Women’s Recovery from Anorexia Nervosa: A Systematic Review and Meta-synthesis of Qualitative Research.
Abstract

Background: Anorexia Nervosa (AN) is a complex and challenging condition and recovery can be a slow and difficult process. Predicting factors remain largely unknown.

Aims: This paper aims to systematically review qualitative studies which have investigated female service users’ experiences of recovering from AN and carry out a meta-synthesis of the themes they identified.

Methods: Meta-ethnography was used to select and synthesize the studies. Articles published between 2002-2017 were searched in PsycInfo, EMBASE, CINAHL and Medline. Studies were included if they explored recovery from AN using a qualitative methodology. The methodological quality of the studies was systematically and critically appraised.

Results: Fourteen studies were selected for inclusion. Common themes reported by participants describe the process of recovery from AN as dealing with a fragmented sense of self, a turning point where insight and commitment to recovery is developed, and, in recovery, a reclamation of self through meaningful relationships, rebuilding identity and self-acceptance.

Conclusions: Recovery from AN is experienced as a complex psychological process with many contributing factors. Findings highlight the need to reconsider clinical practice and treatment provision to incorporate the psychological components of self-identity into recovery programs.

Key words: Qualitative systematic review, meta-synthesis, lived experience, Anorexia Nervosa, recovery
Introduction

The pathway for AN is reported to be influenced by a number of risk factors including genetic predisposition, familial difficulties, low self-esteem, depression and high anxiety (Steinhausen, 2002; Vall & Wade, 2015). The course of AN can have severe adverse effects on the individual, indeed AN has been found to have the highest mortality rate among eating disorders (Arcelus, Mitchell, Wales & Nielson, 2011) and outcome studies suggest that less than half of sufferers are recovered at follow-up (Harbottle, Birmingham & Sayani, 2008). Despite research on treatment effectiveness and on-going development in therapies, recovery rates have not improved and successful intervention remains limited with up to one-fifth of sufferers developing a chronic condition where they do not recover from their anorectic symptoms (Steinhausen, 2002).

Several problems have been highlighted with research into treatment effectiveness for AN which include high attrition rates, small sample sizes, insufficient rigor in design and analysis, and a lack of standardized definitions (Agras, Brandt, Bulik, Dolan-Sewell & Fairburn, 2004; Watson & Bulik, 2013). Although some recent studies have utilized longitudinal designs (Eddy et al., 2017; Le Grange et al., 2014), most researchers have investigated only short-term physical recovery and in order to determine whether full recovery has been achieved, a more comprehensive and long-term approach (including the measurement of psychological, behavioural and social functioning) is needed (Bardone-Cone et al., 2010; Strober & Lock, 2015). There remains a lack of evidence on the factors that lead to successful recovery and it is thus not possible to reliably predict which patients will recover and which will develop chronic AN (Strober, 2004; Zipfel, Giel, Bulik, Hay & Schmidt, 2015).

There are significant methodological issues in relation to the definition and measurement of recovery from AN with criteria varying vastly between studies and no consensus on definition. The majority of the research on recovery from eating disorders has used quantitative outcomes with a medical model perspective that defines recovery from AN as
failing to meet diagnostic criteria (due to weight gain and return of menses) (DSM-V; APA, 2013) and/or improvement on eating disorder self-report questionnaires (e.g. Eating Disorder Examination Questionnaire – EDE-Q; Fairburn and Beglin, 1994). However, these indicators do not necessarily represent a return to normal functioning and full physical and/or psychological wellbeing. Whilst patients may have regained weight, they may still be experiencing significant psychological distress (Lowe et al., 2001) and may not have acquired adaptive coping skills. Indeed, researchers have recently identified the need for a resolution of physical, behavioural and psychological symptoms. However to date such an approach has not been consistently or widely used (Bardone-Cone et al., 2010; Strober & Lock, 2015).

A number of researchers have used qualitative methods to explore the experience of having an eating disorder (ED), perceptions of treatment and the identification of recovery factors (e.g. Colton & Pistrang, 2004; Tierney, 2008). The findings of these studies reveal that recovery from AN goes beyond conventional treatment factors and identified a number of personal and inter-personal factors (e.g. motivation for change, engagement in activities/experiences that improve self-esteem, supportive relationships) as fundamental to recovery (Federici & Kaplan, 2008; Lamoureux & Bottorff, 2005). However, our understanding of AN recovery and how to prevent chronicity remains limited.

A review of 23 studies by Bell (2003) on AN patients’ experiences of treatment suggests that support, understanding and empathic relationships (professional or non-professional) are essential factors for facilitating successful treatment and that interventions that address psychological and physical outcomes are essential for recovery. Only 11 out of 23 papers included in this review were qualitative studies of patients’ with AN, while the remaining studies focused on patients’ with bulimia nervosa (BN), mixed eating disorder populations or families and caregivers.
Espindola and Blay (2009) conducted a systematic review and meta-synthesis of sixteen qualitative studies published from 1990 to 2005 on patients' understanding of treatment for AN. They identified several second order themes including the ‘process of change’ and the ‘perception of treatment modalities’. From this, a third order interpretation yielded a meta-category of ‘self-reconciliation’. This review focused on all forms of eating disorders and, like the previous Bell (2003) review, lacks a detailed appraisal of the methodological quality of the included studies.

More recently Duncan, Sebar and Lee (2015) conducted a meta-synthesis of 8 qualitative studies exploring individuals experiences of AN recovery published between 2004 and 2013. This identified a number of second order themes across studies, including ‘regaining power and control’, ‘finding and accepting one’s self’ and ‘acknowledging the consequences of anorexia nervosa’. From this, a third order interpretation yielded two meta-categories of ‘empowerment’ referring to a process of reclaiming power and control over one’s life and ‘self-reconciliation’, the latter referring to a reflective process of redefining one’s identity through recognition of the consequences of AN. Duncan and colleagues’ review benefits from a standardized critical appraisal of methodological quality. However, as in previous reviews, a number of the studies included mixed ED samples.

This inclusion of mixed ED samples is problematic as despite the suggested trans-diagnostic nature of EDs (Fairburn, Cooper & Shafran, 2003), it can be argued that unique differences in presentation may be overlooked (Birmingham, Touyz & Harbottle, 2009). AN, for example, is associated with severe and continuous caloric restriction and weight loss, while caloric restriction is regularly punctuated with binging episodes for patients with BN, resulting in typically normal weight presentations (Fairburn & Harrison, 2003). This can allow for BN sufferers to more easily conceal their disorder from others and maintain a functional social and work life, therefore avoiding detection and treatment for greater lengths of time (Pettersen, Rosenvinge & Ytterhus, 2008). Thus, revealing the secretive nature of their ED to others is often cited as an important aspect of the BN recovery process (e.g. Lindgren,
Enmark, Bohman & Lundström, 2015; Nakamura, 2012). Because of obvious weight loss in AN, which others cannot fail to notice, there is less chance that the condition remains hidden. There are also differences in the recovery trajectory for AN and other EDs. AN has been found to have lower long-term recovery rates compared to BN, as well as higher mortality rates and lower reported quality-of-life compared with other EDs (Arcelus, Mitchell, Wales & Nielsen, 2011; Bamford & Sly, 2010 Fichter & Quadflieg, 2007). There are also distinct differences in treatment requirements among EDs (e.g. inpatient care and nasogastric feeding are more specifically linked to AN; Fox, Larkin & Leung, 2011; NICE, 2004). Thus, despite the potential utility of ED trans-diagnostic research samples (Fairburn et al., 2009), individual patients’ experiences of onset, course, treatment and recovery may vary depending on the particular form of ED disorder, which does not allow for the participant homogeneity required by most qualitative research methodologies. In the light of previous reviews including mixed samples, there is a need to summarize the existing qualitative research on recovery from AN exclusively, in a succinct body of evidence.

The current paper expands on the previous reviews by systematically reviewing the most recent qualitative research on the experience of recovering from AN, whilst providing in-depth methodological appraisal of the qualitative studies in a meta-synthesis. The term meta-synthesis is commonly used to describe a number of methods that involve thorough examination and interpretation of the findings of qualitative research. The themes and quotations from qualitative studies are synthesized and as the methods are interpretative in nature, the aim is to further develop understanding and explanations of phenomena, generating more substantial and new insights and understanding (Walsh & Downe, 2005). This review distinguishes itself from similar reviews of literature (e.g. Duncan et al., 2015) by focusing upon studies with exclusive AN samples and excluding studies with mixed ED samples for which recovery experiences may differ.

We have systematically searched and collated qualitative research evidence that may throw light on the following questions: How is the journey to recovery experienced by women
diagnosed with AN? What do service users consider to be important factors determining long-term outcome?

**Method**

**Search Strategy**

A systematic search of the literature was conducted to search for articles published in a 15-year period (between 2002 and May 2017) using Medline, PsycINFO, Embase, and CINAHL (2002-2017). The following exploded search terms were used:

- “Anorexia” OR “Anorexia Nervosa” AND “Recovery” AND “Qualitative” OR “Narrative” OR “Thematic analysis” OR “Phenomenolog*” OR “Grounded”

Additional studies were located from manual searches of previous reviews and article reference lists.

**Inclusion and Exclusion Criteria**

Studies identified were evaluated and selected if they met the following inclusion and exclusion criteria:

**Inclusion criteria**

- Published in the English language
- Published in a peer reviewed journal
- Included individuals who met DSM-IV or DSM-V criteria for diagnosis of AN
- Reporting qualitative research on experience of recovery from AN
- Included adolescents and/or adults only

**Exclusion criteria**

- Primarily quantitative in research design, including only parts of qualitative methodology
- Unpublished, case study or book chapter
- Review articles
- AN was not the primary problem or included a mixed ED sample

**Results**

The systematic search yielded 308 papers which were screened according to relevance of title and abstract. From these, 34 required further scrutiny to determine whether they met the review criteria. Studies were excluded because they included a mixed eating disorder sample (N=10); did not focus on the experience of recovery (N=8); had a predominantly quantitative focus (N=1) or was a case study (N=1). Finally, fourteen papers were included in the review.

A summary of the characteristics of all the studies reviewed and strengths and limitations is presented in Table 1.

**Quality assessment**

The quality of studies included in the current review was assessed using a quality appraisal checklist (see Table 2) incorporating ten evaluative criteria from existing qualitative quality frameworks (CASP, 2002; Mays & Pope, 2000).

Using the outcome ratings of Cesario, Morin &, Santo-Dondo (2001) each criterion was assessed and given a score of 3 points if well addressed, 2 points if adequately addressed, 1 point if poorly addressed and 0 points if not applicable or not reported, to determine a profile of strengths and weaknesses. A total quality score was given (max. 30). Studies that met 75%-100% of the maximum total score (22.5-30) were given a grade of “++”. These studies were considered to have high transferability. Studies that met 50%-74% of the maximum total score (15-22.4) were given a grade of “+”. These studies were defined as having a moderate transferability. Studies that met less than 50% (<15) of the maximum total score were given a grade “-“ and were said to have low transferability.

The quality ratings for the fourteen studies are presented in chronological order in Table 2. The studies will be referred to by the number allocated to them in this table.
Ratings range from 13 (studies 4 and 7) to 27 (studies 8 and 13) and a trend is observed that suggests that since 2003 quality has improved over time. Nine studies have a total score of 75% or more and are assessed to have high transferability (studies 2, 3, 8, 9, 10, 11, 12, 13 and 14). Three studies have a total of 50-74% and were assessed to have a ‘moderate’ transferability (studies 1, 5, and 6). Two studies have a total of <50% and were assessed to have ‘low’ transferability (studies 4 and 7).

Table 2 about here
Critical Appraisal

All fourteen studies reviewed are contextualized by describing existing literature, with all researchers making a clear statement of their rationale and research aim.

Most studies appear to have a good match between research aims and chosen methodology. Of the fourteen studies reviewed, nine used interviews, three used autobiographical accounts of recovery, one used telephone interviews and one used a mix of focus groups and interviews. A range of qualitative approaches were utilized with five of the reviewed studies using grounded theory, three using interpretative phenomenological analysis, one using content analysis, one using narrative enquiry, one using thematic analysis and three studies did not specify the approach utilized. Three studies used QSR-NVivo software to aid analysis.

The sample sizes range from 5-69 (median 15) and include 271 participants in total (aged 14-64). Most studies include details of recruitment procedure and participant characteristics. All of the samples except one (study 14) are exclusively female. The majority of the studies do not report additional demographic information such as ethnicity or socio-economic background. Indeed, only four studies report on the ethnicity of participants (studies 2, 3, 7 and 13). A strength of study 2 and 9 is the detail included on SES, marital status, religious beliefs and educational level of participants.

Recruitment varied across the fourteen studies, with studies recruiting participants who had used hospital services (1, 6, 9 and 13), child and adolescent psychiatry clinics (4), through posters, flyers & newspaper advertisements (2, 3, 5, and 11) broadcast on radio and television (11), ‘snowball technique’ (2, 9 and 5), flyers circulated to self-help organizations (3), community sources and internet postings (7), and research databases from registered charities and adverts on their websites (8 and 13).
The definition of recovery varies across studies. Six studies use absence of symptoms (1, 4, 6, 9, 11, and 13). Study 9 has absence of symptoms confirmed by self-report, doctor and a family member. A strength of study 11 is the use of objective recovery criteria (BMI taken at time of interview, absence of behavioural features of an ED, and scoring within one SD of community norms on all subscales of the EDE-Q). Self-reported recovery is used by studies 2, 3, 5 and 8. Studies 10 and 14 chose autobiographical accounts that describe recovery as either weight gain or physical and psychological improvement. Study 12 uses autobiographical accounts of individuals “recovering from AN”, defined as someone who acknowledges AN, the harm it causes and who has made a conscious decision to recover. Studies 7 and 13 recruited participants still in the process of recovery, defined by scores on the EDE-Q.

Credibility of findings is most frequently assessed by having more than one researcher involved in the analysis (1, 4, 6, 9, 10 and 11). Some studies (8, 12, 13 and 14) had discussions amongst authors but transcripts were not independently coded. Study 7 had 20% of sample interview coded by another researcher. Only studies 2, 9, 10 and 13 reported having reached a point of data saturation. Study 11 aimed to achieve credibility by keeping an audit trail to ensure transparency, coding by two researchers, memo writing and verifying the analysis with participants. Two earlier studies (2 and 3) also involved participants in verifying and refining their analysis. All except study 4 use quotes to support their interpretations. The majority of the studies do not explicitly demonstrate reflexivity by considering the relationship between researcher and participants, and/or a critical examination of the researcher’s assumptions, background and biases. The exceptions are studies 5 and 13 who both provide a thorough report and reflection on their assumptions and biases and their specific viewpoints, study 8 which utilizes a qualitative support group.
to encourage reflexivity and the authors of study 12 who provide a brief reflection on their prior assumptions and kept a reflective journal of the data analysis process.

Reference to ethical considerations also varies across studies. Eleven studies state that they sought ethical approval or gained participants’ consent. Studies 10 and 12, due to their use of autobiographical qualitative data in the public domain, did not seek approval, as it was deemed unnecessary. Study 5 only makes reference to ensuring confidentiality and anonymity.

Finally, evidence of contribution and implications to existing knowledge of the research are provided by all studies. Acknowledgement of study limitations is generally provided, with the exception of studies 2, 3, 4 and 5. Four studies do not give suggestions for future research (1, 3, 4 and 6).

Meta-Synthesis: Extraction and Data Synthesis

Meta-ethnography (Noblit & Hare, 1988), a type of meta-synthesis, was used in the current review. This method was chosen as it allows the synthesis of studies that employ a range of qualitative methods whilst preserving the structure of the primary data. The seven stages of meta-ethnography are presented in Table 3 (Atkins et al., 2008; Noblit & Hare, 1988).

Due to the interpretative nature of conducting the meta-synthesis care was taken to ensure the first author (CS), who took the lead in this analytical procedure, was aware of her own experiences and understanding of recovery. A reflective journal was kept during the analytical process, along with regular discussions with colleagues and regular supervision sessions with the second and third authors (BSK and NL).

Meta-synthesis Findings
The key factors in women’s experience of recovery from AN identified by the meta-synthesis are presented in Table 4.

The over-arching third order theme across all studies is a development, understanding and acceptance of the self, which is achieved in recovery. Women develop their self-worth “the subjective feeling of having value as a human being simply by virtue of existing.” (Granek, 2007 p. 378)

Quotations from study participants appear in italics, quotations from study authors do not.

**Fragmented Sense of Self**

**No Sense of Self**

In six studies women expressed the development of AN in the context of not having a sense of self or self-worth (2, 3, 5, 8, 11 and 13).

"With anorexia they experienced “a huge sense of no sense” of who they were… “What we’re all trying to find is … that sense of self. Who am I? What are my boundaries?” (Lamoureux & Bottrorff, 2005 p. 174.)

“Who I am, what I want, and where I fit in” and “Restricting all your needs: spiritual, personality, nurturing. You live for everybody else.” (Weaver et al., 2005 p.192).

Whilst experiencing AN women judged their personal worth according to external standards; they experienced their life as “out of control” and had rigid expectations of what they thought they should be.

“I was living with a focus that was outside of myself, so my worth was dependent on what others thought or said about how I behaved or what I accomplished… and how well I did a thing” (Lamoureux & Bottrorff, 2005 p.181).

“I didn’t feel like I was good enough to eat and I felt guilty every time I… took in anything… I thought I shouldn’t feel the feelings I did … so I decided I was a bad person” (Lamoureux & Bottrorff, 2005 p.176).
Weaver et al (2005) describe the impact of not having a sense of self thus:

“They do not know how to differentiate their own needs and wants separately from what they perceive others expect of them” p. 193.

**Powerless in Relationships**

Some women described histories of sexual abuse in which they felt so powerless that they lost sight of their inner self and this sparked a need to be in control.

“I don’t like being out of control…. I think any sort of like, any, again issues of control … any sort of sexual assault of any kind, someone’s taking some sort of control away from you so, I think, if that something that happens to you, you are going to be a person that wants to be in control.” (Granek, 2007 p. 374)

“A memory that I had completely blocked as a child was uncovered. During the course of therapy I suddenly remembered that I had been sexually abused by my brother. This revelation was very distressing and intense for me. My need for control made a lot more sense. It seemed clearer to me why I wanted to torture myself and why I felt so controlled and angry as a child.” (Dawson et al., 2014 p.16)

Other women described relationships with partners, parents or treatment teams that were experienced as controlling, over-shadowing or abusive and not meeting their emotional needs (studies 2, 3 and 11).

“I started to become aware that the anorexia wasn’t a choice, it was a reaction. As a teenage girl the only thing I could control was my body because I had no power. Exploring the issues behind the eating disorder was helpful for me - knowing where my need to be perfect came from and realizing that I achieved perfection through eating.” (Dawson et al., 2014 p.16)

**AN as Part of Identity**

It appeared that women in the studies included in this review developed AN to manage their inner turmoil, sense of powerlessness and need to feel worthy or valued. However, they then began to lose themselves further into the obsession of AN, and this compounded a lack of a sense of self as AN became a part of their identity (studies 2, 3, 8, 11, 13 and 14).
“The eating disorder seemed to provide a sense of self and become all that participants were, making it hard to separate the self from AN. Individuals became 'an anorexic', with AN providing an identity. Participants viewed themselves as anorexic, and it was what they were known for. The eating disorder seemed to give them a self-image, a persona, and it was an identity over which they had control” (Williams, King & Fox, 2016 p. 221)

“Women define themselves by the AN, equating self-worth with weight loss” (Weaver, Wuest & Ciliska, 2005 p. 194)

“I wasn't allowed to associate with other people.... I wasn't allowed to play sports ... so there was nothing else in my life that I was good at. My only other identity was grades and my body.... I was always known as the skinny one.” (Lamoureux & Bottorff 2005 p. 175)

When recovery was contemplated, fear of losing their AN identity and the functional role it served was often expressed.

“I think just that anorexia gives you a sense of being that you wouldn’t have otherwise... and I think without that you wouldn’t be, well, I wouldn't feel like a person at all” (Williams, King & Fox, 2016 p. 221)

“When faced with removing the eating disorder from their lives, a sense of loss was felt... Participant 6 acknowledged that her “eating disorder is also a coping mechanism, and so losing that coping mechanism can be hard” (Smethurst & Kuss, 2016 p. 6)

**Turning Point**

A ‘turning point’ was expressed by women across most studies to reflect a number of factors that led them to commit to pursuing recovery (1, 2, 3, 4, 6, 9, 10, 11, 12, 13 and 14).

**Consequences of AN**

Women described how they came to acknowledge that AN was a problem and that the negative consequences and losses associated with AN (physical, psychological & social) led them to make an active decision towards recovery.

“What am I doing to myself? What the hell is going on here? Like because something’s wrong. Before I didn’t see it as a problem—me not eating and losing weight. I thought it [AN] was the greatest thing in the world.” (Weaver et al., 2005 p. 196)
“It was quite shocking as well to see the damage the starvation and restriction can have and how this affect not only your body but also your thought processes” (Jenkins & Ogden, 2012 p.27)

“My body was crying out with pain from places I never thought could produce pain. I was thinking, ‘This isn’t fun. Why am I doing this to myself? I don’t deserve this’. From that day on I searched for the right treatment and found a therapist and dietician who led me in the beginning stages of recovery” (Hay & Cho, 2013 p. 735)

One participant described a sense of “hitting rock bottom.” “After eight years of going in and out of hospital I decided I was sick of it. I was sick of yo-yoing in and out of hospital. ‘That’s it!’ I thought.” (Dawson et al., 2014 p.15)

and others of getting to the point where they were:

“sick of being sick” (Lamoureux & Bottorff, 2005 p. 177)

Some expressed frustration, not only with the physical and psychological toll of AN, but also with the time and effort wasted in maintaining the disorder:

Lisa expressed her regret at forfeiting ‘the chance to excel at something... in exchange for the empty talents of memorizing calorie counts.’ (Bradley & Simpson, 2014 p. 19)

Commitment to Recovery

A number of women spoke of their willpower and determination in taking responsibility for their own recovery increasing after the ‘turning point’:

“I think that my own drive to get better and my commitment to myself had been incredibly important. I’m not doing it for anyone else because, as much as your parents and your friends care for you, it’s not their problem. This is up to me. I have to do this” (Federici & Kaplan, 2008 p. 4)

“In order to get out of it, I had to decide to do it and also decide on the path to take . . . Nobody else was going to do it for me.”(Dawson et al., 2014 p. 18)

while also recognizing and accepting how difficult the recovery process would be:

“Being able to take one step at a time and accept that recovery is a long process was an important realization for the women… ‘if there’s one constant in recovery, it’s that everything takes time. Nothing is a quick fix.” (Bradley & Simpson, 2014 p. 20)

Pregnancy, a desire to get pregnant and responsibility towards family also were mentioned as factors that helped this process.
“I committed myself to recovering for my sake and for the sake of my children” (Hay & Cho, 2013 p. 736)

“…my focus changed, it wasn’t my body anymore, but my baby’s…” (Espindola & Blay, 2013 p. 2)

Self-Awareness

A number of women began a process of self-awareness and discovering themselves during the ‘turning point’; they had begun to see themselves beyond AN but were struggling to “tolerate feelings of inadequacy and powerlessness and limited sense of identity without relying on AN” (Lamoureux & Bottorff, 2005 p. 177).

“To recover from AN, participants described needing to accept the fear of the unknown and take a leap of faith into discovering who they were without the eating disorder… there was an initial recognition that separating the self from AN was needed to recover” (Williams, King & Fox, 2016 p. 225)

One participant described the need to tolerate her sense of vulnerability and fears of being exposed and not knowing who she was:

“That’s what characterized the struggle for me … the forward and the back.... It felt … as I moved forward, I was moving into territory that was unknown ... an identity ... that was unknown ... into behaviors that felt unfamiliar.... So it wasn’t a comfortable place. It was more comfortable even though it was torturous, there was some kind of comfort in knowing how to restrict my diet. Trying to let go of that, I felt so vulnerable… And that’s where the scariness came from, that vulnerability. (Lamoureux & Bottorff, 2005 p. 175)

The quotation highlights the difficult transition for women when moving towards recovery, as if fighting AN is a fight against their own identity. One participant even described the process of reclaiming her prior identity using precisely such an adversarial metaphor:

“Anorexia is a thief that has stolen my self-confidence... my dreams of a full, rich, joyful and normal life. I want back what anorexia has stolen... Like any thief, anorexia isn’t going to just give me back the traits it has stolen from me... I have to take back my stolen life.” (Bradley & Simpson, 2014 p. 16)

The process of self-awareness “enabled women to get in touch with previously unknown aspects of themselves” (Weaver et al., 2005 p. 196). They began to know
who they were, based on their own needs, beliefs, likes and choices, not based on others’ expectations of them or AN.

“I went to [name of treatment center] so I could take the mask off and try to be me, whoever that was. . . . I had a lot of help finding me… You know, when I talk about my sports, that’s part of who I was. And still part of who I am.” (Weaver et al., 2005 p.196)

In doing so, women had to actively ask for help, to let people in and begin to trust others.

“Trust was ... such a big part [of my recovery] because I always had a fear ... that I couldn't trust people, they would betray me somehow ... if they knew the real me” (Lamoureux & Bottorff 2005 p.176)

“My family was very supportive at the beginning of my recovery, and I think that was the most important part… for them to take the illness seriously… their understanding [and] willing[ness] to accept that I wasn’t doing this to make myself sick.” (Federici & Kaplan, 2008 p. 6)

Reclamation of Self:

Meaningful Relationships

In all studies participants reflected on meaningful relationships with others as being an integral component of reclaiming a sense of self in their journey to recovery. Relationships, whether with partners, family, friends, others with an ED or therapists, enabled women to learn to accept themselves through the experience of acceptance by others.

“The therapist was the most important person during my recovery, because speaking to her about how I felt and what I thought about, and also feeling accepted by her, were the most healing aspects to me….” (Espindola & Blay, 2013 p.3)

“What helped me the most, my boyfriend helped me realize that I’m attractive, and that I’m a good person without the need to be skinny, like he made me realize that I’m a worthy person. That I’m a person worthy of loving without being skinny.”(Granek, 2007 p. 372)
Developing skills in expressing thoughts and feelings, and being assertive in relationships helped women to feel validated and respected. In turn, they began to respect and see value in themselves.

“Going through that process allowed me to reclaim and even discover maybe a sense of self because for the first time in my life I actually set some boundaries.... I actually could speak up for myself and say this was okay or that was not okay....” (Lamoureux & Bottorff, 2005 p.177)

“When I overcame my fear of speaking up, of saying ‘no’ and going against my family, I grew stronger and overcame anorexia… leaving my home and my parents being distant for a time, this was essential for my cure.” (Espindola & Blay, 2013 p.3)

Women began to restructure their relationships to meet their own needs, to detach from those relationships that did not (e.g. “leaving husband” “leaving home” Tozzi Sullivan, Fear, McKenzie &, Bulik, 2003 p.148) and develop a capacity to take care of themselves:

“I'm learning how to take care of me. And I’ve never done that. And that comes along with meeting my own needs, identifying what my needs are, and having the courage and strength to go ahead and meet them. To try to do it, I can only do what I can do. And the thing is, if I don't meet it not to be really hard on myself. I'm very, very hard on myself. I've been hard on myself for years. And I am learning not to be so. So self-care, self-nurturing, I’m learning that. Some people call it selfish. I used to. But I don’t anymore. I call it self-care.” (Weaver et al., 2005 p. 197)

One woman described this process and a reconceptualization of what defines a worthy person:

“my own conclusion I came to, was that being a better person in terms of being kind to other people and other beings and being you know, a happy person... surrounding myself by people that I liked, things that I liked, interesting travel, that’s a much better way to, get to be, that’s a better definition of a good person then just being thin.” (Granek, 2007)

Having religious beliefs was identified as an important aspect in some women’s journeys to recovery (studies 1, 9 and 10).
“…I didn’t feel alone at all, because I believed there was a higher power, stronger than all the ghosts, stronger than this disease.”(Espindola & Blay, 2013 p.3)

Rebuilding Identity and Self-Acceptance

From their experience of having relationships with others, the women began to redefine themselves and their personal worth. They described the importance of accepting themselves as they were and rebuilding an identity.

“I have a new identity, I am a student, a friend, I have a social life and I know that people don’t see me as anorexic, I might have a history of that but they see me as other things first” (Jenkins & Ogden, 2012 p.29)

“It was like having a valuable smashed plate and putting all the pieces back together to rebuild your identity and reclaim it.”(Dawson et al., 2014 p. 21)

Participants often reported a change in values, developing a capacity to be kind and compassionate to themselves whilst accepting their imperfections, which was a final stage in the process of recovery (studies 2, 3, 10, 11, 12, 13, 14).

“All participants documented a change in values once in recovery. For example, Participant 2 stated, “It is now about learning to live your life again... To do fun things. To do things you enjoy.” (Smethurst & Kuss, 2016 p. 7)

“Recovery means accepting the full catastrophe of life. It means juggling many different roles and tasks, and it also means that you won’t be everything to everyone. It means dealing with people rather than calorie counting manuals. It means—and this is a big one for me—accepting uncertainty and imperfection.” (Bradley & Simpson, 2014 p. 17)

Discussion

This review synthesized fourteen papers containing qualitative data on women’s experiences of recovery from AN. It is unique because it only includes participants recovering from AN and reports a detailed critical appraisal of the methodological quality of the studies included. This provides a succinct body of evidence and thus new insights and understandings of the recovery process of AN.

The findings of this review suggest that recovery is a complex psychological process. Initially, when experiencing AN women have diminished sense of self, feel powerless
in their relationships and AN becomes their life and part of their identity. To move towards recovery the individual must reach a ‘turning point’ where they develop insight into the function and consequences of AN, and commit and take responsibility for recovery. The experience of meaningful relationships, through which they feel accepted and validated, enables women to reclaim an identity and sense of value and worth separate from AN. According to the women in the studies reviewed, this process of acceptance by others and then the experience of acceptance of the self is an essential factor that facilitates recovery.

The current review has a number of strengths and limitations. The review utilized the most recent qualitative studies on recovery from AN exclusively and used a clear critical appraisal procedure to assess each paper. The meta-synthesis allowed the integration of findings from studies with various qualitative methods to better understand the journey to recovery from AN, whilst increasing the size and diversity of the total sample. The method used (Noblit & Hare, 1988) is well established for synthesizing qualitative research and allows for a clear and detailed synthesis of the research findings whilst taking account of the methodological variability of studies and the transferability of the findings.

However, some question whether qualitative studies of different theoretical approaches can be integrated (Dixon-Woods et al., 2006; Mays, Pope & Popay, 2005). Also, the fourteen studies recruited participants in various stages of recovery or still in the process of recovering. Participants’ views of recovery may be influenced by their stage in the recovery process, making them a less homogeneous sample than can be ideally achieved.

The studies provide an insight into women’s experiences of the recovery process. The findings support previous research that explain AN as a functional strategy and as a means of asserting control (e.g. Bruch, 1978; Strober, 2004) and suggest that
care needs to be taken so that treatment is not experienced as threatening the women’s sense of control or exacerbating feelings of powerlessness. Clinicians need to be trained to understand the strategic functions of AN, to understand and meet the emotional needs of patients, and utilize reflective practice to explore personal attitudes towards patients, to facilitate the therapeutic process (Strober, 2010).

The importance of motivation in recovery from AN is well-established (e.g. Federici & Kaplan., 2008; Dawson et al., 2014). The meta-synthesis of the studies reviewed here suggests that women who achieve recovery first reach a ‘turning point’ after which motivation to get well increases; the negative consequences of AN are acknowledged and insight into the function of AN is achieved. Women then develop a sense of autonomy and take an active part in their recovery. In doing so, they begin to appreciate meaningful relationships and develop a new sense of self. This highlights the need for interventions that facilitate self-definition and expression, separate AN from the individual and their healthy qualities, and assess readiness to change (Dallos, 2004; Espindola & Blay, 2009).

The findings of this review highlight the importance of developing supportive relationships in the therapeutic process. Whilst the findings do not suggest one particular approach to use in therapy, it does suggest the need for therapists and therapy teams to validate and respect clients’ perspectives. Thus, the findings support the evidence that the quality of the therapist-client relationship is a powerful factor in promoting change (Asay & Lambert, 1999; Wampold, 2001). An awareness of this may influence how treatment teams engage individuals with AN. The influence of meaningful relationships is crucial in recovery and highlights the importance of maintaining and establishing a stable and reliable social support network.

The themes regarding the development of identity in the process of recovery mirrors the normal adolescent process of the development of self (Erikson, 1982). Erikson
(1982) proposed that self-development begins with trust in others to navigate through feelings of doubt, inferiority and confusion over identity. The developmental processes of separation-individuation, autonomy and achieving a clear identity, are key tasks in the adolescent period, and these are themes that emerged here in the descriptions of reclamation of self during recovery from AN. Rather than occurring as a natural developmental task, development of identity becomes a conscious task for the individual recovering from AN (Lamoureux & Bottorff, 2005) indicating that prevention programs may benefit from incorporating interventions aimed at developing self-worth, identity and self-esteem at a young age.

Participants attributed their recovery to various psychological components but very few of the participants attributed their recovery to the physical process of gaining weight, which is the predominant focus of most clinical recovery programs. Indeed, the finding that treatment focuses too heavily on weight gain with a lack of help to address underlying psychological difficulties was implicated in the experiences of women with severe and enduring AN reported by Stockford (in preparation). This supports the importance of psychological, behavioural and social functioning in determining the outcome of AN (Bardone-Cone et al., 2010) and a need for incorporating dominant psychological and social components into recovery programs.

This review has highlighted the need for integrating the development of a clinical measure of identity that would enable practitioners to understand what components of self-identity are important in AN recovery. In view of the limitations of the studies reviewed, future research with increased methodological rigor is needed. In particular, the majority of the studies did not address reflexivity. Therefore study interpretations may have been affected by researchers’ own assumptions and values. This is an area that needs to be addressed in future research and may require researchers to have further training in order for them to feel confident in their
skills and awareness of their own assumptions and values and how these may influence the data analysis. Moreover, most studies used vague recovery criteria and lacked objective assessment of recovery status. And as the literature on male experiences of recovery and the impact of different cultural backgrounds on AN recovery is scarce, further research could address these omissions and compare the experiences of groups with different demographic characteristics.

In conclusion, qualitative research allows for understanding and exploration of the lived experience of recovery from AN. The current review indicates that recovery is a complex psychological process, which involves women reclaiming an identity and sense of value and worth separate from AN. The experience of acceptance through meaningful relationships and then the experience of acceptance of the self appear to be the most important factors in determining long-term outcome. These findings need to be utilized to inform future research and current service delivery.

References


