

Exploring the Role of Counselling in Young Women's Healing from Disordered Eating

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Author Note

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Dedication

With much love, I wish to dedicate this thesis to my parents, a continual source of strength and inspiration. The myriad sacrifices you have generously made over the years in order for me to pursue my dream will never go unrecognized. I am forever indebted to you both. To my mother, thank you for your continued support and encouragement. The pride you have taken in me means so much. To Dad, I am thankful for your wisdom, and eternal optimism and belief that I can achieve whatever I want and for providing me with the means to do so. My gravest of cares are calmed by your presence. Thank you both for instilling in me the work ethic and confidence to succeed at whatever I chose to undertake. I continue to learn from your example.

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Abstract

A key element influencing the healing process for women experiencing disordered eating is the incorporation of counselling. However, there is limited qualitative research on the impact of counselling on women's healing from disordered eating. The purpose of this study was to investigate what six young women, aged 26 to 30 years, with a history of disordered eating found helpful in their counselling experience. Narrative inquiry, specifically descriptive narrative thematic analysis was used for this study. Young women who were no longer attending counselling and who identified as healed or healing from disordered eating were recruited for participation in individual semi-structured research interviews. Participants shared their personal story of healing from disordered eating and the role that counselling played in their efforts to heal. Each interview was audio taped, transcribed, and analyzed based on Lieblich, Tuval-Mashiach, and Zilber's (1998) Holistic Content Analysis. Results suggest the importance of certain counsellor qualities and the therapeutic relationship to women's healing from disordered eating. The therapeutic relationship fostered expanded understanding of the experience (attitudes and behaviors) and consequences of participants' disordered eating and provided them with a safe space to explore new ways of being with themselves and others. Women's stories also revealed 'defining moments' that occurred during the counselling process that impacted their ability to heal. Suggestions for future research and implications for counselling practice are identified.

Keywords: disordered eating, eating disorders, healing, counselling, psychotherapy

Definitions

The following definitions are used throughout this study:

Counselling: Counselling is a form of talk therapy commonly used as treatment for normative, everyday human concerns or more intensive concerns such as disordered eating. Counselling requires building a relationship with the client and involves the process of assisting and guiding clients, by a trained professional, to resolve personal, social, or psychological problems and difficulties (Merriam Webster Dictionary, 2009). The process aims to amplify clients' healthy coping skills and improve their sense of self-worth, self-awareness, and wellness.

Disordered Eating (DE): Disordered eating refers to the development of abnormal eating behaviours that negatively affect an individual's health and well-being (American Psychiatric Association, 2000; Fairburn, Cooper, Bohn, O'Conner, Doll, & Palmer, 2007). Disordered eating behaviours do not necessarily meet clinical diagnostic criteria like Eating Disorders. Instead, disordered eating is a descriptive phrase associated with obsession with food and distortions of body image. Disordered eating behaviors include, but are not limited to: chronic restrained eating, compulsive eating, habitual dieting, irregular and chaotic eating patterns, yo-yo dieting, repeated weight fluctuations, and extremely inflexible unhealthy behaviours with food and exercise (American Psychiatric Association, 2000; Fairburn et al., 2007).

Healing: Healing refers to the subjective process of moving towards enhanced meaning-making and sense of wholeness in the aftermath of distressing life events (Emanuelli, Waller, Jones-Chester, & Ostuzzi, 2012). The healing process often requires one to address negative emotions and develop an attitude of self-acceptance in the face of adversity (Lander, 2012).

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Chapter 1: Introduction

Healing for women struggling with disordered eating can be a long and arduous journey. For most women, moving towards enhanced emotional, mental, and physical health and personal acceptance and forgiveness happens gradually (McGilly & Szablewski, 2010) and can take years after initial help seeking (Pettersen, Thune-Larsen, Wynn, & Rosenvinge, 2013). A woman's capacity to heal from disordered eating often requires professional intervention, deep self-reflection, and personal courage. Interventions such as professional counselling are often recommended to treat women with disordered eating. In counselling, women address personal factors motivating their disordered eating and reflect on and develop new understandings with the help and guidance of a qualified counsellor. The counsellor works to create a safe space to encourage the process of healing. By providing a non-judgmental and safe environment, the counsellor helps women work through problems associated with their disordered eating and learn healthy perspectives, coping skills, and ways of being (Sly, Morgan, Mountford, Sawyer, Evans, & Lacey, 2014). Counsellors with appropriate expertise can help foster meaningful connections with their clients that help them explore and come to understand the depth and breadth of the impact of their disordered eating experience (Anderson & Corson, 2001; De la Rie, Noordenbos, Donker & Van Furth, 2008; Sly et al., 2014). Effective counselling allows women to confront their vulnerability in a safe environment and begin to envision a future without disordered eating.

There are multiple dimensions to healing including physical, cognitive, emotional, psychological, and social (Emanuelli et al., 2012). Each dimension is gradually addressed at different times during the counselling process. Clients start to gradually understand their eating difficulties, gain personal autonomy, build motivation for improving health practices, and feel socially supported (Vanderlinden, Buis, Pieters & Probst, 2007). Duncan, Miller, Wampold, and

Hobble (2010) suggest the “therapeutic relationship,” or relationship between the client and therapist that involves positive feelings and attitudes, can help the client experience change and growth. At its best, the client-counsellor relationship inspires “active and worthwhile engagement” (McGilly & Szablewski, 2010, p. 199) that heightens the likelihood of successful treatment and psychotherapeutic trust (De la Rie et al., 2008; Pettersen et al., 2013; Sly et al., 2014).

The process of healing from disordered eating is close to my heart. My interest in this area began after I decided to heal from my own disordered eating. For five years, I struggled on and off with anorexia nervosa, over-exercising, and sometimes bingeing and purging. Growing up in a mid-sized prairie city, I led a very normal life, complete with a supportive family that provided me with an abundance of opportunities. As a little girl, I was “girly;” I was fascinated by beautiful hair, always wanted to look “dolled-up,” loved playing with makeup and Barbie dolls, and wanted to be a dancer. At four years of age, I was enrolled in dance lessons; I danced for the next 15 years. Dance, by nature, focuses on perfection of both performance and appearance (i.e., costumes, makeup, hair, posture, and the body). The more pressure I experienced to be perfect, the more preoccupied I became with perfection. In short, I wanted to look like the perfect dancer.

At 12 years of age, I enrolled in personal development classes at a modeling school where I learned how to eat properly, paint my nails, take care of my skin, and set a table. Emphasis was placed on the development of a modern lady. At puberty, I experienced a growth spurt, growing to 5’10” and the local modeling school recognized me as someone with the potential for a professional career. Being a model is the pinnacle of beauty in western culture; as a young girl this was my fantasy. I sought to meet the modeling standards for weight and shape

by restricting my food intake. I was provided with many modeling opportunities, but began to face difficult obstacles I was not equipped to cope with as a teenager. In high school, I was offered modeling contracts and dance grew increasingly competitive. It was at this point that my mom, my greatest supporter, became sick with cancer and I was bullied by the friends I trusted. My opportunities became a burden. I started to feel pressure from modeling agencies that told me, at 119 pounds, that I needed to drop weight. I started to identify with losing weight as a way of coping with the difficulties I was experiencing in my life.

My disordered eating helped me escape the painful emotions arising from being bullied and my mom's illness. I was lost and searching for a purpose. If I restricted my food, I could control my emotions. I felt I was no longer a good daughter, a perfect dancer, a good student, and a good friend; rather, I was fixated on controlling my body and my feelings. For five years, I struggled with feeling inferior and angry. I was resentful of unexpected life circumstances I could not logically interpret or cope with. I took my confusion and pain out on my body, thereby controlling the feelings that built up internally.

When I was 20 years old, I allowed myself at last to make sense of my experiences with my eating difficulties. I put my health and wellness first and started my healing journey. I met a counsellor who specialized in treating women who struggled with disordered eating. She disclosed her own story of living with and healing from her eating struggles. She shared the impact that her eating behaviours had on her and her family and the way these problems consumed her life. The relationship we shared and the trust we established facilitated my healing. My personal experience has inspired my genuine interest in exploring women's personal narratives of healing from disordered eating. I hope to extend research on how counselling interventions make a difference for women affected by disordered eating.

1.1 Overview of Study

The proceeding literature review (Chapter 2) provides an historical understanding of disordered eating and its behavioural, physical, mental, and emotional consequences. Counselling interventions that facilitate healing from disordered eating will also be presented. The behaviours associated with disordered eating are commonly associated with a diagnosed eating disorder. Within this study, disordered eating behaviours do not necessarily meet clinical diagnostic criteria. Instead, disordered eating is a descriptive phrase associated with obsession with food and distortions of body image.

To date, most research focuses on clinically diagnosed eating disorders, even though sub-clinical eating difficulties are much more common in the general population. Current literature is also almost exclusively quantitative and addresses clinically diagnosed eating disorders. To inform the current study, the overall ‘experience’ particular to an eating disorder is discussed. Research on treatment and intervention for those with disordered eating tends to focus only on diagnosed eating disorders and effectiveness of therapeutic techniques. The current research on healing from disordered eating discusses the effectiveness of interventions and strategies that promote wellbeing (Pettersen et al., 2013).

A review of the literature suggests that there is a lack of qualitative research on ‘disordered eating.’ More importantly, interventions for disordered eating, counselling for disordered eating and what it takes to heal from disordered eating are not addressed in current research. The current study aims to increase understanding of what helps women ‘heal’ from disordered eating and the role that counselling can play in this process. This knowledge may inform counselling intervention and provide hope to women who suffer from disordered eating.

This study also aims to add women's own voices to research in this important area of women's health.

Many causes of disordered eating have been postulated over the years. Early historical literature discusses disorders around eating as a woman's circumstance attributed to irrational minds, behaviours, and feminine standards (Hepworth, 1999; Peace, 2004). Women's identity has been postulated as at conflict with the self, which is believed to lead to disordered eating experiences (Hepworth, 1999; Malson, 1998; Stein, 2007). Women who have experienced disordered eating patterns may describe a 'voice' constantly running through their heads, which obsesses about food and the body (Tierney & Fox, 2010). Women have described their experience of disordered eating as a "buzz" or a "high" that contributes to feelings of control over their bodies when using disordered eating patterns and behaviours (Dignon, Beardsmore, Spain, & Kuan, 2006). Women's disordered eating patterns and behaviours may be related to uncertainty in life and lack of control (Sternheim, Konstanellou, Startup, & Schmidt, 2011). Emotions and the inability to self-regulate and cope may also contribute to disordered eating (Brockmeyer, Bents, Holtforth, Pfeiffer, Herzog, & Friederich, 2013; Espeset, Gulliksen, Nordbo, Skarderud, & Holte, 2012). Distorted perceptual awareness of the body such as size, shape, and form may be influenced by disordered eating (Keizer, Smeets, Dijkerman, Uzunbajakau, Van Elburg, & Postma, 2013; Radomsky, De Silva, Todd, Treasure, & Murphy, 2002). Women with traits of perfectionism can be prone to disordered eating and relapse of behaviours can occur (Bardone-Cone, Sturm, Lawson, Robinson, & Smith, 2011).

Counselling has been reported as an effective intervention for women suffering from disordered eating (Vanderlinden et al., 2007). More generally, Duncan et al. (2010) determined the importance of the therapeutic relationship and identified several common factors that

influence the efficacy of counselling across a variety of theoretical modalities and clients' presenting concerns. Importantly, the counselling process should promote clients' self-awareness, acceptance, and change (Noordenbos, Oldenhav, Muschter & Terpstra, 2002; Vanderlinden et al., 2007). Although the importance of the therapeutic relationship is recognized, It is important to learn more about how the counselling process influences healing for women with disordered eating.

1.2 Statement of Purpose

It is essential to understand the experience of disordered eating and associated behaviors, thoughts, and feelings associated with healing. The current study aims to provide information about women's healing from disordered eating and the role that counselling can play in this process. Researchers and mental health practitioners need to understand the existential struggle young women experience in relation to their bodies. Along with the importance of the therapeutic alliance, 'defining moments' during counselling, and various counsellor qualities that were important to women's healing process were explored.

Descriptive thematic narrative analysis was used to foreground women's voices within this inquiry. Personal stories shared by women within semi-structured narrative interviews provided data to answer the following questions: What helped them heal from disordered eating? What did they find helpful in their counselling process? What have they taken away from their counselling experience in terms of personal growth? And, what were some defining moments arising from their counselling experiences?

1.3 Significance of Study

This study aimed to provide an increased understanding of the role of counselling in healing from disordered eating. It discussed the therapeutic alliance, defining moments during

counselling that promoted healing, and counsellor qualities that were important to the women's healing process. Results may be of interest to educators and mental health professionals who work in a therapeutic capacity with young women living with and hoping to heal from disordered eating.

1.4 Chapter Organization

The organization of this study follows the standard thesis format. Relevant literature and is presented in Chapter 2. Chapter 3 outlines methodology followed by details on participant recruitment, data generation, and data analysis. The women's narratives and thematic analysis will be presented in Chapter 4. Chapter 5 will include a summary of the findings and connections to extant literature. Implications for counselling practice and further research will be identified.

Chapter 2: Literature Review

The following literature review incorporates three main sections: the historical understanding of disordered eating, the experiences associated with disordered eating and counselling for disordered eating.

2.1 Historical Understanding of Disordered Eating

Early historical literature discusses eating disturbances as a woman's circumstance (Hepworth, 1999). Disorders and diagnoses of eating disturbances have been designated a "female problem" since the first report of an 'anorexic' in medical literature. In 1968, Richard Morton described a case of woman's odd eating patterns and behaviours as a manifestation of her nervous consumption or tuberculosis (Pearce, 2004). Since the 19th century, understanding of the etiology of women's eating disturbances have progressed from a medical issue or clinical entity to an individual moral issue, "a woman's disturbed nerve force" (Pearce, 2004, p. 3; Hepworth, 1999). In 1874, physicians Sir William Gull and Dr. Lasegue described "women's starving disease" and coined the term 'anorexia,' believing the condition to originate in women's minds (Pearce, 2004, p. 3).

Particularly during the 19th century, eating disturbances were overpoweringly conceptualized as a female issue. Moreover, the discourse of femininity was largely determined by social expectations of the time, with middle class woman perceived as a "fragile, passive, illogical, irrational and deviant type" (Hepworth, 1999, p. 28). Sir William Gull further stated that a diagnosis could be attributed to "the irrationality of women, a resistance to dominant ideals and mental perversion" (Hepworth, 1999, p. 30). Looking back from a different perspective, women were using these behaviours to resist the oppression and expectations they felt from men,

the lack of freedom to choose a career, lack of personal self-awareness, and feelings of isolation in their homes (Hepworth, 1999).

From the 19th to the early 20th century, eating disturbances were described as abnormal behaviour, explained by women's nervous minds and correlated to hysteria, mental somatic illness, nervousness, and madness. By the 1930s, the Diagnostic and Statistical Manual of Mental Disorders defined criteria for these eating disturbances to be diagnosed (Chassler, 1994). Understanding of the etiology of eating disturbances and their psychiatric diagnostic criteria advanced into the latter part of the 20th century; the medical profession became the dominant force in further pathologizing such presentations as eating disorders (Hepworth, 1999).

However, the many volumes of the “Diagnostic and Statistical Manual of Mental Disorders (DSM)” (American Psychiatric Association, 2000), and associated criteria, did not represent “value-free truth but instead socio-culturally and socio-historically specific ways of defining behaviour, and the constructed masculine privilege” (Crago, Yates, Fleischer, Segerstorm, & Gray, 1996, p. 45). Thus, standard medical terminology placed women at greater risk of being pathologized and labelled (Crago et al., 1996, p. 67). The number of DSM categories and sub-categories expanded into a discrete, consistent, homogeneous clinical entities with an identifiable etiology for the eating-related symptoms women reported (Hepworth, 1999). Such definitions denied the social and discursive contexts of women's lives as well as the gendered nature of the science that decrees how women's bodies are to be studied (Hepworth, 1999).

Hepworth (1999), a feminist theorist, accused the diagnostic medical model of pathologizing eating disturbances and the women who struggle with them. Its weight-focused approach to understanding and managing eating disturbances lead to the medicalization of eating

disturbances or disordered eating. The medical model was influenced by and reflective of masculine rationality; what was seen as deviant in women's behaviour was constructed as an irrational quality and an inherent feminine trait (Hepworth, 1999). Hepworth (1999) discusses how the medical model constructs women as passive victims of manipulation through media and social images. Women's body image is dictated by societal roles displayed through media, creating identity conflict for many women (Hepworth, 1999). This identity conflict stems from socio-cultural and gender-specific constructions of female identity. The socio-cultural, biomedical, familial, and feminine components are direct reflections of interrelated discourses and social practices placed upon women by the cultures they inhabit (Hepworth, 1999).

An "identity conflict is noted in the development and maintenance of eating disorders" (Ison & Kent, 2010, p. 475). According to Malson (1998), a woman's sense of self is structured around the disorder. For example, in theory the self without anorexia and an emaciated body would simply be an empty shell, devoid of identity. A lack of identity causes feelings of despair for women and they start to question where they belong in the world (Malson, 1998).

Sociocultural influences impact identity conflict by dictating how women are to 'ideally' look, think, and feel (Bowman, 2006; Garner & Garfinkel, 1997; Hepworth, 1999; Malson, 1998). The 'feminine ideal' represented in media and consumerism are thought to fuel the development and maintenance of eating disturbances (Ison & Kent, 2010). The experienced 'feminine' and 'feminine ideal' creates a discrepancy between awareness of one's self and identification of that self within the world (Garner & Garfinkel, 1997; Hepworth, 1999; Malson, 1998). Not surprisingly, the majority of eating disturbances, at their worst, can meet diagnostic criteria for diagnosis; once diagnosed, these disorders further control and limit one's identity, reinforcing the idea that there is impairment within the self.

When disordered eating becomes an identity for women, it is believed to serve as a mask used to navigate through life (Stein, 2007). The disordered eating is neither random nor an unfortunate occurrence, but in fact serves a purpose for these women. Stein (2007) investigated identity impairment in women with anorexia and bulimia. “The cognitive model of the self concept” was applied to investigate identity development, self-schemas and social interaction (Stein, 2007, p. 59). The model also provides further understanding of ‘self-definition’ of self-concept and identity in women with eating disorders. Self-concept refers to “cognitive-affective structures of identity development and that once elaborated in memory, gives self-certainty, sameness and continuity over time” (p. 59). Identity is a “global construct referring to personal attributes and social roles” (p. 59).

Stein’s (2007) study addressed positive and negative self-schemas in one’s self concept and their interrelatedness with ‘fat’ self-schema in women with eating disorders. Stein (2007) predicted “overall identity development is a core vulnerability of fat body weight self-definition and eating disorder symptomatology” (p. 58). Participants were women ($N=26$ anorexic, $N=53$ bulimic and $N=32$ control group). The measurements used looked at self-schemas, ‘fat’ self-schema, disordered eating attitudes, and eating disorder behaviours with information processing indicators, adjective endorsement rates, and response latency scores (Stein, 2007).

Each woman completed a Structured Clinical Interview, Eating Disorder Inventory (measure of disordered eating attitudes and behaviors) and the Healthy Behaviour Questionnaire. Weight and height were also recorded. The self-schema measurement included personal attributes women wrote about themselves on blank cards. The women rated the importance of their attributes (11-point scale) and if they were positive, negative, or neutral. Information processing of the ‘fat’ self-schema was measured by presenting appearance related adjectives

($N=63$) on a computer and a “Me/Not ME” response choice (Stein, 2007). The ‘fat’ scale included 10 of these adjectives (pleasantly-plump, chubby, overweight, etc.). The procedure was completed over four sessions and data was analyzed by variance and covariance to test the hypothesis that the women with anorexia and bulimia differ from controls in the structural properties of self-concept (Stein, 2007).

Stein (2007) found that women with anorexia and bulimia had more negative self-schemas and fat schemas than the control group. The women with eating disorders had different cognitions about themselves and fewer positive self-schemas in memory. Women, particularly those with bulimia, scored higher on the fat adjectives than those in the control group. Women with anorexia were found not to have a ‘fat’ schema. The authors suggest the “pattern of findings observed in the anorexic group is not likely to be simply a function of treatment” (Stein, 2007, p. 67).

The ‘fat’ schema score was strong for women who had struggled with bulimia. It showed information processing evidence of a fat schema available in memory. The ‘fat’ schema “predicted body dissatisfaction, drive for thinness, bulimic attitudes and eating disorder behaviour” (Stein, 2007). Thus, this research suggests that identity impairment can lead to disordered eating attitudes and behaviours. The discovery of the number of positive and negative self-schemas and interrelatedness of eating disorders predicts the availability of a ‘fat’ body weight schema, which in turn predicts disordered eating attitudes and behaviours (Stein, 2007). Interventions that are used to help treat eating disorders possibly fail to take into account the ‘fat’ schema, a source of disordered eating behaviours and attitudes (Stein, 2007). Interventions that promote new positive self-schemas could reduce eating disorders and disordered eating

behaviours and attitudes (Stein, 2007). These findings suggest the importance of considering identity and self-concept in the treatment of eating disorders.

2.2 Women's Experience with Disordered Eating

It is possible that as a woman's new identity becomes fused with disordered eating, her thoughts and behaviours further influence and reinforce her distorted sense of self. Women who have experienced disordered eating have described a 'voice' constantly running through their heads; this anorexic 'voice' influences thoughts and behaviours associated with disordered eating, pushing women to disordered eating (Tierney & Fox, 2010). Tierney and Fox (2010) investigated 22 women diagnosed with AN in order to see how the anorexic 'voice' affected their condition. Participants were asked open-ended interview questions regarding what it is like to live with an anorexic 'voice' (Tierney & Fox, 2010). Thematic analysis yielded 10 main themes:

“feel[ing] part of something, giving a steer to life, provid[ing] comfort and safety, constant presence, entrapped in undesirable situations, attacking the sense of self, demanding and harsh task master, powerful entity, dangerous state of being, and breaking free” (Tierney & Fox, 2010, p. 247).

Participants appeared to have dynamic relationships with their voices. Over time there is a shift from the voice as a positive presence to a “forceful, demanding and unquestioning” presence (Tierney & Fox, 2010, p. 249). Participants explained the three phases of these relationships: first, they were drawn into the relationship, then they became ensnared in the relationship, and finally they were able to live life without the relationship once they realized its promises were empty. The women were first drawn in out of vulnerability to a voice that distracted them from other problems in their lives. The voice helped them to maintain control, to

escape negative emotions, and to create order by making difficult life decisions more manageable. Later, participants felt ensnared in their relationship with their voice and started to despair its strength. It became controlling and ever present, pushing personal limits through distortion of the body and perfectionist standards. Life without the voice was possible when they realized how it let them down. They recognized the perpetual lies and started to question the voice's true motives.

According to Tierney and Fox (2010) attention to the disordered eating 'voice' during treatment may improve outcomes for women living with disordered eating. Further, knowledge of the 'voice' and how it influences disordered eating suggests how exhausting it can be to live with disordered eating. Knowing how this voice encourages its victims to abuse their bodies through starvation, bingeing, purging and other dangerous methods of weight control can inform more sensitive use of intervention strategies. Techniques for assisting clients in managing their 'voice' can facilitate healing (Tierney & Fox, 2010).

Dignon et al. (2006) asked 15 women with disordered eating "what caused" their food troubles (p. 942). Participants shared their personal stories within open-ended narrative interviews. They also completed a questionnaire on emotional state and attitudes. The narratives were analyzed and coded. Dignon et al. (2006) found eating disturbances were associated with "unhappiness and loss" (p. 945). The women shared that they experienced a lack of control due to personal circumstances such as neglect, trauma, abuse, bullying, and death which was addressed through disordered eating. A difficult life circumstance was often the "trigger" to engage in disordered eating (Dignon et al., 2006, p. 945). The disordered eating was "sustained" by behaviours and strategies to avoid food (Dignon et al., 2006, p. 945).

According to these participant's unhappiness arising from a traumatic event, failing to 'fit in,' being bullied, and having high expectations and low self-confidence also contributed to 'triggering' their eating disturbances. Not liking how one looked and who they were was a 'trigger' for body dissatisfaction. Exercising and controlling food intake created feelings of being in control and addressed shortfalls in their lives. A 'buzz' or addictive high, experienced when controlling and restricting their food, 'sustained' eating disturbances. The more the women lost weight, the more people noticed and offered compliments. One participant reported: "once I started to lose weight, I felt good about it, so I continued and I loved it, it was like an addictive high" (Dignon et al., 2006, p. 950). Strict behaviours and 'obsession' with the process escalated a 'spiral' and reinforced elaborate strategies to avoid food. High standards of 'perfectionism' created unattainable goals. Media portrayal of the 'perfect body' furthered obsession and control with food. The women expressed knowing their eating disturbances were personal and dysfunctional. The behaviours were not only used to achieve 'being skinny' but also to cope with what 'triggered' their disordered eating. Difficult life events 'triggered' dysfunctional behaviours, attitudes, and complex beliefs and rituals (Dignon, et al., 2006). The women's narratives revealed the intensity of living with eating disturbances and the importance of intervention strategies that interrupt this cycle.

Sternheim et al. (2011) interviewed women with anorexia nervosa to further understand how they coped and managed their feelings of uncertainty. Women were recruited from inpatient units and asked to participate in focus groups wherein semi-structured interviews served to draw out information. Focus group data was transcribed and analyzed according to Interpretive Phenomenological Analysis. The dominant theme was a feeling of uncertainty that caused

women to feel out of control. To reduce uncertainty, participants controlled their eating behaviours (Sternheim et al., 2011).

Not having control over life's uncertainties was reported as a very negative experience. In order to cope with these experiences, participants withdrew from themselves, shut others out, avoided loved ones, and sought to control their surroundings (e.g., routines, structure, planning one's life, double checking, fixing things, counting calories, and exercising) (Sternheim et al., 2011). These women explained their experiences with uncertainty as bad, threatening, and uncontrolled. They understood uncertainty to be a normal process, but perceived it as worse for them than for the average person.

Participants explained the concept of uncertainty both externally and internally. Externally, uncertainty manifested as a perception of the world as bad; this caused participants to worry about judgment and to experience a lack of control over their external environments as well as their weight gains and losses. If participants felt strong enough to recover they still had feelings of doubt about living without their eating disorder. Feeling uncertain also caused them to question their identities, wondering how others saw them and if they could leave their anorexic identities behind (Sternheim et al., 2011). They were disarmed at the thought of not knowing what a new identity would entail if they were to let go of their control over food and their bodies.

In a recent study, Espeset et al. (2012) used descriptive grounded theory to explore how women with eating disturbances managed negative emotions (i.e., sadness, fear, anger, and disgust). Fourteen women aged 20 to 39 years with diagnosed eating disturbances, participated in semi-structured interviews. They were asked "in your own words tell me about your emotional

life...” followed by prompts, such as “what do you do to cope with sadness?” (p. 453). The interviews were thematically coded according to grounded theory procedures.

Espeset et al. (2012) found that all participants admitted to using disordered eating behaviours to manage emotions in various ways. Disordered eating behaviours were “ways to cope with their emotions, distance themselves from emotions, and suppress their emotions” (Espeset et al., 2012, p. 454). Four emotional regulation strategies emerged: (1) ‘avoiding emotions’ (i.e., defocusing or avoiding awareness); (2) ‘inhibiting expression’ (i.e., avoiding expressing negative emotion); (3) ‘suppressing emotion’ (i.e., the use of an eating disorder to modulate the intensity of their emotions); and (4) ‘releasing emotions’ (i.e., exercise serving to channel out difficult feelings (Espeset et al., 2012, p. 455).

Emotions such as “sadness, anger, disgust and fear” were regulated by eating behaviours. When sad, the women automatically related sadness to “feeling and looking fat” (Espeset et al., 2010, p. 455). When angry, they inhibited by focusing on food and body to escape their feelings. Some of the participants engaged in purging to control their anger and in over-exercising to avoid anger. Food also became an instrument used to punish loved ones. By refusing to eat for days on end, they would incite worry and fear in others. Fear was regulated by suppression; restrictive eating to the point of hunger helped participants to focus, control and therefore reduce fear. Purging also helped participants to calm their fears and to stay in control. Constant body checking enabled them to manage fear because they were afraid of gaining weight. Food and body awareness behaviours contributed to participants avoiding places where people would see them. Their eating disorders allowed them to cover their body and engage in intense and restrictive eating when they felt disgusted by their bodies (Espeset et al., 2012). This research extends understanding about how women with eating disturbances avoid, inhibit, suppress, and

release their emotions. The regulation strategies these women with eating disturbances used suggests the intensity of their emotions and how they used their bodies to channel their feelings in ways that they experienced as more manageable.

A more recent study by Brockmeyer et al. (2013) investigated food restriction, weight loss, and reduced experience of negative emotions in 25 women diagnosed with Anorexia Nervosa (AN). Brockmeyer and authors (2013) wanted to explore whether women with AN reported fewer positive emotion in sad, autobiographical memories. For example, they hypothesized that women who restricted their food intake would feel less emotion if they lost a loved one, or experienced separation or other negative life experiences compared to the control group. They also hypothesized that the lower the body weight of a woman with AN, the fewer negative emotions she would retrieve. Participants diagnosed with AN were recruited from inpatient hospitals and day clinics, while those in the healthy control group were recruited from media advertisements and then screened appropriately. Emotional processing was measured by asking all participants to write down their memories in as much detail as possible in response to sad, autobiographical memories.

Brockmeyer et al. (2013) found that Body Mass Index (BMI) and the number of negative emotion words in the narrative responses were positively correlated in participants with AN ($r=0.57$, $p=0.003$, 95% CI: 0.20, 0.77), but not in healthy controls ($r=-0.20$, $p=0.34$, 95% CI: -0.67, 0.62). Further analysis found that low BMI in participants with AN correlated with fewer negative emotions, demonstrating a direct relationship between lower body weight and decreased retrieval of negative emotions in women with eating disturbances. Such findings contribute to a better understanding of the persistence with which disordered eating can be maintained through negative emotional memories and experiences (Brockmeyer et al., 2013).

Radomsky et al. (2002) conducted a study using Thought Fusion Action (TFA) on a clinical sample of patients with AN. TFA theorizes specific perceptual distortions in women with eating disorders, wherein there is a “belief that having a thought about a negative event increases the likelihood of a feared event and the related belief that having a negative thought is morally the same as carrying out the corresponding negative action” (p. 1170).

Accordingly, TFA framed how eating a forbidden food would increase the person’s shape and weight, thus representing an illicit act that would make a person feel fat. Participants were 20 women patients diagnosed with eating disorders according to the DSM-IV (American Psychiatric Association, 2000), with a mean age of 27.7 years and a mean BMI of 14.8. Participants were asked to complete a questionnaire package that included the Thought-Shape Fusion (TSF) scale that measures cognitive distortions associated to eating pathology, the Maudsley Obsessional Compulsive Inventory (MOCI), and the Beck Depression Inventory (BDI). Participants were requested to write down a food they considered to be extremely fattening. They then responded to a series of questions about how a certain stimulus (picture of food) made them feel when they imagined eating the food and rated it on a scale from 0 (not at all affected) through 100 (extremely affected).

Radomsky et al. (2002) found that the majority of participants decided to neutralize the sentence by imagining not eating the food. Two participants even removed the paper from sight. Another participant counted in fours to make herself feel she did not eat the food, while another drew a thin girl to neutralize the effects of writing the sentence. Participants that neutralized the sentence (i.e., imagined not eating the food) reported significantly less anxiety ($p < 0.003$), less guilt ($p < 0.007$), and a mitigated focus on weight gain ($p < 0.05$) and feelings of fatness from writing the sentence ($p < 0.03$), as well as urges to neutralize ($p < 0.007$). These results showed that

patients with AN have cognitive perceptual biases, since those who chose to neutralize (i.e., 75% of sample) experienced significant reductions in anxiety symptoms. The non-neutralizing participants had lower TSF, MOCI, and BDI scores than the neutralizers, confirming the presence of perceptual distortions in women with eating disorders. These results demonstrated how participants fused thoughts, perceiving their body shape to change from eating even without eating (Radomsky, et al., 2002).

Bardone-Cone et al. (2011) investigated perfectionism as a trait that may play a role in recovery from and recurrence of eating disturbances. Bardone-Cone (2011) and colleagues view healing from an eating disorder as the absence of eating disorder symptoms (i.e., physical measures) without consideration of the broader psychological elements of treatment such as perfectionism of the body. Bardone-Cone et al. (2011) considered individuals who no longer met the criteria for eating disorders but did not appear to be fully recovered. They compared different conceptualizations of perfectionism in women who were healthy and never had eating disturbances, to those with a previous diagnosis of an eating disorder. By defining healing in a comprehensive way, they observed that individuals who are fully recovered displayed lower levels of perfectionism compared to women with present eating disorder symptoms. Healing was consequently defined as “physical, behavioural, and psychological healing” (Bardone-Cone et al., 2011, p. 5).

More specifically, Bardone-Cone et al. (2011) recruited a relatively large sample of young adult females, including 53 with eating disorders, 15 partially recovered, 20 fully recovered, and 67 healthy women with no eating disorder symptomology. All participants underwent diagnostic interviews to determine lifetime and current eating disorder diagnoses. They found that women who fully recovered from an eating disorder exhibited levels of

perfectionism similar to the healthy women with no eating disorder symptomatology (Bardone-Cone et al., 2011). The women who had recovered from an eating disorder had recovered physically and behaviourally but not psychologically (Bardone-Cone et al., 2011). This similarity occurred across all conceptualizations of perfectionism; that is, trait perfectionism (i.e., setting high standards for oneself and feeling that others expect perfection from oneself), perfectionism related to self-presentation (i.e., trying to present as flawless to others), and frequency of perfectionism-related thoughts. These results suggest that perfectionism is considered a risk factor for eating disorders and that some individuals who have recovered from eating disorders may retain elevated levels of perfectionism (Bardone-Cone et al., 2011).

2.3 Healing from Disordered Eating

Disordered eating behaviours may develop to clinical levels later in life, which is why the role of counselling in the healing process is an important preventative intervention to investigate (Fairburn et al., 2007). It is also important to address what disordered eating is: abnormal eating patterns that do not present at clinical levels warranting a clinical diagnosis. Abnormal eating patterns can include binge eating, dieting, skipping meals regularly, self-induced vomiting, obsessive calorie counting, self-worth based on body shape and weight, misuse of laxatives or diuretics, and/or fasting or chronic restrained eating (Fairburn et al., 2007). To be diagnosed with an eating disorder the severity of behaviours and level of functional impairment across life domains are considered. Disordered eating and diagnosed eating disorders cause damage to personal, emotional, social, and physical wellbeing (Fairburn et al., 2007). Disordered eating is problematic because of how it can lead to damaging health concerns and the ultimate diagnosis of an eating disorder. A poor understanding of what constitutes healthy eating and effective ways of coping with life stressors are thoughts to contribute to disordered eating (Fairburn et al.,

2007). Further knowledge about disordered eating and associated behaviours used to manage stress and unhappiness with body appearance and self-image may help other sufferers and those tasked with helping them.

According to Emanuelli et al. (2012) healing falls into five underlying dimensions. The dimensions are a combination of physical, cognitive, emotional, psychological, and social factors. Emanuelli and authors (2012) recruited 238 women with eating difficulties and clinicians who work in the field, and asked them to complete both a demographic and healing checklist. The healing checklist involved 52 questions ranked on a 7-point Likert scale (1= not at all important to 7 = extremely important). The questions focused on healing of: (1) psychological, emotional, and social criteria (e.g., having friends, being in touch with one's feelings, not depending on others' opinions); (2) weight controlling behaviours (e.g., use of diuretics, vomiting, and excessive exercising); (3) non-life threatening features (e.g., skin being dry, no constipation) and life threatening features (e.g., monthly periods, heart beat); and, (4) appearance (e.g., not feeling fat, accepting own appearance).

All participants rated the importance of each dimension of healing ($p = <0.001$) (Emanuelli, et al., 2012), but clinicians and sufferers assigned different levels of importance to the criteria overall ($p=<0.001$) (Emanuelli et al., 2012). Sufferers rated psychological, emotional, social, and appearance rated factors as more important for defining healing than clinicians; clinicians rated physical and somatic criteria as more important to healing (Emanuelli et al., 2012). No differences were found among individuals with different eating pathology. It is possible that these differing findings are because most sufferers in this study were not yet recovered (Emanuelli et al., 2012).

Pettersen et al. (2013) noted a lack of research on the process of recovery from eating

disorders and interviewed women to explore this phenomenon. Thirteen women ages 18 to 54 were interviewed. The recovery process for the women related to themes of grief, commitment, and reconciliation and showed how recovery was possible (Pettersen et al., 2013).

The women expressed grief for the time lost living with their eating disorder. Shame and guilt was felt when they realized the negative consequences arising from their eating disorder and how it affected important relationships, work, school, family life, and opportunities to have children (Pettersen et al., 2013). Although difficult, it was crucial to their recovery to acknowledge and experience these losses and associated emotions. They were able to learn alternative ways of coping, establish a sense of normality and identity, and eventually accept the losses incurred as a result of their eating disorder (Pettersen et al., 2013). Once the women reconciled the feelings of shame and guilt, they forgave their losses and moved forward in their recovery. The process of reconciliation and forgiveness provided new meaning and allowed a healthy identity to emerge.

The women expressed that they understood their eating disorder was destructive in all situations and their need to develop alternative coping strategies to recover. The eating disorder was deemed an important part of their identity; establishing an identity without it was difficult. However, accepting their losses resulting from their eating disorder, overcoming the victim role, and letting go of high expectations was experienced as more important to their recovery than personal forgiveness (Pettersen et al., 2013). These findings suggest “healing from eating disorders is unidirectional by moving from illness to wellness” (Pettersen et al., 2013, p. 87). Setbacks and symptom relapses are common and may reflect a process towards reconciliation of the consequences of living with an eating disorder (Pettersen et al., 2013).

Eating disturbances and their symptomatic behaviours are known to be resistant to therapy and indeed, women may take several years to recover (Vanderlinden et al., 2007). Anorexia nervosa is considered one of the most difficult disorders to treat with drop-out rates as high as 50-58% for both in-patient and out-patient samples receiving specialized treatments for eating disorders (Sly et al., 2014). Moreover, eating disorders leave women with severe or even irreversible damage to their bodies and minds (Vanderlinden et al., 2007). Some counselling interventions consider the origin of the disorder and emphasize making meaningful connections to the present for patients enduring the disorder (Anderson & Corson, 2001).

2.2.1 The Counselling Process.

In counselling it is believed that the quality of the therapeutic relationship in general, facilitates clients' openness to and self-awareness about change and is the most important facilitative factor in counselling (Duncan et al., 2010). The therapeutic relationship is the context wherein clients discuss and explore issues central to their healing processes. Duncan et al. (2010) explained that a good therapeutic relationship is expected to be empathic, wherein the therapist is sensitive and demonstrates the ability and willingness to understand clients' thoughts, feelings, and struggles from their unique points of view. The therapeutic relationship will be strong if there are agreed upon client goals and tasks to attend to during the healing process. Counsellors positive regard, warmth, acceptance, and non-judgement of clients' experiences are important elements of the therapeutic relationship (Duncan et al., 2010).

2.2.2 Counselling for Disordered Eating.

There are necessary ingredients in the psychotherapeutic relationship that create and expedite the healing process for women with eating disorders (Vanderlinden et al., 2007). Vanderlinden et al. (2007) researched women recovering from eating disorders (n=132) and

compared their perspectives to therapists' (n=49). Each participant was asked to complete a questionnaire package consisting of 20 questions that considered the main therapeutic elements and tools offered to patients while in therapy. Women and therapists rated the importance of each of these 20 items on a Likert scale ranging from one to 10. Examples of these therapeutic elements included improving self-esteem, having problem-solving skills, and assessing body experience (Vanderlinden et al., 2007). Findings revealed that therapists and patients believe there are four main therapeutic factors that assist in healing from an eating disorder: (1) understanding the eating problems (e.g., gaining insight into the disorder's meaning and origin); (2) gaining autonomy (e.g., self-esteem, social relationships, learning to relax, dealing with problems and solving them); (3) motivation for healing (e.g., giving up the eating disorder, learning to eat normally, accepting target weight); and, (4) receiving social support (e.g., parents, family members, therapeutic team) (Vanderlinden et al., 2007).

These findings suggest that therapists and patients share the same views about what constitutes effective treatment. The only significant difference between the groups was that patients evaluated the support from therapists or therapeutic teams as significantly more important than did the therapists themselves ($p < 0.001$). Therapists' scores on giving up social isolation were significantly higher compared to the patients' views of its importance ($p < 0.05$). These findings suggest the importance of carefully considering what constitutes effective counselling from the clients' perspective.

In 2008, De la Rie et al. investigated the quality of treatment of eating disorders from both therapists' and patients' perspectives. Therapists were recruited through specialized treatment centers (n=73) and current and former eating disorder patients (n=148) were recruited from the community (e.g., websites, organizations, advertisements, and via eating disorder

clinics). Patients with eating disorders were screened with a questionnaire package and required a DSM-IV (American Psychiatric Association, 2000) diagnosis of an eating disorder. The authors developed the Questionnaire for Eating Problems and Treatment utilized to assess treatment quality from patients' and therapists' perspectives. Three parts were involved: the first and second included treatment trajectories, and the third an evaluation of treatment received. Open-ended questions were incorporated.

The results illustrated therapists ranked elements that focused on the patient as most important for the quality of treatment. The important points listed by the therapists as effective in treatment was respect, learning how to eat normally, focus on weight and improving body image, being taken seriously, explanation on eating disorder, keeping an eating diary, and being able to talk about eating behaviours. Differing somewhat, the patients rated as most important "trust in therapist, being taken seriously, treatment that addresses the person, being able to talk about feelings, focus on self-esteem, being respected, talk about thoughts, address underlying issues, talk about eating behaviours and being accepted as are" (De la Rie et al., 2008, p. 311).

Both therapists and clients most often mentioned treatment focus, therapeutic alliance, and communication skills as strong elements in the quality of treatment, but valued these elements differently. Clients mentioned that often the therapeutic alliance helps throughout the entire process and is central to facilitating healing. The therapeutic alliance supports the client to gain self-acceptance and awareness of their problem.

Typically, the therapeutic alliance is perceived as central to success in treating eating disorders. Sly et al. (2014) explored the elements contributing to the development of a stronger alliance in the treatment of eating disorders. Eight women who had a diagnosis according to DSM-IV (American Psychiatric Association, 2000) criteria participated in qualitative interviews

focused on gathering information about treatment history and experiences of care and the therapeutic alliance. The text analysis of transcribed interviews produced dominant categories that served as rules for engaging in a good therapeutic alliance: alliance as a key experience; being active and not passive; taboo talking; and the importance of first impressions (Sly et al., 2014).

Participants reported the therapeutic alliance as a key element in determining successful treatment. Participants reported that the therapist's active involvement in treatment was helpful. Active therapists always involved the woman in the treatment process, providing her with options and explaining the process. These practices facilitated respect between the therapist and client and a level of communication about what worked well and what did not. Taboo talking allowed women to talk about the disordered eating behaviours they were still using or struggling with during treatment instead of dismissing them altogether. The permission to talk openly about struggles increased safety and understanding in the relationship. First impressions were also critically important for the women, especially concerning how the therapist was dressed physically. Therapists who dressed professionally and appeared healthy (physically) were taken more seriously.

McGilly and Szablewski (2010) emphasize the importance of identifying key aspects of the healing process experienced by patients with an eating disorder. The therapeutic alliance helps reduce premature treatment termination and increases helpful termination. It also helps women learn healthy coping skills in the relatively safe context of a therapeutic relationship. Women expressed there are several elements to building a therapeutic alliance. Elements important for the women were a therapist who: was non-possessive, warm, and gave unconditional positive regard; was active and displayed worthwhile engagement; embodied

authenticity and being ‘real’ in the therapeutic context (McGilly & Szablewski, 2010). Other elements that were important for therapists to display were: empathy and trust; endurance and frustration tolerance; humbleness; transparency; and, ability to self-nurture (McGilly & Szablewski, 2010).

The therapeutic alliance is an “active and worthwhile engagement that heightens the likelihood of success in eating disorder treatment” (McGilly & Szablewski, 2010, p. 6). To move forward in the healing process, therapists recommend that clients bring their commitment to the counselling process. Clients should be honest, faithful, humorous and open to their healing process. Client’s positive attitude in group and individual therapy is also important (McGilly & Szablewski, 2010). McGilly and Szablewski (2010) suggested that qualitative research has the potential to answer more questions about the healing process; it allowed for an in-depth look at the experience of healing from disordered eating, focusing on the individual and her personal context.

2.4 Summary

The review of current literature outlines a historical understanding of disordered eating and how it affects women. As Hepworth (1999) explained, historical understandings of disordered eating often deny the social and discursive context of women’s lives as well as the gendered nature of the science that decree how women’s bodies are to be studied. With this said, the research suggest that women often engage in disordered eating because of a negative image and concept of their self (Stein, 2007). They are thought to escape the reality of a situation and/or traumatic life events with disordered eating (Espeset et al., 2012). Research has found that women who struggle with disordered eating seem to present with more perfectionistic tendencies (Bardone-Cone, 2011). Research has also found that women deal with difficult emotions

(Brockmeyer et al., 2013; Espeset et al., 2012), manage uncertainty (Sternheim et al., 2011), and neutralize feelings associated to food (Radomsky et al., 2002) through their disordered eating behaviours. The behaviours associated with disordered eating are complex and the experience is different for each woman. Women admit to feeling grief, loss, and shame due to time and opportunities lost as a result of their eating difficulties (Pettersen, 2013). Duncan et al. (2010) believes the therapeutic relationship is imperative to the counselling process. Research supports the positive change and healing within a trusting therapist-client relationship is important in the healing process from disordered eating (De la Rie et al., 2008; McGilly & Szablewski, 2010; Sly et al., 2014). This study extended this avenue of inquiry by examining the experience of healing and the role that counselling played in this process for six young women with a history of disordered eating.

Chapter 3: Methodology

The following chapter outlines the methodology used to explore women's stories of healing from disordered eating and the role counselling played in their healing process. I was specifically interested in what the women found helpful in counselling and how the counselling process positively influenced their personal growth. I interviewed the women using open-ended questioning (Lieblich et al., 1998), which yielded descriptions about the experience of disordered eating, the counselling process, and deeper understanding of young women's healing process.

The main objective of this research design was to collect stories by authentically listening to the women and the context that influenced their story, and analyze them according to the research questions (Josselson, 2007). As the researcher, I was aware of my own biases about the topic and acknowledged how both the researcher and participant shape the story. I incorporated several women's stories and performed a cross case analysis of patterns and themes common across accounts (Josselson, 2007). I respected the individual uniqueness, personal values, and text of each woman's story while generating themes and patterns (Josselson, 2007).

A personal story is often rich, revealing one's thought processes and conveying meaning and emotion. Stories are remembered then retold, transferring knowledge of intimate human experience. In this study, I wanted to gain further understanding of the personal meaning of healing and the role that counselling may have played in the lives of women who have experienced disordered eating. This was done by offering women a chance to share their personal stories about healing and the role that counselling played in this experience. The stories women told appeared genuine and were expressed with compassion and empathy; they reflected women's beliefs, motives, and thoughts about healing from disordered eating. These personal stories were lived, felt, and experienced and revealed how they were able to let go of

dysfunctional eating behaviours and begin to accept a healthy relationship with food.

A qualitative research design aims at comprehending a human and/or social problem from multiple view points (Christensen, Johnson, & Turner, 2011) and provides information on the personal experience. Qualitative research is important, as it is conducted in natural settings and requires procedures for contrasting holistic and complex images of the area under investigation (Christensen et al., 2011). It incorporates data gathering and interpretive methods that are sensitive to individuals' contexts (Haverkamp & Young, 2007). The strength of qualitative research is its focus on enhancing understanding by providing detailed descriptions of social phenomena (i.e., healing from disordered eating) and empowering participants to share their story, which is often important to the healing process.

The following sections outlines my research questions and paradigmatic assumptions (i.e., ontological and epistemological beliefs) and methodology: descriptive narrative thematic analysis. Information on ethical considerations, recruitment strategies, data generation and analysis, and strategies used to establish trustworthiness pertinent to my descriptive analysis close this chapter.

3.1 Epistemological and Paradigmatic Assumptions

The research question, *what stories do young women have to tell about healing from disordered eating and the role that counselling plays in this process?* is based on social constructivist ontological and epistemological assumptions. These assumptions deal with the nature of social reality and what actually exists (Hollway & Jefferson, 2000). The ontology underlying and informing both my research position and my questions presupposes no single existing social reality. As suggested by Hollway and Jefferson (2000), social reality is constructed by those who experience it. Furthermore, my epistemological position finds no

apparent objective truth to be known, as knowledge is constructed by and between individuals (Elliot, 2005; Hollway & Jefferson, 2000). A researcher with these assumptions recognizes that her perspective has significance, which appears in complex semantic forms.

The social constructivist paradigm informs my research, as I am concerned with individual, everyday lives and experiences. Researchers who approach their topic from the social constructivist paradigm undertake a quest for valuing diverse human experiences (Elliott, 2005). Such researchers find meaning in existential circumstances; the phenomenon of alleviating disordered eating through engaging in a counselling process is influenced by clients' personal experiences. Researchers informed by social constructivism look at "how" questions and focus on meaning making by identifying practices and understanding the ways people participate in the ongoing construction of their lives. Social constructivists recognize and emphasize the context of social, historical, and cultural norms that shape individuals, including their personal views (Elliott, 2005).

Consistent with a social constructivist perspective, I approached this inquiry by valuing and listening to women's stories of healing from disordered eating and how engaging in a counselling process influenced their experiences. As Polkinghorne (2007) states, "Storied evidence is gathered not to determine if events actually happened but about the meaning experienced by people whether or not the events are accurately described ..." (p. 479). I was listening for what was helpful to their healing and wondered about the 'defining moments' that occurred for them in their counselling process as they worked to heal from disordered eating.

3.2. Descriptive Narrative Thematic Analysis

Descriptive thematic narrative analysis can be applied to "any study that uses or analyzes narrative material" (Lieblich et al., 1998, p. 2). Using stories as data enables the researcher to

interpret and appreciate individual or group identities or values (Van Den Hoonard, 2011). Stories explain a personal experience that holds identity, personality, and meaning surrounding the self (Polkinghorne, 1988; Van Den Hoonard, 2011) and allows the researcher to ask individuals who they are and how they make sense of their experiences in the world, thus revealing the inner world of the individual (Lieblich et al., 1998; Polkinghorne, 1988; Van Den Hoonard, 2011). Descriptive narrative research looks deep into an individual's understanding by observing how it is constructed through interactions with the self, and by considering how the human experience is organized not according to a stable model, but instead by the real, present moment with the researcher (Polkinghorne, 1997).

A personal story holds rich content about an individual's identity and inner reality (Lieblich, et al., 1998). A story – told, revised, and retold throughout life – are indeed reflective of one's identity. My opportunity to research personal lived events with the use of individual stories offered deeper understanding of how individuals participate, create, and employ sense-making strategies. It allowed me to gain insight into a personal experience through studying “accounts of events across time that are individual actions... gaining significance from the way in which they are embedded within an individual's story” (Gergen & Gergen, 2006, p. 224).

Descriptive narrative research is a practical framework. It addresses human purpose, desires, limitations and opportunities put forward by the physical, cultural, and personal environments of the individual (Van Den Hoonard, 2011). In descriptive narrative research it is important to capture personal meaning and theorize about it in an insightful way (Hollway & Jefferson, 2004). Hollway and Jefferson (2004) recommend following an open-ended interview guide when collecting a story and to pay attention to the context of what influenced the story. Afterwards, when analyzing the story, consistency is achieved by following a framework

(Holistic Content Analysis) (Lieblich et al.,1998) and focusing on the research questions (Hollway & Jefferson, 2004). Most importantly, researchers need to understand the stories as they are presented, by noting how individuals connect to their experiences and observing the details that they perceive as crucial in their lives (Hollway and Jefferson, 2004).

3.3 Ethical Considerations

Before starting my research, an application for ethical approval was submitted to University of Saskatchewan Behavioral Sciences Research Ethics Board. Informed consent was established at the beginning of the interview process with each participant. During the discussion of informed consent, the purpose of the study was discussed along with the participant's rights and responsibilities. The participants were informed of how their anonymity would be maintained by assigning a pseudonym to individual accounts. They were also informed about: their right to withdraw from the study, the audio recording process, the interview length (60-90 minutes), how data would be secured in an encrypted computer accessible only to the researchers, and how and for how long data will be secured after completion of the study (see Appendix C).

Despite implementing the measures described above, I anticipated that ethical challenges could arise given the sensitivity of the topic. Participants retained the right to not answer any of the interview questions, take a break from the interview process, or withdraw from the study at any time before the data was aggregated. The women who participated in the study had disclosed their concerns about disordered eating within the context of counselling relationships prior to the research interview, so there was less possibility for emotional distress beyond what the women were likely able to cope with. The women commented that sharing their personal story for the purpose of this research was empowering. By sharing their story, they came to further understand

their growth and process of healing from disordered eating. They hoped their contribution would help others heal from disordered eating (Bardone-Cone et al., 2011).

My personal connection to this topic was apparent to myself throughout the research process. While conducting this research my health and self awareness was important to me. I made sure I prioritized maintaining good self-care practices for my own emotional wellbeing. I accomplished this primarily through journaling about my experience with the research process. I used meditation and mindfulness activities to help with stress. I also saw a counsellor regularly to debrief my experience about how the research process affected me.

I am aware that my personal experience and biases can influence the research process. My self-care practices enabled me to be grounded during the research process so I could genuinely listen to each woman's story. I believe it is my personal connection to this topic that enabled me to have increased sensitivity to the women as they shared their stories. Each woman had a different voice and took me on a different journey. I was able to recognize my own personal relationship to the topic, which deepened the meaning of the research process. I also gained deeper understanding of the data because of my authentic connection to this topic.

3.4 Participants

Purposeful sampling was used to recruit women for participation in this study. Purposeful sampling is a type of nonprobability sampling in which the researcher consciously selects participants for inclusion in order to ensure that the study includes certain characteristics relevant to the study (Merriam, 2009). Purposeful sampling is often used when information-rich data must be included and ensures participants included in the research are experts and knowledgeable in the topic area and are engaged in the research process (Merriam, 2009). Eligible participants were women between the ages of 18 and 30 that attended counselling in

their effort to heal from disordered eating, were willing and able to share their personal stories, and were presently not in a state of physical or emotional crisis. Participants were recruited through a recruitment poster (see Appendix A) and recruitment letter (see Appendix B). The recruitment poster was disseminated around the University of Saskatchewan campus and included the participation criteria and the researcher's contact information. The recruitment letter explained the details of the study and individual professionals were asked to provide the information to female clients for their consideration. Women who felt they met the participation criteria contacted me themselves, without the knowledge or involvement of their individual counsellors. Once contacted, I sent the recruitment advertisement (see Appendix A) and informed consent form (see Appendix C) explaining the purpose, goals, and risks and benefits of the research. They were asked to review the documents and bring the signed consent form to the interview.

Six women met criteria for participation in this study. The women ranged in age from 26 to 30 and identified that they were 'healed' or 'healing' from disordered eating, and had sought counselling. None of the women indicated that they were in emotional crisis at the time of the interviews, and all were able and willing to share their stories.

3.5 Data Generation

Semi-structured interviews were used for collecting research data (Van Den Hoonaard, 2011). The flexibility of this method allowed women to share openly of healing from disordered eating and the role that counselling played in their experience. Due to the complexity of their experiences each woman expressed healing differently. The interview aimed to collect in-depth data about the women's lives, experiences, and perceptions and served to reveal context about how the counselling process influenced their healing process (Elliot, 2005).

Semi-structured interviews allowed me to engage actively with the women and focus on the quality of the interaction between myself and each participant (Elliot, 2005). The interview guide (Appendix D) was used to focus on the research questions during the interview, but did not limit participants to specific questions. The use of probing questions encouraged the women to expand on what was already said with the aim of deepening responses to increase clarity and the quality of the data. The interviews took place in a quiet place at the University of Saskatchewan. The interview room in the Education Building was used three times; the Qualitative Research Laboratory in the Arts building was used three times. A pilot interview was conducted with a former Graduate student to ensure that questions were appropriate and understandable to participants.

3.5.1 Myself as a Research Instrument.

As the main researcher in this study, I acknowledge that ultimately I was the instrument of data generation and analysis throughout this research process (Merriam, 2009). However, as mentioned, an interview guide was used to help me conduct semi-structured interviews. Each interview was audio recorded. The audio recording enhanced the credibility and dependability of the study by reducing the risk of missing important information that was shared by the women during their interviews. After each interview, I transcribed the audio records in denaturalized form (Oliver, Serovich, & Mason, 2005). These recordings and transcriptions were stored in a securely locked computer to which only the researcher had access to for the duration of the study.

3.5.2 Research Interviews.

Research interviews started with a thorough, collaborative discussion of informed consent, participants' rights, and participation requirements (see Appendix C). This discussion

was important as it informed the participants of their rights and was an important tool for creating respect during the research process. The process ensured participants remained aware that their identity would remain anonymous and each participant was invited to choose a pseudonym used in reporting of findings. The participants chose: Dawn, Sila, Kristin, Nicole, Christian, and Megan as their pseudonyms.

Data collection began at the beginning of the interview process. The initial meeting with participants placed emphasis on the establishment of a rapport and explaining the interview process. Once I felt I gained adequate rapport and the participants were comfortable I began the interview with general questions to obtain background information pertaining to the research questions. Some examples are below (See Appendix D for full interview guide).

I would like to hear the story of how you gave up your disordered eating, how you worked towards healing and what was involved?

- a. When and how did your healing from disordered eating start for you?
- b. Can you explain the upsides and downsides of the healing process?

Questions then followed from general to more specific. The purpose of the interview was to prompt the participants to reveal in detail their experiences, specifically their experiences of attending counselling to facilitate healing from disordered eating. Questions used to probe the women's stories addressed their experience in counselling. For example, the women were asked "how did you think about yourself before and after counselling?" I wanted to learn how their perceptions, behaviours, distortions, feelings, and personal relationships impacted their healing.

After each interview, I debriefed with the women about the experience. Contact information for counselling services was provided to help with any post-interview distress. It was important for me to end the interview on a positive note and leave the women feeling

empowered. The nature of our conversation allowed deeper reflection about their experiences. The women stressed the importance of sharing their experience and encouraged others to embark on their own healing process. Megan personally disclosed how “healing” it was to share her story and how it helped her gain further insight about her and her future. Kristin stressed how important it is for society to acknowledge disordered eating as problematic. Nicole discussed social expectations around dieting and how dieting promotes disordered eating. Nicole also explained how unfair it is that society views personal struggles with food so negatively. Sila disclosed her realization of not being alone, and how many people struggle with disordered eating. Dawn stressed her wish that others acknowledge the possibility of healing from disordered eating and regard this as an important aspect of personal growth.

3.6 Data Analysis

There are many different ways to read, interpret, and analyze narratives (Lieblich, et al., 1998). For example, Holistic versus Categorical and Content versus Form Analysis are different analytic strategies utilized in narrative analysis (Lieblich, et al., 1998). Within this study, Holistic Content Analysis was used to delineate themes in women’s accounts and understand these themes in relation to one another as a dynamic whole. This approach to descriptive narrative analysis suggests a direct process for reading content in a holistic manner. The process of Holistic Content Analysis revealed themes of what was important in counselling to promote women’s healing from disordered eating. The process of descriptive narrative analysis began during the interview.

First, the study proceeded with formal analysis by reading each transcribed interview several times until a pattern emerged, usually in the form of the foci of each individual participant’s story. It was during the initial read that I let the women’s narratives and my own

thoughts work together. At certain times, a passage would jump out at me that seemed apparent and important to my knowledge of healing and disordered eating. I continued to read deeper and record notes on my thoughts and how I understood the material.

Second, I engaged in cross narrative analysis by comparing and contrasting the themes from the women's stories. Exceptions to general impressions were noted, as well as any unusual features of the story (e.g., contradictions, unfinished descriptions, etc.).

Third, special foci and content or themes were focused on as the stories evolved from beginning to end. Such foci were identified due to repetition or the number of details the women provided about an instance. The content was then drawn out into smaller themes using visual mapping on a poster. Once the themes had emerged, I wrote down on another poster what I used to 'connect' different subcategories. Visual mapping and grouping strategies helped organize the themes that came forward from the women's narratives (Lieblich et al., 1998). The themes that emerged through this analytic process included: (1) the importance of the therapeutic alliance and counsellor qualities; and (2) particular defining moments and experiences that occurred during counselling that promoted healing.

3.7 Trustworthiness

Trustworthiness helps ensure quality in qualitative inquiry. Traditionally in post-positivist paradigms, the criteria of validity, reliability, and generalizability are essential for the research to be accepted and received as suitable for use (Loh, 2013). Trustworthy research brings forth an honest and empathetic experience of a phenomena and enhances the ability of the reader to understand the participants' decisions, thoughts, and emotions that are meaningful to their experience (Loh, 2013). Within this study, trustworthiness was achieved through credibility,

dependability, confirmation capacity, and transferability of the research process and findings (Lincoln & Guba, 1985; Merriam, 2009).

Credibility was established through my recruitment process, purposeful sampling, and interview process. Peer debriefing gave a distinct contribution to the knowledge of the topic (Loh, 2013). Dependability was ensured through the informed consent process, interview process, and participant debriefing after each interview. Confirmation capacity was achieved through reflexive journaling and rechecking of data alongside researcher thematic descriptions. Transferability was increased by providing distinct descriptions of the research method and process.

Credibility was established through the process of data collection and analysis based on the intended research question (Loh, 2013). Exploring how counselling influenced women's healing from disordered eating is a complex phenomenon; therefore, appropriate methods were used to increase trustworthiness. The use of purposeful sampling, recruiting women who self-identified as healed or healing from disordered eating, and the use of semi-structured interviews contributed to the credibility of the results of this study. Purposeful sampling yielded information rich cases with diverse experiences that allowed greater possibility of shedding light on various aspects of the research question.

Recruitment from local counselling services by recruitment letters and around University campus with call to participate posters facilitated purposeful sampling. The women had to experience attending counselling for disordered eating and identify as healed or healing from disordered eating. Individual interviews were used as an appropriate means for collecting rich detailed accounts of the women's individual experiences in this sensitive area. A semi-structured

interview questionnaire was used to make sure each participant was asked the same question. Questions of a probing nature were used to ensure each conversation maintained focus.

The women in the study were aware of the peer debriefing process. Peer debriefing is a review of data, research process, and findings by someone familiar within the phenomena (Loh, 2013). Peer debriefing helped ensure the themes that originated from the stories were authentic to the women's experience and conveyed in an authentic manner. The women were aware of peer validation process and consented to it during the process of informed consent. I made sure my peer debriefers knew I valued the women's experiences and wanted to make sure they were interpreted respectfully and authentically. Peer debriefing was done with two Registered Psychologist (Stephanie Martin and Lynn Corbett) with expertise in disordered eating and eating disorders. They provided validation that the thematic results were consistent with the relevant research literature, her experience, and conveyed the women's stories appropriately.

Dependability refers to the stability and consistency of my study. Overlap methods of triangulation were used to ensure dependability (Lincoln & Guba, 1985). Women's stories are presented in such a way to allow the reader to feel part of the women's experience and phenomenon. Informed consent was discussed with participants at multiple times throughout the research process, which ensured participants understood their rights, participation requirements, and the research process. The participants and I confirmed they met criteria to be involved in the research, and that they were in no immediate crisis and could readily talk about this sensitive subject.

The interview was done in a natural conversational form with semi-structured questions, which allowed participants to openly talk about their experiences. The interview guide enhanced dependability of the research process. Each participant was asked questions allowing her story to

unfold. Probing questions to keep the participant on track were used to ensure deeper understanding of their personal experience. This process assisted in focusing and narrowing the interview in order to generate enough quality data to answer the research questions. Debriefing after the study allowed the participants an opportunity to share their experience of the research interview. If the women experienced sharing their story as empowering, their accounts seemed more dependable (Emanuelli et al., 2012). All interviews were audio recorded; denaturalized verbatim transcription of audio files (Oliver et al., 2005) facilitated Holistic Content Analysis (Lieblich et al., 1998) and enabled me to convey the women's stories in an authentic and faithful form (Oliver et al., 2005).

Confirmation of the results and how they could be confirmed or corroborated by others was important. I clearly documented my approach and methods and checked and rechecked my interpretations of the data throughout the process of analysis. I also decided to make my personal experience, opinions, thoughts, and feelings visible and acknowledged as part of the research process. A reflexive journal was kept to record personal ways of relating to and understanding the data throughout the research process, particularly during the process of analysis.

Finally, trustworthiness was ensured through transferability. Transferability refers to how the findings can be transferred to other groups or settings. Ultimately, the evaluation of context is up to the individual reader (Merriam, 2009). In order to enhance transferability, my research process is clearly outlined with distinct descriptions of the method, research question, participant selection, data generation procedures, and approach to analysis. The findings were presented in rich detail highlighting both the uniqueness and commonalities found between the stories the women shared. Also, women's own words were used to substantiate the findings. With this information, readers can assess whether the results of this study will apply to different contexts

that have a focus on understanding the role that counselling plays in young women's healing from disordered eating.

Chapter 4: Results

The purpose of this descriptive narrative study was to learn more about young women's healing from disordered eating and the role that counselling played in this process. Six women, aged 26 to 30, participated in a narrative interview. Each woman's story revealed her experiences of healing from disordered eating and what was helpful in her counselling experience. Through their counselling process, they gained insight about themselves and disordered eating that facilitated their personal growth and investment in healthier lifestyles. Certain qualities and skills of the counsellor assisted in building a therapeutic alliance with the women during their counselling sessions. The therapeutic alliance enhanced the counselling process by helping each woman come to understand why she used disordered eating behaviours and encouraged them to pursue life without disordered eating. Women's stories are presented, followed by an elaboration on thematic descriptions of (1) the importance of the therapeutic relationship and counsellor qualities to women's healing and (2) 'defining moments,' or turning-points, that occurred for each of the women during her counselling experience that made personal growth possible. Verbatim quotations from the interviews are used to 'anchor' the following accounts in participants' own words (Oliver et al., 2005).

4.1 Women's Stories

4.01 Melanie.

My eating disorder has been my childhood friend, my teenage confidant and my adult partner. Today, I cannot say that I am 100% recovered and live a completely 'normal' life free from my disordered eating. However, I can say with full confidence that for the first time in 28 years, counselling has helped on my way to healing. One day at a time, one healthy decision at a time.

Melanie reflected on the meaning of her disordered eating, which she understood was caused by living in a household wherein eating unhealthy meals that lacked portion control was an aspect of everyday life. In a constant state of bingeing as a child, it was normal for her to have eight cookies for dessert. At age 12, she weighed 160 pounds. For her “fat was being made fun of, miserable, and completely ignored by the opposite sex.” Melanie’s extreme control over her food caused her to become anorexic and to lose sixty pounds before entering high school. With her significant weight lost, she finally felt a sense of value and worth as a human being with a female body. Boys started paying attention to her, popular girls invited her to sleepovers – she felt ‘visible’ and had friends.

Melanie’s healing began when she hit “rock bottom.” She found herself in the emergency room after a car accident; she was anxious and afraid and, once again, wondered who she was as a person. She realized at 28 years of age that she had had enough of her disordered eating and wanted more in life. She decided to move forward on her path of healing and sought counselling for her disordered eating. Melanie described her relationship with her counsellor as safe; her counsellor was kind and empathic. Her counsellor shared personal experiences of disordered eating, which inspired Melanie to believe healing was possible and enhanced her relationship with her counsellor.

A defining moment for Melanie during counselling was learning balance with food. Her counselling process generated insight about her disordered eating behaviours and how it impacted her sense of self. Melanie commented:

... In counselling, I was able to recognize that when I am physically un-balanced - as in not eating properly, putting too much emphasis and focus on food, controlling it, restricting or under- or over-exercising - I am mentally unbalanced. And with a

mental/physical unbalance comes a really distorted view of myself. In this state of mind, I view myself in the negative self. I become 'fat,' 'ugly,' 'stupid,' 'worthless' and a victim to my eating disorder. On the flip side, if I am living a balanced lifestyle - eating properly, treating myself in moderation, exercising a healthy amount, meditating, limiting alcohol consumption, going to counselling, writing in my journal, slowing down and connecting to my breath etc. - I see myself as I truly am by finding balance in all areas of my life.

Another defining moment emerging through the counselling process for Melanie was realizing why she used disordered eating behaviours. Melanie struggled with extreme weight control and high standards of perfectionism. During counselling, she learned how to stop controlling food and over exercising. When she stopped these behaviours, she became more compassionate towards herself. Through counselling, she learned her perfectionist standards were unattainable. Melanie was driven to have the perfect body, relationships, and work environment and aesthetic, which left her unhealthy, unhappy, and without a sustainable and meaningful purpose in life.

Another defining moment in Melanie's healing journey was when she understood her identity without disordered eating. She shared:

... In counselling, I realized I have never truly felt like myself because I've never really had much of an identity or sense of self. I was either teachers' pet [she had to get perfect grades and do extra credit; teachers loved her], a girlfriend [she ate pizza, loved the Calgary Flames, and listened to country music], a wife [she liked the HABS, listened to Tool, and liked South Park] or some other person, some other mould that I would try to

fit into, just to have sort of an identity because I've learned, having false, 'borrowed' identity is easier than having no identity at all.

Melanie's counsellor helped her to discover things about herself that were not about how she looked, food, exercise, body, and weight. Once she let go of her disordered eating behaviours and engaged in "soul searching" she was able to move towards an expanded sense of self and greater self-acceptance.

4.02 Nicole.

I was always told throughout elementary and high school I was the 'skinny girl' 'cause I danced and was athletic. I knew what I could get by eating, and restricted a lot to keep up the image. When I got pregnant with my daughter, counselling helped me learn how to eat and let my body change; I couldn't be perfect.

Nicole was the "skinny girl" and "athletic girl" in her adolescent years. She was a competitive dancer across genres and stayed the exact same weight from grade seven until 20 years of age, by controlling and restricting her food intake and over exercising. Her disordered eating behaviours were driven by her belief that looking skinny was ideal in society. At 20 years of age she became pregnant; she felt alone and sought out counselling services for her disordered eating.

Nicole's counsellor was skilled in creating a positive, empathic bond. Her counsellor listened to her struggles with eating nutritionally and how hard it was for her to cope with weight gain during her pregnancy. Counselling helped Nicole understand why she controlled her food and the dangers of restricting to attain a thin body. During her counselling process, a defining moment for Nicole was when she was able to create a new identity for herself as a soon-to-be

mother instead of remaining the “skinny girl.” Nicole’s developing identity as a mother helped her begin to embrace a healthy lifestyle that could be modeled to her daughter.

4.03 Christina.

I was diagnosed anorexic when 14; I would lie to my family about eating at school, and my friends about eating at home. Eventually both sides caught on and joined forces to prevent me from denying my problem. I did not seek formal counselling for all this till I was 20 and having problems with depression related to failing to meet the extreme pressures; [my eating disorder] helped me gain acceptance.

Christina’s struggle with disordered eating started at 14 years of age. By the age of 20, she was ready to get help for her struggles and sought counselling. She described her counselling experience as encouraging and supportive. Christina’s counsellor helped move the topic of her eating disorder along each week, which helped Christina note the progress she was making towards her goals. There were always alternative coping skills provided to help Christina deal with the stress of letting go of her disordered eating behaviours. Homework was also suggested (i.e., journaling) to augment Christina’s change process. Christina was over controlling with food and held herself to high standards in many facets of her life. Through counselling, she learned to let go of her disordered eating behaviours and gradually learned to relax her concern about others’ potential judgments. Christina learned that her need to control stemmed from not feeling good about herself.

During the counselling process, a defining moment for Christina was when she realized her ability to feel good enough, competent in her own right, and accept and love herself for who she was. Another defining moment in the counselling process for Christina was realizing her perfectionist standards were rooted in her mother’s expectations. Her mother’s standards for her

academic achievement and body were extreme and unattainable and resulted in Christina resenting their relationship. Counselling helped Christina to decrease her focus on her Mother's judgments and to identify and accept her own personal values and beliefs.

4.04 Sila.

I was really insecure - controlling what I was eating, putting focus on food and perfection. Notebooks, journal writing, everything I was eating because there were specific rules for it. It was time consuming and I would do things like eat in my room. I was trying to be perfect, but it was hard and I was always worried about what people thought about me. Counselling helped me change my thoughts and behaviours.

Sila's disordered eating was influenced by her emotions. She felt insecure and was depressed and anxious about past life decisions. She controlled and restricted food as an attempt to limit her emotions. Sila believed if she could attain perfection with controlling food, she could find happiness and approval from others. Sila sought counselling for disordered eating in hopes of finding meaning and purpose in life.

During the counselling process, a major defining moment for Sila was finding her spirituality. Her counsellor knew she was searching for this purpose and connected with her on a spiritual level. Her counsellor told Sila a story of the 'middle path.' With this story, Sila was able to understand the middle path in life was about having balance and not needing to use disordered eating behaviours, such as controlling and restricting food intake, to be someone she was not. The story of the middle path resonated with her; she wanted a middle path for herself. Sila shared:

... counselling changed my thoughts and how I looked at myself. I learned a story of the first Buddha. He lived a life of luxury and over indulged in everything: food, women, and

whatever he wanted... that was super unhealthy and didn't make him happy... this is the Large Buddha. When he wandered outside his palace, he saw suffering, pain, and wanted to find meaning in life. Going off on his journey he did the extreme opposite and nearly died by denying himself of everything... he did not eat anything and suffered... then someone gave him milk and he found the middle path called enlightenment.

During counselling, another defining moment for Sila was becoming more self-aware. Her increased self-awareness allowed her to understand her emotions and what triggered her disordered eating behaviours. After reflecting on her past behaviours, she began to see the world differently and learned how to care for herself without disordered eating. Sila understood her new self-awareness as part of her spirituality and the identity she longed for. The counselling process also helped her gain self-acceptance and let go of guilt resulting from past experiences.

4.05 Megan.

I've been in treatment twice for disordered eating, and thought the skinnier I would get the happier I should have been (being overweight my whole life) and I was miserable. My friends hated me, I hated me; my whole life revolved around workouts and weird eating schedules. Counselling helped me learn my triggers and to not place so much judgment on myself. It took a lot out of me.

As a child Megan was taught, "you are what you eat" and was encouraged to over eat. As a teenager she started starving herself by restricting her food intake. This ended up making Megan feel hopeless. Anorexia left her with thoughts of suicide; she was hospitalized three different times for suicide attempts. During treatment, she struggled to understand her distorted perceptions of her body and disordered eating behaviours. By her third admission to hospital, Megan was ready to begin healing. Her relationships with the members of her intervention team

(counsellors, psychologist, and psychiatrist) helped in her healing. They all held positive mindsets on days she struggled. They constantly reminded her of how far she was coming along and provided positive feedback on how to continue down the road to healing. Being able to trust her team during the healing process allowed Megan to learn new strategies to heal. The reflection strategies she learned helped her get through the hard days. Eventually Megan was able to put her emotions into perspective and learn new, healthy behaviours.

A defining moment within Megan's counselling process was when she realized her ability to understand her disordered eating behaviours, particularly why she used them. Megan was not comfortable unless she felt in control of everything. She needed to know in advance what she was doing or eating and had to be in constant motion when performing a task. She believed the more in control she was and the less she ate, the greater her chances were of achieving the perfect body.

After counselling, Megan felt at ease with eating food and had the ability to limit the placement of value on amounts and types of food. Her intervention team helped her move towards healthy beliefs about food and herself. She was able to create a new relationship with food, wherein she would eat healthy and know how food was supposed to feel in her body. For Megan, defining moments during her treatment process were coming to an understanding of what healthy eating meant and learning what triggered her disordered eating behaviours. Counselling intervention allowed her to make sense of her disordered eating and begin to accept what a healthy adult body feels and looks like.

4.06 Kristin.

My eating disorder started when I was 14 years old - I was sexually assaulted.

Counselling made me understand that being a really quiet, introverted and very sensitive

individual left me susceptible to an eating disorder taking a hold of me as a coping mechanism, is how I made sense of it. It's painful, scary, and a daily challenge to move forward towards health; it's a choice you must make every single day and it comes with a huge bag of emotional garbage.

Kristin described herself as very sensitive and introverted and made a connection between her experience of pain and trauma and her disordered eating experience. At 14 years of age, Kristin was sexually assaulted. During counselling, she was able to disclose her assault, which marked the beginning of her healing journey. Kristin was not ready to begin healing until the last few years, when she realized that life was passing her by as a result of her eating disorder. Everyone important in her life was healthy; living with disordered eating was isolating and she was lonely. Her sister was married and having a child and her friends were in serious romantic relationships. Kristin's counsellor, her main support, was described as kind, compassionate, supportive, and constantly reminded Kristin how far she had come and that she had the capacity to live a healthy life. Their connection, cultivated through the counselling process, helped Kristin gain confidence to pursue a life beyond disordered eating.

A defining moment in the counselling process for Kristin was when she began to understand the extent of the toxic relationship she had with her body. She began to realize that she never felt good enough to be healthy. She believed if she were perfect in all ways, others would accept her. Kristin's counselling process helped her develop an identity without disordered eating. Her counsellor helped her realize her distorted understanding of 'perfection' and that being a good daughter, sister, and aunt were positive for her identity. She began feeling worthy of love and embraced the healthy relationships in her life. Kristin's ability to cultivate an identity without her eating disorder facilitated her healing from past trauma.

4.2 The Importance of the Therapeutic Relationship and Counsellor Qualities

The women's narratives suggest the important role that counselling played in their efforts to heal from disordered eating. Each woman commented on the therapeutic abilities their counsellors brought to the counselling process, particularly their knowledge about and ability to cultivate a trusting relationship or bond that made it possible for the women to open up and talk about their disordered eating, thereby opening the doors to healing. Specifically, the women expressed they established a therapeutic connection based on trust because of their counsellors' skills, kindness, intelligence, attentive listening, and presence.

The kindness their counsellors exhibited revealed their authentic care. By being patient, compassionate, and conveying empathy they displayed their ability to be kind. A patient counsellor accepted the time needed for healing and allowed the women an opportunity to reflect on their own experiences. Counsellors' ability to relate to the women's personal experience showed compassion and empathy. For Kristin, her counsellor's kindness and compassion made her feel comfortable disclosing her past trauma. She shared:

... [My counsellor] was kind and compassionate and treated me as a regular human being that is capable of mastering my dreams. She has helped me come to terms with happened during my assault, as well as what happened during my years of bullying. The kindness and compassion that I received over the years definitely helped me to share my experience and struggles, which encouraged the healing process.

Personal disclosure of counsellors' healing from disordered eating helped the women feel understood and facilitated deeper connection based on a shared humanity and hope. Melanie's counsellor helped her feel capable of achieving a life without disordered eating by disclosure of

her own personal struggle with disordered eating. For Melanie her counsellor's kindness impacted her healing. Melanie shared:

... She was extremely kind, a great listener and very patient. She let me figure things out on my own and gave me many tools during the process. She taught me how to be compassionate with myself. Our relationship helped my healing because it showed there are people who care about the wellbeing of others. She was the living, breathing example of someone who overcame disordered eating herself. She showed me I was not alone. This disease has affected so many people and I can move forward from this and become successful and maybe someday help others in similar situations.

The counsellor's intelligence and personal knowledge about disordered eating and healing helped establish trust. Counsellors displayed non-judgment, genuine care, and attentive listening, thereby creating an empowering space for client's sharing of vulnerabilities. For example, Nicole's counsellor created an empowering space for her to feel safe and at ease. She shared:

.... She guided me through the process. She made it easy for me to open up and talk about my eating issues and what was causing them. She let me take it where I wanted to go and recapped what happened last time we met. Our relationship helped me reflect on my life and have lots of "AH HA" moments, where things became clear of why I used disordered behaviours.

Attentive listening gave the women time to express emotions. It reassured them that they were heard and understood. Attentive listening helped focus counselling sessions by acknowledging insights gained and changes made between sessions. Consistent feedback on progress and homework to complete between counselling sessions also helped. For example,

homework tasks such as journaling and mindfulness exercises (e.g., breathing exercises) helped the women extend the work of counselling beyond regularly scheduled sessions. Christina expressed that her counsellor's ability to move the counselling process along helped build their relationship. She shared the following about her counsellor:

... [My counsellor] was supportive, moved the topic along week to week, so we were always moving forward and not getting stuck re-hashing the same issues. [She] provided me with coping skills to deal with my stress and provided me with a safe place to clear my mind. The relationship helped me get rid of my negative thoughts and helped me focus on the positives in life.

Personal presence displayed by the counsellor also facilitated trust within the client-counsellor relationship. Counsellors' moment-to-moment presence during the counselling process allowed for validation of progress and enhanced personal meaning making and sense of hope for the women. For Sila, being taught to live presently in the moment shifted her perception away from disordered eating. She shared:

... [My counsellor] was present in the moment with me. She gave me a new perspective and a new way to look at myself. I went from hating everything, all the negative emotions, feeling sick, unhealthy, to totally and radically shifting my perception of how I saw things differently.

These positive relational experiences created a unique and safe context for the women to reveal their challenges with disordered eating and risk in the hard work of healing. Within their accounts the women commented on 'defining moments' in their healing processes.

4.3 Defining Moments of Healing

Through the counselling process the women were able to learn about and eventually

understand why they used disordered eating behaviours. Personal insights became defining moments in their process of healing which opened the possibility for learning healthy behaviours to take with them into their futures.

Defining moments in counselling related to understanding the depth and distraction of disordered eating attitudes and behaviours. The women's beliefs were relentlessly perfectionistic and unrealistic. The women often referred to how they believed they needed to feel, look, and achieve. Having high standards that were unachievable would cause stress, which would trigger their disordered eating behaviours. Christina expressed a defining moment was when she realized her worth as a person was not based on being perfect:

... I know that what I was doing was unhealthy, and that it was from a need to be 'perfect,' that if I could be 'perfect' academically and physically others would like me. I had to learn that my self-worth was more than my body image, or my academic achievements of wanting to be perfect.

For Nicole, Krista, and Sila defining moments included acceptance of their bodies, understanding their unrealistic standards about how their bodies should appear and how disordered eating influenced body perceptions. The ability to learn and accept that there is no 'perfect body' facilitated their healing. Nicole shared how her past experiences as a young dancer shaped her distorted beliefs about her body. Conceiving her child and becoming a mother helped expand her understanding of her body's power and function. She shared:

... I was the skinny girl, had the body I wanted. When I got pregnant, I had to accept that my body was going to be different and I couldn't attain the skinny image any longer. My counsellor helped me understand that my standards were not normal for a mother-to-be and I had to think about my baby. The downside was retraining my body and lifestyle,

mind, and body and watching the scale go up. Counselling helped me understand change was good and letting go of the stress I put on counting food.

For Krista, a defining moment was her understanding of why she never accepted her body. Controlling food intake allowed her to present a false image. Counselling helped her to understand her false images of perfection, which helped her accept wellness. Krista shared the difficulty of this experience:

... Before counselling I just did not care enough to get better, I have never been 'well' since I first developed my eating disorder. I have only managed to float above the surface and was always trying to achieve some image of perfection that was other than myself. Counselling has helped me want to eat. I am on a special diet now that is helping me gain weight. Counselling has made me want to put on weight. Although I have damaged my body pretty bad, making my body hard to digest food, now I see what disordered eating has done to my body.

As for Sila, learning to feel secure with herself and understand why she tried to be perfect for others was a defining moment. Learning how to redirect her energy towards health and wellness was important to her. In counselling, Sila learned the confidence to acceptance who she was. She shared:

... In counselling, I learned I was really hard on myself, critical, and insecure. I didn't take very good care of myself, always trying to be perfect, perfection was hard to achieve because I was always worried what others thought of me. When I was insecure, I was really controlling what I was eating. Moreover, I would put all my focus into notebooks, journal writing on everything I was eating and have specific rules for it. I rather tried to follow Canada's Food Guide. It was time consuming and I would do things like eat in my

room, my family was concerned about my health and me. It affected my relationship with my parents and siblings. I have now a lot more time to focus my energy elsewhere.

During counselling, exploring why they wanted to appear perfect and held such unrealistic standards about their bodies was important to each women's healing from disordered eating. For some women, their standards about attaining the perfect body, exercising the perfect amount, and restricting food intake was what they viewed as 'perfection.' For others, perfection meant achieving the perfect job, getting top marks in academic pursuits, and becoming the impeccable wife, daughter, and friend. Megan shared her struggle with perfectionistic standards and her ability to change her thoughts and perceptions about perfection:

... My self-thoughts before counselling were that I was not good enough unless I was restricting and looking a certain way, trying to achieve what I thought was perfect in the eyes of everyone else. With treatment I was able to change those thoughts and perceptions into healthy ones and learn to cope when I start having negative self-image. After treatment, looking back at photos, I can properly see how crazy and unrealistic my views were before. I still hold a slightly distorted view of myself and I think I always will, but its manageable now and not to an extreme.

Through counselling the women learned about their disordered eating behaviours and how they became a substitute for dealing with the real issues or circumstances in their lives over which they felt they had little or no control. Their counsellors helped them make sense of this behaviour and begin to cultivate an identity not anchored to controlling their weight, but rather in moving to acceptance of a healthy, balanced approach to eating and life style habits. Christina shared her struggle to control and how important it was for her to come to understand this through her counselling process:

... I struggle with control, but I learnt to accept that I am a ‘control freak’ and how to use it in positive ways, not negative ways, on my body. I was so obsessed with the calorie content in everything I ate, would micro-arrange food on my plate, so I had to learn to channel that energy into something else. I would go to the pantry, and only see the calories and walk away, this would happen 5-10 times before I finally ‘let myself’ eat something (this is during healing), eventually I only had to walk away once or twice before I could make a decision.

The women’s counsellors helped them gain personal insight into their disordered eating dynamic and helped them to develop more realistic goals for themselves, their bodies, and their self-image. For Megan, learning realistic goals with food and understanding how to relax was important in her healing. A defining moment for Megan was being able to be at ease with food. She shared:

... My behaviours before treatment were not normal. I was miserable and not comfortable unless I was in absolute control of everything. I needed to know in advance what I was doing or eating and constantly moving. After treatment, I learned how to relax and not stress out, be at ease with food and not place such value on amounts and types of food etc.

For Melanie a defining moment in her counselling process was when she understood the concept of balance towards food and self-compassion. She shared:

... I have found that creating a food balance for myself has been helpful. Practicing compassion had come into play. I got so used to eating with so many restrictions - never allowing myself to have that treat or glass of wine, or even that second serving of carbs and if I did, then would come the guilt, the strict dieting, the over exercising, and the self-

hate. I had to find balance, allowed myself a treat every once in a while, and NOT have any negative consequences for myself. I find that, every time, I am less and less likely to beat myself up over those indulgences and I can simply enjoy them for what they are - a little well deserved treat.

Coming to understand their disordered perceptions and their bodies was important to all of the women. Before counselling they experienced their bodies as arenas of dissatisfaction. To feel better, they restricted their food intake, over-planned meals, and over-exercised. For example, Melanie described a defining moment of understanding her disordered eating patterns and behaviours. For her, knowing how to regulate these behaviours helped her heal:

... The majority of my life I have only placed value on myself if I was doing everything perfectly - exercising daily, eating extremely healthy, having the perfect clothes, hair, makeup, etc. etc. If I didn't do all of these things, and if I didn't have the attention of others (especially males) my self-worth would go out the window. If I 'gave in' and drank that glass of wine, or overindulged on that sushi date, I would end up hating myself and perceive myself as a failure. That hasn't changed entirely yet, but I RECOGNIZE these perceptions and see how quickly they can change merely with food or exercise. I recognize these patterns and with patience, understanding, and compassion I am working on changing these negative perceptions for good.

Through the counselling process, particularly the therapeutic relationship, the women were able to come to understand why they wanted to attain these unattainable standards and eventually found new, healthy ways to be with themselves, others, and in the world. The focus on being perfect was associated with not being content in various areas of their lives. Through counselling, the women were able to explore and begin to resolve the areas of discontent,

conflict, and trauma in their lives. The women were able to understand that when they sought to attain 'perfection' they were distancing themselves from self-acceptance and a sense of well-being.

In summation, the women's stories revealed their struggles associated with disordered eating and provided an in-depth perspective of the impact of counselling on their healing process. Each of the women experienced counselling as a place of refuge and healing. Through the counselling process, particularly within an authentic and trusting therapeutic relationship, they expressed and explored the range of emotions, experienced defining moments or turning points in their healing, and learned about and practiced healthier habits. Indeed, each woman's story was subjective and rooted in time and place. However, they are each important because they reveal new ways of understanding the process of healing from disordered eating, which can be applied within counselling to inspire clients' hope for positive change.

Chapter 5: Discussion

The following provides a brief summary of the research findings and discusses the limitations of the current research, connections to literature, directions for future research, and implications for counselling practice.

5.1 Research Findings

This study explored healing from disordered eating and the role counselling played in this process. Specifically, six women shared their stories of healing from disordered eating, highlighting the importance of the therapeutic alliance and certain counsellor qualities and the defining moments that occurred during counselling that were important to their healing process.

The interviews provided an in depth look into women's personal and emotional struggles with eating. The participants shared their attitudes and behaviours associated with disordered eating and how they came to heal as a result of engaging in the counselling process. They elaborated on how counselling impacted and supported their healing and, more specifically, what helped in counselling for the women to achieve healthy attitudes and behaviors towards food.

Defining moments are points in time that the women believed were important as they began to realize that disordered eating no longer served them. In counselling, these moments emerged when they were able to make sense of who they were relative to their disordered eating and found purpose and meaning to their experience with disordered eating. For these women, defining moments arose in the context of a facilitative counselling atmosphere. The women defined healing as their admission and acceptance that disordered eating was no longer of value in their lives. Healing was about self acceptance and finding new ways of coping with stress and relating to food. Finding balance, understanding self, moving towards health and wellness, and gaining self love were important to the women's healing from disordered eating. The women

commented on the healing power of coming to terms with the past and envisioning a different future.

The women's defining moments were 'times in counselling they learned and understood about their disordered eating.' For the women, it was important to come to understand their disordered eating whether it was about past trauma, low self-esteem, lack of a solid sense of self, or distorted beliefs about food. Some women realized that they gained attention from others as a result of their disordered eating. Weight loss caused them to become someone different - they 'fit in' and were acknowledged by peers, family, and the opposite sex. Feeling noticed and important reinforced their high expectations and standards about their bodies. Once they gained knowledge of the causes and consequences of these disordered beliefs and unrealistic standards, they came to understand and define who they were without disordered eating.

Another defining healing experience was the women's relationships with their respective counsellors. The counsellor's therapeutic abilities and knowledge deepened their understanding of disordered eating. Effective counselling skills, kindness, intelligence, active listening, and presence were all common to the women's experience with their counsellors. Kindness allowed the women to feel normal, capable, and experience some self-compassion. Being able to trust their counsellors allowed the women to express themselves and experience non-judgement and validation. Counsellors' skills in active listening created presence and helped the women gain further insight and empowered positive change. Constructive feedback from counsellors was important, as it helped the women understand their disordered eating perceptions and behaviors. The women appreciated the professional knowledge and expertise of their counsellors.

The women's accounts suggest that healing was a gradual process but also worth the journey. The majority of the women maintained that the development of a therapeutic

relationship with the counsellor was facilitative of their healing. For these women, a connection (bond) and certain counsellor qualities helped create an environment that was safe, open and empathetic to their disordered eating experiences.

The women discussed how important it was that their counsellors helped them understand their drive to control food through restricting food intake, over-exercising, and over-planning meals, and dislike of their bodies. Through the counselling process, the women were also able to make sense of why they held such high standards of perfection and believed that achieving such standards was essential to happiness. In counselling, they discovered new healthy behaviours that facilitated their experience with themselves, food, and others.

These findings suggest that healing from disordered eating is possible. It is a journey and a personal experience. Counselling provided a different perspective and the support and opportunity to learn about one's self. As suggested, women's healing was facilitated by the development of a positive therapeutic relationship due to their counsellors' personal qualities, skills, and knowledge about disordered eating. Within the counselling relationship, therapeutic release and positive change and growth was possible for these women. The women maintained that the level of therapeutic interaction encouraged within their counselling sessions provided an opportunity for them to feel motivated in their efforts to heal. Finally, there is much to learn about how the counselling process influences healing for women with disordered eating, but another line of inquiry might consider the impact of negative experiences with counselling for this population.

5.2 Connections to Literature

The current research has stressed how troublesome and difficult it can be to live with disordered eating. Participants in this study expressed experiencing emotional challenges and life

events that they attempted to manage and neutralize with disordered eating (Brockmeyer et al., 2013; Radomsky et al., 2002; Sternheim et al., 2010). A triggering event caused them to engage in disordered eating behaviour more often, at times (Dignon et al., 2006). Some of the women expressed trying to be perfect or wanting to look perfect in different areas of their lives (relationships, body image, school, and work) (Bardone-Cone et al., 2011) reinforcing the use of disordered eating. The women expressed they wasted time fixated on food which prolonged their healing process (Pettersen et al., 2013). Their control of food was used to inhibit dealing with emotions (Sternheim et al., 2011). Counselling appeared to be an appropriate and helpful intervention for these women (Fairburn et al., 2007) as it provided a 'healing space.' (McGilly & Szablewski, 2010).

The current research stressed the importance of the therapeutic relationship and how it is established during the counselling process (De la Rie et al., 2008; Duncan et al., 2010; Emanuelli et al., 2012; Sly et al., 2014; Vanderlinden et al., 2007). The alliance between the client and therapist is important in determining the success of treatment (Duncan et al., 2010; Sly et al., 2014). The therapeutic relationship aided the healing process when personal goals were achieved through consensus and recommended tasks were consistent with these goals (Duncan, et al., 2010; Emanuelli et al., 2012).

The counsellor's communication skills and qualities of positive regard, warmth, and acceptance fostered the women's hope for change (Duncan et al., 2010). Effective treatment, respect, trust (De la Rie., 2008), and unconditional positive regard (McGilly & Szablewski, 2010) allowed the women to embark on their healing process. The women in this study emphasized the relationships they had with their counsellors positively impacted their healing

process (De la Rie et al., 2008; Duncan et al., 2010; Emanuelli et al., 2012; Sly et al., 2014; Vanderlinden et al., 2007).

The “active and worthwhile therapeutic relationship heightened the likelihood of success for eating disorder treatment” (McGilly & Szablewski, 2010, p. 6). The counsellor’s ability to embody non-possessive warmth and unconditional positive regard towards the client and their struggles is noted as influencing positive treatment outcome (Duncan et al., 2010). The extent to which counsellors demonstrate active and worthwhile engagement, embodied authenticity, and being real, empathy, trust, endurance and frustration tolerance, humility, transparency, and the ability to self-nurture seems to matter to clients and their process of healing in general (McGilly & Szablewski, 2010). De la Rie et al. (2008) found similar results with eating disorder patients who agreed that the therapeutic alliance was central to facilitating their healing by enabling them to feel ‘accepted’ and more ‘aware’ during their therapeutic process. The development of a therapeutic relationship between the counsellor and the patient impacts the growth of an open and interactive relationship that influences the treatment process (Vanderlinden et al., 2007).

McGilly and Szablewski (2010) proposed the need for qualitative research that addresses the personal context of healing from disordered eating. There are scant reports in the literature on how individual women experience counselling, what is learned in their counselling process, and how they developed the ability to heal from disordered eating. The women’s stories reported herein allowed a deeper understanding of how their experience with counselling facilitated their healing from disordered eating.

5.3 Suggestions for Future Research

There are several suggestions for future research arising from this study. An enhanced understanding of long term healing from disordered eating would help women know more about

what the future might look like and how they can maintain wellness and protect themselves from relapse. In addition, research with women who have recovered from disordered eating would be beneficial. Further knowledge of what ‘recovered’ means for different women would deepen knowledge about the process of healing towards recovery that could be applied in clinical or counselling contexts.

Future research could also consider the male experience of healing from disordered eating. Although males were not included in this study, this does not dismiss the fact that men also struggle with disordered eating. Exploring what works for them in counselling and if there are certain aspects of the counsellor-client relationship that helped their healing would be an important contribution to research in this area of men’s health.

Further exploration of women’s experience with specific behaviours and attitudes is important and would be helpful in broadening understanding of what healing means. Disordered eating is a broad descriptor that encompasses many different attitudes and behaviours that do not necessarily meet criteria for the diagnosis of an eating disorder. Exploring how specific attitudes and behaviours are triggered for individuals would inform important prevention education and mental health intervention initiatives.

In addition to sharing personal stories, it might be beneficial to involve participants in the creative process at various stages of the research process. As a qualitative researcher, I decided to present the narratives in a very intentional way. However, the participants did not take part in or provide voice for how they would like their stories shared. For example, if they were involved in the co-construction of the stories it would have enhanced the trustworthiness of findings. By inviting participants’ active involvement in the creative process of reporting findings, the

credibility of this study would increase and perhaps a deeper understanding of their thoughts and feelings would be gained.

Each woman viewed healing in a different way. This is understandable because healing is based on unique personal circumstances and experiences. Some of the participants talked about wanting to achieve balance and finding their spirituality as important in their journeys. Others talked about letting go of their past and understanding how it affected them. My study addressed the role of counselling in women's healing from disordered eating. It would be interesting to look further into what women experience when they do not attend counselling, or when they attend counselling and do not find it helpful to their healing.

Women age 18 to 30 are in a stage of transition from adolescence to adulthood (Heatherton, Mahamedi, Striepe, Field, & Keel, 1997). This stage of life involves an exploration of life goals. When women start to settle down, consider marriage, have children, establish careers, and develop a strong and coherent sense of identity (Heatherton et al., 1997), it is possible that the importance they place on physical appearance reduces (Heatherton et al., 1997). However, more research on disordered eating and healing for women in this stage of life is needed.

Future research with women aged 30 to 40 years or older, focusing on their experiences with counselling and healing from disordered eating could provide more information on what healing is like for older women. For example, women who are in their 30s are believed to have a more entrenched and developed identity around food and body relative to their younger counterparts (Emanuelli et al., 2012; Pettersen et al., 2013). Their stories would be a valuable contribution to deepening understanding not only of the experience of disordered eating at a

different stage in the developmental spectrum, but of the nature of change and what matters as women move through their lives with a history of disordered eating.

5.4 Limitations of Current Research

There is scant research that addresses the nuances of healing from disordered eating. Furthermore, few qualitative studies look at women's experiences of what helped them heal within the counselling process. This study explored how women see themselves as having healed or healing from disordered eating and the role that counselling played in their process.

A limitation of the current study was having only one point of data collection. Follow-up interviews with each participant would have allowed for greater focus on specific details of the women's accounts, which may have refined their understanding of what was pivotal in their healing process. As well, adding a focus group as a method of data generation would have created an interactive atmosphere between participants, which might have yielded more or different information about healing from disordered eating.

A definition of disordered eating is currently not available. It is important for research to address the severity of disordered eating across a spectrum from non-clinical to clinical forms. Before the women began their healing, some were clinically diagnosed with an eating disorder, while others engaged in sub-clinical forms of disordered eating behaviours off and on. Interestingly, the women did not understand the difference between disordered eating and diagnosed eating disorders and some had never heard of the term disordered eating. The women who participated in this study used language consistent with the medical model (i.e., diagnostic criteria for eating disorders) when sharing their stories. A clear definition of disordered eating would have allowed consistency in my recruitment process and provided further insight specific to healing from sub-clinical forms of disordered eating. A future research strategy might propose

a definition for disordered eating. An overly broad definition of this phenomenon compromises the advancement of research that might inform prevention and intervention strategies for women not yet clinically diagnosed with eating disorders.

From a social constructionist perspective, women's experience with disordered eating are still being discussed in medical terms; women tend not to receive intervention until they have reached clinical or diagnosable levels of disordered eating. Women who subjectively experience distress as a result of disordered eating are not always acknowledged as being in serious enough need of intervention, yet this is where prevention efforts hold the most promise. Thus, diagnosed eating disorders have become a 'culturally bound' syndrome (Hepworth, 1999) that minimizes the distress caused by sub-clinical forms of eating disorders.

Further qualitative research needs to address mental health professionals' understanding of how to effectively intervene when clients present with disordered eating. Rather than addressing food consumption, it appears important that women grasp something beyond control and weight as they strive to heal. The ability to develop autonomy and healthy attitudes and behaviours in relation to food and wellness could reduce symptoms of disordered eating and improve relapse rates. However, it is important to acknowledge and attend to how disordered eating is a subjective experience.

Another limitation of this study relates to my participant recruitment process. The length of time since defining oneself as 'healed' from disordered eating was not one of my selection criteria. Recruitment criteria included women who were able and willing to share and talk about their experience, who self-identified as healed or healing from disordered eating, and who were not in a state of physical or emotional crisis at the time of the interviews. The women's time since healing from disordered eating were all different. Several of the women identified with

being healed for an extended period of time, whereas others had just begun their healing process. Future studies might address more clearly where in the healing process women locate themselves, as this appeared to impact the subjective view of healing. However, capturing diversity with this variable deepened understanding of the healing process for this sample of participants.

A goal for qualitative researchers is to develop knowledge through exploring and understanding experiences of small groups of participants (Merriam, 2009). Qualitative research can be used to gain a better understanding of any phenomenon or to gain more in-depth information that may be difficult to understand quantitatively (Van Den Hoonaard, 2011). As a result, findings from this study may be transferable, but the decision as to how well the findings can be transferred to another context is up to the individual reader (Van Den Hoonaard, 2011). Transferability also depends on understanding the difference between disordered eating and eating disorders. As the researcher, I was able to provide suggestions about the relatedness of the findings by providing detailed descriptions of the participant selection process, how data was collected, and how they were analyzed. The findings provide rich detail highlighting the uniqueness and commonalities found between the participants as well as addressing my research question.

5.5 Implications for Counselling Practice

The women in this study disclosed that they suffered from disordered eating for varying amounts of time. Some of the women shared their disordered eating was at clinical levels and that they had relapsed several times during the course of healing. Healing can be a long journey and full recovery is often a challenging process. I was interested in the women's progress towards healing and the role that counselling played in this process. Learning what mattered to

these women in their counselling experience could inform other mental health care professionals' practice with women wishing to heal from disordered eating.

The findings of this study corroborate Redenback et al.'s (2013) recommendations that 'best practice' emphasizes the importance of the therapeutic relationship. The quality of the therapeutic relationship is the most significant indicator of treatment success for women struggling with disordered eating. The therapeutic relationship is a collaborative relationship and is essential to the healing process (Ryan et al., 2011). An effective therapeutic approach to addressing disordered eating involves supporting the client with behavioural changes and providing a non-judgemental space for the client to explore irrational thoughts related to food and eating (Redenback et al., 2015). Based on participants' stories, I suggest several 'healing components' for creating an authentic therapeutic relationship with women hoping to heal from disordered eating.

5.5.1 Healing Components.

Healing components inform what can make healing possible through the therapeutic relationship for women with disordered eating. These components include: personal qualities, knowledge, presence, inviting change, and motivation from the counsellor.

First, certain personal qualities are essential to a counsellor's ability to influence the therapeutic relationship on an emotional level. The characteristics are portrayed through the counsellor's personality and individuality within the counselling process. Developing trust and being trustworthy, having a positive outlook, bringing knowledge to the situation, providing guidance, kindness, compassion, empathy, and cultivating a safe place to promote reflection and self-acceptance are all important. Counsellors working with women who are struggling with

disordered eating are encouraged to be mindful of the importance of these personal qualities in their therapeutic work.

Second, counsellor's knowledge about disordered eating is an important element of healing. Disordered eating is a complex disorder with complex behaviours and attitudes that every individual experiences differently. Knowledge about disordered eating and what is likely to promote healthy lifestyle changes in women's lives seemed to facilitate further trust in the therapeutic relationship.

Third, being 'present' as a way of being is crucial to therapeutic change (Rogers, 1980). When a counsellor is closest to their inner self, their intuitive self-presence is growth promoting for the client (Rogers, 1980). Presence is an inner receptivity that involves counsellors' openness to clients' multidimensional internal worlds (Geller & Greenberg, 2012). The counsellor who is open and in contact with their own bodily experiences can readily access their knowledge, professional skills, and wisdom (Geller & Greenberg, 2012). Knowledge of their personal body is thought to provide tools for understanding and responding authentically to the client. The counsellor's responses modeled during counselling acknowledged clients' disordered eating experiences enabling them to feel safe. For example, Dawn shared "my counsellor talked to me like a human being and it showed she understood me." Counsellor presence helped the women to be more present to and aware of themselves, which may increase their ability to regulate their emotions and disordered eating behaviours.

Fourth, counsellors' ability to invite change for the client is important for healing. Change of any kind, positive or negative, can be unsettling, but is pivotally important. An effective counsellor creates an atmosphere that is safe so that their client can address her disordered eating and relationship with food in an honest way. An effective counsellor holds a

non-judgmental stance by observing without placing judgment on the client's current situation (Choate, 2013). It is important that the counsellor provides a 'secure base' wherein clients will feel free to face unsettling material (i.e., emotions and circumstances) and trust the feedback and guidance provided by the counsellor to further their healing process (Choate, 2013).

Lastly, creating motivation within the client is important to healing. Motivational dynamics such as goal consensus and collaboration support client autonomy, self-motivation, and engagement in the counselling process (Ryan et al., 2011). Ryan and Deci (2008) reported that their clients mentioned three important components of the therapeutic relationship: (a) agreement on therapeutic goals; (b) agreement on therapeutic tasks; and (c) an interpersonal bond. Agreement on these goals and tasks is thought to enhance the therapeutic relationship by enabling the counsellor and client to work together throughout the counselling process.

According to Sly et al. (2010), when participants felt understood, they were more motivated.

These 'healing components' can guide counsellors in their establishment of a therapeutic relationship with women hoping to heal from disordered eating. The women expressed how healing was possible for them in their stories. The therapeutic relationship was pivotal to their healing journey. In closing, counsellors supporting women in their efforts to heal from disordered eating need to be mindful of their presence and attentive to the value women place on the importance of the therapeutic relationship. With this being said, healing is important and subjective to each person; it challenges one's ability to change and generates greater self acceptance and feelings of empowerment. Healing from disordered eating can be one of the most important, yet challenging, journeys in one's life. For my participants and myself it was a journey worth taking as it allows one to live with high self-regard and an expanded sense of meaning, hope, and well-being.

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Appendix A: Recruitment Poster

Appendix B: Recruitment Letter



My name is Jill Zurevinski. I am a Graduate Student from the Department of Educational Psychology & Special Education at the University of Saskatchewan. I currently work under the supervision of Dr. Stephanie Martin (PhD, RD Psych). I am conducting research in the area of disordered eating. I would like to let you know about a research study that may be of interest to your patients/clients and ask you to consider referring your patients/clients for possible participation.

The research study involves the analysis of psychotherapeutic/counseling intervention services that help women heal from disordered eating. The purpose of this study is to learn more about what young women find helpful emerging from their experience with counseling in their efforts to ‘heal’ or ‘recover’ from disordered eating. Narrative research will provide the methodological framework for this study. Participants will be asked “what happened in your counseling process that influenced recovery and healing from eating difficulties?”. They will also be asked about what “healing” and “recovery” from disordered eating means to them and if they can describe some critical learning moments arising from their counseling process that contributed to their recovery and how they see themselves today.

If you have patients/clients that meet the following criteria, they may be eligible to participate in this study:

1. Women aged 18-30
2. Have attended counselling/psychotherapeutic service for disordered eating
3. Are willing to share their personal story of healing
4. Are not currently in a state of physical or emotional crisis
5. Have access to personal and emotional support

I look forward to speaking with patients/clients in your practice who may be interested in participating in this study. Please feel free to contact me with questions, or have your patients/clients contact me directly, using the contact information provided below.

Thank you for your time and consideration.

This study has been approved by department of University of Saskatchewan Behavioral Sciences Research Ethics Board.

Sincerely,

Jill Zurevinski

Email: jill.zurevinski@usask.ca

Appendix C: Informed Consent



You are invited to take part in the research study: *The impact of psychotherapeutic intervention on young women's experiences of 'recovering' from disordered eating* this project was reviewed on ethical grounds by the U of S Behavioural Research Ethics Board.

Researchers: Jill Zurevinski jill.zurevinski@usask.ca

Dr. S. Martin Stephanie.martin@usask.ca.

Purpose and objective: The purpose of the study is to look at the positive impact counseling has had on disordered eating and how it has helped in healing. The objective is to learn about your personal experience in counselling, to understand more about critical moments or learnings arising from the counselling process that contributed to recovery and how you see yourself today.

Procedure: You are asked to take part in one 60 to 90-minute interview where I will ask you to talk freely about your experience with recovery. The interview will be recorded and transcribed for further analysis. You will receive an honorarium of \$20.00 for your participation, time and travels.

Potential Risks: The risks in this study are low but it is possible you may feel discomfort talking about your experiences. You have the right to decide what you wish to disclose. We will discuss your 'healing.' Participating in this study will provide you with an opportunity to tell an

important personal story and provide valuable information about what was helpful in the counselling experience. The following contact information can be used if you experience any discomfort from the interviewing process.

Saskatoon Mobile Crisis Intervention: (306) 933-6200

Mental Health Services: (306) 652-4100

Catholic Family Services: (306) 244-7773

Family Services: (306) 244-0127

Confidentiality: To ensure confidentiality the data will be safely stored in a secure manner. All information will be kept for five years and then destroyed. **The consent form will be stored separate and apart from the data. Data will also be backed up for on University of Saskatchewan secure Cabinet on PAWS for backup storage.** It is possible that direct quotations will be reported and if personally identifying information will be included in the report, the data will be reported anonymously in an aggregated or summarized form. The data from this research project will be published and presented at conferences and your identity will be kept confidential. Although we will report direct quotations from the interview, you will be assigned a pseudonym and all identifying information will be removed from the report.

Right to withdrawal: Your participation is voluntary and you as the participant are free to withdraw from the research project at any time. A withdrawal will not affect your academic status, and/or access to, or continuation of, services provided by public agencies such as the University, hospitals, social services, schools, etc. Upon withdrawal your data will be deleted from the research project and destroyed. It is to be remembered it is your choice to take part in the study and you can disclose the information you are comfortable with and take breaks in the interview as necessary. **Your right to withdraw data from the study will apply until the data**

has been pooled and/or aggregated. After that, it will not be possible to identify your individual data to remove.

Questions: Any questions that may arise before or throughout the duration of the study can be answered by the researcher. A summary of the research results will be provided upon request.

You can contact me by email: jill.zurevinski@usask.ca

This project was reviewed on ethical grounds by the U of S Behavioral Research Ethics Board.

Any questions regarding your rights as a participant may be addressed to the Research Ethics Office toll free at 1-888-966-2975 or **306 -966-2975** ethics.office@usask.ca

Consent to participate: I have read and understand the information above. I have been able to ask questions and my questions have been answered.

I agree to participate in the study described above, understanding that I may choose to leave this study at any time. A copy of this consent form has been given supplied for my own records.

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

Appendix D: Interview Questions

Narrative Question:

I would like to hear your story of healing from disordered eating, how you worked to heal and what was involved?

- a. When and how did your healing from disordered eating start for you?
- b. Can you explain the upsides and downsides of the healing process?
- c. What do you recall the most about this time in your life?
- d. Who were the supports you have when you started your process of healing and recovery?
- e. How did this change your life? (giving up behaviors)

How has counseling influenced your healing? (before the intervention after the intervention)

- f. Thoughts about self?
- g. Perceptions of the self?
- h. Behaviors?
- i. Distortions of the self?
- j. Feelings about self?
- k. Experiences about self?
- l. Relationships?

What type of counselling intervention did you attend?

- m. When & how long?
- n. What was helpful?
- o. What was this experience like for you?

- p. What new understanding did you take away about who you are as a women?
- q. Did anything defining happen in the intervention that help change, recovery or healing?

Have you been able to move away from what influenced your disordered eating?

- r. Make meaning of it?
- s. How did your relationship with counsellor help in healing?
- t. Can you tell me about your relationship with your counsellor?

In what ways do you see yourself 'healing' from disordered eating?

- u. What does 'healing' mean to you?
- v. What has been helpful to your healing process?
- w. What hasn't been unhelpful?
- x. What are you hopes for the future?
- y. What would you like to share with other women who are having eating difficulties and considering pursuing counselling/psychotherapeutic intervention?
- z. Is there anything else you'd like to share about your story? Anything we've missed that is particularly important to you?