Other (please specify): ________________________________

Please rank the top three most important non-professional services in your recovery process. (1=Most important, 3=Least important)
___ Family support
___ Friends
___ Significant other (spouse, partner, boyfriend/girlfriend)
___ Bulimia or eating disorder peer support group
___ Exercise
___ Yoga
___ Alternative medicine
___ Self-help books
___ Art/music therapy
___ Extra curricular activities (sports, music, drama, etc)
___ Other (please specify): ________________________________

What about these top three most important non-professional services was most helpful to your recovery? (i.e. what did you learn or how did they help).

Please select which of the following spiritual resources you accessed during your recovery process:
___ Prayer
___ Meditation
___ Worship songs
___ Reading religious texts
___ Attending religious services
Taking spiritual/religious courses
Support from faith community
None
Other (please specify): ........................................................................................................

Please rank the top three most important spiritual resources in your recovery process.
(1=Most important, 3=Least important)

Prayer
Meditation
Worship songs
Reading religious texts
Attending religious services
Taking spiritual/religious courses
Support from faith community
None
Other (please specify): ........................................................................................................

What was helpful about these top three most important spiritual resources in your recovery? (i.e. what did you learn or how did they help).

Please rank (on a scale from 1 to 3) how important professional, non-professional, and spiritual elements were to your recovery. (1= most important, 2= second most important 3= least important)

Professional services
Nonprofessional elements
Spiritual elements

In the following section, please describe your experience of recovery in 1-5 sentences.

How has your relationship to food changed (i.e. now vs. when bulimia symptoms were most intense)?

How do you view your body now compared to when bulimia symptoms were most intense?

How do you view yourself today compared to when bulimia symptoms were most intense?

Have your relationships with others changed (i.e. now vs. when bulimia symptoms were most intense)? Describe.

Looking back on your journey, what would you say was the most important factor that led to your healing and recovery?

Demographics
Age _____

Female  Male  Transgender
Employment status (Check all that apply)
___ Full time
___ Part time
___ Student
___ Unemployed but seeking employment
___ Unemployed (homemaker, retired, disability, etc)

How would you describe your current spiritual/religious affiliation?
___ None
___ Catholic
___ Jewish
___ Muslim
___ Buddhist
___ Protestant (please specify) _____________________________
___ Spiritual but not religious
___ Other (please specify) _____________________________

Eating disorder diagnosis: ___________________________________________________________________________

Other mental health diagnosis: ___________________________________________________________________________

Length of time with an eating disorder: __________(years)

Age of onset of eating disorder symptoms: ______

Age at beginning of treatment: ______

Length of time in “recovery:” __________ (years)

Additional Resources:
This survey covered some very personal topics, so should you desire to discuss anything that came up for you during the course of this survey, please consider the following resources:

Counseling and Psychological Services at UST:*
St. Paul Location
MurrayHerrick Campus Center, Room 356
2115 Summit Ave
Saint Paul, MN 55105
Phone 651-962-6780
Email counseling@stthomas.edu
Hours Mon-Fri
8:00 am to 4:30 pm

Minneapolis Location
1000 LaSalle Avenue, Suite 110
Minneapolis, Minnesota 55403
(1st floor of TMH)
Phone 651-962-4763
Hours Mon: 9:00am to 5:30 pm
Tue: 9:00am to 6:30 pm
Wed: 9:00am to 5:30 pm
Thur: 9:00am to 5:30 pm
Fri: 9:00am to 4:30 pm
* Available to current UST students only.
Joy Project:
Provides online and inperson support groups, information on eating disorders, and links to local resources in Minnesota.
www.joyproject.org

The Emily Program:
Provides residential, day treatment, outpatient, and dietetic services for individuals with eating disorders in Minnesota.
www.emilyprogram.com

The Melrose Institute:
Provides specialized, multidisciplinary treatment for eating disorders. Located in St. Louis Park, MN.
www.parknicollet.com/MedicalServices/EatingDisorders

National Eating Disorders Association:
Provides education information on eating disorders and links to local service providers. Call 18009312237 or visit www.nationaleatingdisorders.org/gethelptoday