



From eating identity to authentic selfhood: Identity transformation in eating disorder sufferers following psychotherapy

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Key words

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Abstract

Background: The following article illustrates the development of the identity configuration process of Chilean female patients with an eating disorder (ED) following successful psychotherapeutic treatment.

Method: This was a qualitative, descriptive study, which explored patients' subjective perspectives. In-depth interviews were conducted with 20 female patients, and data were analysed according to procedures established by the Grounded Theory method.

Results: Four dimensions of identity were identified: (1) self-image as idealised versus imperfect; (2) knowledge of one's inner world; (3) impulse control; and (4) life goals. Transcending these themes was the central notion of identity and a shift in this identity from someone who defines themselves by their eating disorder toward a more authentic and complex sense of self.

Conclusion: Results suggest that successful treatment facilitates the construction of an authentic identity, which includes developing a more realistic and complex understanding of themselves and their emotional and physical needs.

Key Points

- 1 The therapeutic process can facilitate the capacity of eating disorder sufferers to develop a healthy sense of identity that reflects their inner experience and is separate from and broader than that defined by their eating disorder.
- 2 An authentic identity appears to develop as the sufferer starts to dis-identify with the eating disorder and a healthy sense of self emerges.
- 3 The process of psychotherapeutic change involves recognition of the way in which the eating disorder has restricted life experience, dreams, and ambitions, thus redefining it as an impediment to the development of happiness and personal growth.

Introduction

Eating disorders (ED) are serious psychiatric illnesses that affect mainly female teenagers and young adults (Hoek & Van Hoeken, 2003). It is well established that while this developmental stage is crucially linked with the process of identity formation, it also increases vulnerability to the pressures imposed by cultural ideals and external aesthetic models, potentially hindering the discovery of authentic values and goals (Correa, Zubarew, Silva, & Romero, 2006; Kernberg, 2005). Indeed, recovery from an ED has been described as a process of self discovery, or "finding me," a complex process of learning about self, recognizing the problematic nature of eating symptomatology, and preparing for behavioural change (Weaver, Wuest, & Ciliska, 2005).

Aspects of Identity Development That Increase Risk of Developing ED

Identity formation or self-concept has been conceptualised as the development of a set of complex, multidimensional structures of knowledge or "self-schemas" (Westen

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& Heim, 2003). Identity impairment has been shown to constitute an important factor in ED symptomatology, with beliefs about the self (self-schemas) as factors that increase vulnerability to eating disorders (Simpson, 2012; Stein & Corte, 2007; Waller, Kennerley, & Ohanian, 2007). In fact, women with anorexia nervosa (AN) and bulimia nervosa (BN) have been shown to have fewer self-schemas, more negative self-schemas, alongside higher interrelatedness of self-schemas. The absence of a positive self-concept and the presence of a negative self-concept were significant predictors of the presence of a “fat self-schema” that in turn predicted ED beliefs and behavioural symptoms (Stein & Corte, 2007).

Anorexic Identity

Several studies have proposed that the AN identity initially functions as a means of gaining self-esteem and social approval through attaining thinness. It is suggested that the control that is exerted over eating in AN is intended to bolster self-esteem, self-confidence, and attractiveness and to compensate for underlying anxieties regarding their ability to cope with interpersonal relationships. Restrictive eating becomes a way of defining one’s identity and provides a means of making sense of one’s experience (Duker & Slade, 1988; Serpell, Treasure, Teasdale, & Sullivan, 1999; Weaver et al., 2005). The omnipotent “anorexic identity” may provide a sense of empowerment and “perfection” that masks a pre-morbid underlying sense of despair, emptiness, and self-hatred (Bruch, 1978; Levenkron, 1983).

The positive valence of the anorexic identity may be further reinforced through a sense of purity and power that results from successfully restricting, as well as a sense of “belonging” and community with fellow sufferers (Warin, 2009). However, these factors are counterbalanced by the negative or stigma-laden social identity that often accompanies AN (Rich, 2006).

Bulimic Identity

There is a dearth of studies that have specifically examined identity in bulimic disorders, nor compared identity development in anorexic and bulimic populations. There is some evidence that in comparison to controls, those with bulimic disorders may experience higher levels of perceived enmeshment in their relationships with others (Schupak-Neuberg & Nemeroff, 1993; Smolak & Levine, 1993) and experience greater confusion in regard to their identities (Sparks, 1993).

There is a shortage of research with qualitative methodology that has investigated the patients’ perspective regarding the causes and factors that contribute to recovery and/or remission from eating disorders

(Espíndola & Blay, 2013; Redenbach & Lawler, 2003; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). The current study is framed within a broader project that aimed to investigate and describe the aspects of self that changed as a result of psychotherapy in patients with eating disorders. Within the context of the larger study, the main objective of the current article was to identify significant themes associated with recovery across ED diagnostic groups from the testimonies of female patients who had received treatment for an ED. The theme of identity change emerged spontaneously from this data and is therefore the focus of this study.

Method

Methodological Approach

This was an exploratory investigation with a descriptive design, and a qualitative methodological approach based on *Grounded Theory* developed by Glaser and Strauss (1967) which was chosen due to its inductive and emergent nature (Glaser, 1992). Although this study did not generate an explicative model from the data, we argue that it does fit within the Grounded Theory paradigm, albeit at a descriptive level only (i.e., open coding). In this study, grounded theory was chosen as a method of data analysis (i.e., abbreviated version). The methodology for this study more closely resembled grounded theory-lite, which utilises grounded theory techniques in order to generate categories (and concepts), and to comprehend the relationship between the various categories (and concepts) (Pidgeon & Henwood, 1997).

Participants and Data Collection

Participants were referred by six specialist eating disorder therapists (four fully qualified psychologists with master’s level training and two psychiatrists). The main treatment models used by the services were Psychodynamic and Cognitive Behavioural Therapy (CBT). The inclusion criteria were: (1) female patients diagnosed with an ED (diagnosis made by a clinical interview based on the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (American Psychiatric Association, 2000)); (2) who had received psychological treatment for the ED; and (c) currently in the final or follow-up stage of treatment, as defined by Kirszman and Salgueiro (2002). We did not use hard data, but rather the judgment of the therapist (based on Kirszman and Salgueiro’s criteria, which includes a range of benchmarks such as weight gain, reduction in eating disordered symptoms, reduction in session frequency) to determine whether or not the patient was in recovery (and had reached their therapeutic goals).

Both anorexic and bulimic disorders were included in the sample in order to obtain a heterogeneous sample representative of the typical mix of diagnostic groups seen within a clinical setting in Chile. This allowed the researchers to identify transdiagnostic similarities across generic aspects of recovery that superimposed theoretical model, diagnosis, setting, etc., in order to achieve saturation of the main categories.

Sample size was not predetermined but was based on the criterion of *theoretical saturation*, that is, the data collection process continues until no new information arises. The sample included 20 Chilean female patients, coming from three large cities in Chile. Their ages ranged from 18 to 33 years of age, with a mean age of 23.7. Nine patients were diagnosed with AN, eight with bulimia nervosa (BN), and three with an eating disorder not otherwise specified. All of them were single with no children, and came from different socioeconomic levels (upper to lower middle class) (Table 1).

Data were collected through recorded semi-structured interviews, lasting between 90–120 minutes, which were transcribed by a psychology research assistant up to one month later. Interviewers were master's level clinical psychologists (with no history of therapeutic contact with the patients). As explained earlier, the original study from which this research was developed was focused on the overarching theme of psychotherapeutic process. The content reported in the current work (i.e., regarding

identity) emerged when patients were asked about the type of changes that occurred during therapy. As a consequence, the original interview questions changed as a function of the new emerging themes. Some of the original open-ended questions asked in the interviews were: What was your experience of the process of therapy? What changes did you notice throughout the course of therapy? How important are these changes [you have made] to your life? What aspects or dimensions of your life underwent change in the course of therapy? What personal characteristics changed? What do you see as the most important or relevant aspects of therapy that were connected to the experience of being successful or recovered?

Data Analysis

After the recorded material was transcribed, data were analysed and articulated descriptively through *open coding* (Krause, 1995).

In our open coding, we used two phases. In the initial phase, the process of analysing the data involved ordering the interview data into categories and sub-categories using an emergent approach, thereby organising information based on the stories told by patients without imposing explanatory theories or models. At this stage, our results were closely linked to raw data, attempting to remain close to the patients' original wording. In the

Table 1 Sample demographics

	Age	Diagnosis	Occupation	Number of treatments (psychologist and / or psychiatrist)
1	18 years	AN	Student (school)	1
2	18 years	AN	Student (school)	1
3	30 years	BN	Student (kinesiology)	2
4	19 years	BN	Student	1
5	21 years	AN	Student (medicine)	2
6	24 years	AN	Student (psychology)	1
7	19 years	BN	Student	2
8	24 years	BN	Nutritionist	1
9	25 years	BN	Social worker	2
10	26 years	AN	Student (History)	1
11	25 years	AN	Nutritionist	1
12	33 years	EDNOS	Journalist	6
13	29 years	EDNOS	Sociologist	4
14	24 years	EDNOS	Student	2
15	24 years	BN	Student (nursing)	2
16	21 years	AN	Occupational therapist	1
17	24 years	BN	Student (nutrition)	1
18	24 years	AN	Student	3
19	23 years	BN	Student	2
20	22 years	AN	Beautician	2

AN, anorexia nervosa; BN, bulimia nervosa; EDNOS, eating disorder not otherwise specified.

second phase, information was grouped by topic, and four themes emerged. As explained earlier, information was grouped according to dimensions that naturally arose from the data.

Data analysis was conducted by the research team, which included five psychologists trained in qualitative methods, and specifically in Grounded Theory. Triangulation was carried out to build consensus on the categories that were emerging. The process of data analysis was carried out in parallel, and then the team discussed the categories and finally reached agreement. In order to facilitate triangulation of analysts (González, 2000), meetings were being held at each stage of data analysis in order to discuss and reach consensus on findings, emerging categories, and preliminary results.

Ethics

This study was approved by the Ethics Committee of the Psychology Department of a university in Chile. Interviews were authorised by therapists, and patients participated voluntarily and signed written consent forms.

Results

From the analysis, four themes were identified illustrating changes throughout the process of therapy. The evolution of each dimension is described, as well as what patients identified as having helped them achieve these changes (Table 2).

Self-Image

Patients described the need to “cancel” themselves out and disappear. Moreover, the body was perceived as the cause of overwhelming emotions that they couldn't contain, leading to a desire to completely extinguish it.

I didn't look at myself in the mirror, I stopped existing. For me, in my body, it was a . . . a sense of feeling sooooo much, but at the same time yes and no, to not be, to be or not to be, uh . . . feeling so much yet denying yourself so much, this is what's really getting in the way of really being . . . I wished I were foam and I could float, and say goodbye to my body, I didn't want it at all, I didn't want anything to do with it (XIV).

The development of the disorder, especially in patients presenting with symptoms of AN, led to difficulties recognising themselves in the mirror, which may have been a way to actualise their aforementioned desire to disappear.

. . . I was feeling like I wasn't myself anymore, for example I'd look in the mirror and I didn't see myself, it was like I was someone else (IV).

Towards the end of the treatment process, patients described that they were able to recognise themselves better than they had previously; they acknowledged that before asking for help, all of their concerns gravitated around weight, whereas after treatment that was no longer the case. There was also a change in the way they perceived their own body and a greater willingness to allow others to see them.

I used to go out fully covered [. . .] I used baggy clothes, I didn't show my silhouette . . . now I try to show more . . . (VIII)

Knowledge of the Inner World

An inability to discriminate between inner processes could be observed from the beginning, even in the way in which treatment was sought. Patients consulted for external reasons, and were taken along by a family member, sent by their school, or referred by another

Table 2 Pre- and post-therapy themes described by patients recovered from an eating disorder

Theme	Pre-therapy	Post-therapy
1. Self-image	Hide their bodies/desire to disappear	More realistic knowledge about body and needs
2. Lack of knowledge	1. Lack of knowledge about the eating disorder Unable to recognise its risks Egosyntonic symptoms The food facilitates management of affect 2. Unable to deal with loss 3. Lack of discrimination between body sensations and emotional experience	Improved recognition of risks of eating disorders, decreasing the guilt, anger, and sadness Improved emotional expression Improved discrimination of bodily sensations and emotions
3. Impulse control	Food control Need to control others Control as a mean of personal organisation	Healthy development of personal control
4. Life goals	Living only in the present focused on their symptoms, food, and weight	Development of future goals (including their families) Development of personal autonomy

health-care provider. Thus, initially there was often a reluctance to seek treatment among ED sufferers, whereby they maintained a passive attitude towards both the disorder and treatment. In most cases, the exacerbation of symptoms that led to treatment was preceded by a significant loss, such as the death of a relative or close friend to which they had not been able to respond in an emotionally healthy manner nor to think about or process in a mindful or self-aware way.

... she had cancer since she was 3 or 4 years old and we lived next door to each other, so we lived the whole process of her disease together, and then she passed away in '96 and I thought 'I'm alone, this is terrible'. . . and before that she was really skinny and so I said I was fat, next to her who looked super skinny . . . and I didn't accept that it was obviously because of the cancer that she was that way, no, I felt extremely fat and I wanted to lose weight . . . and I don't know exactly when I heard about people vomiting but I thought 'why don't I try that?' . . . so I started with that . . . and at first I didn't do it that much but when she died, I felt totally depressed . . . (III)

Patients emphasised that at the beginning of treatment they had no awareness of the disorder or of the risks it involved. Since the symptoms are ego-syntonic, patients had great difficulty understanding that they were suffering from a disorder. Another element reflecting lack of discrimination of their inner world entailed the meanings attributed to food. Among other things, it represented how emotions were handled; the starvation state enabled them to "eliminate" or avoid experiencing feelings.

Oh, it was a little bit like not being here. Always, like not wanting to be here, here on Earth, like not being connected, because food connects you. It connects you with others, with the Earth. Not wanting to eat before was like not being here, like being and not being. Like flirting with life all the time, eating and vomiting, being—not being, you know? (XIII).

Patients described great difficulties discriminating between bodily sensations and psychological or subjective feeling and emotion. They tended to manage their emotions through the symptoms of the disorder, being unable to recognise, mentalise (to understand the mental state of oneself and others which underlies overt behaviour) or verbally describe them.

When I felt guilty, I exercised a lot and vomited . . . I cried, I felt bad and the next day I didn't eat (II).
Everything I felt was transferred to food, and I stopped eating (VI).

I was depressed therefore I ate . . . I would relax when I ate, then I vomited, and then I felt terrible (III).

In addition, patients expressed that food gained importance because it became the only important thing to worry about, everything revolved around it.

During the course of therapy, patients were gradually able to identify personal motivations for participating in treatment, which were associated with the discomfort produced by the disorder. However, in the earlier stages they described feeling ambivalent about this recognition, as although they recognised they had a problem, they believed that they must deal with it on their own.

I didn't tell anyone, it was like: this is mine, it's my problem, I'll deal with it on my own (XVII).

Patients described that towards the end of treatment, they had a better integration of their own internal experiences and greater self-acceptance. They felt that they had been able to develop a more realistic perception of themselves, as well as a better understanding of the different aspects of their own personality and ways of functioning.

I see myself more. How I really wanted to be and how I really am. I envied those energetic girls who seemed to be included in everything and knew everyone. I didn't dare to do those things, the idea was there but I didn't act on it. Now I'm more how I wanted to be (VII).

According to the patients, one of the achievements after undergoing treatment, which also allowed for greater self-knowledge and self-acceptance, was that it enabled them to understand their symptoms as manifestations of the ED, and also the reasons associated with the development of the illness. The change generated by understanding the causative factors associated with the illness facilitated their self-understanding, thereby decreasing guilt, anger, and sadness.

Today I feel like it was all on the cards . . . that in the end the disorder which I had was a solution to a lot of problems I was going through . . . and it was the only solution I could find . . . because a different answer no, no, it wasn't a possibility for me and today I feel like the disorder forced me to have to look at a lot of things about myself, and I feel like this has been a great opportunity for me (XII).

Patients' accounts also reflected a more spontaneous expression of their feelings and emotions.

I started facing things and talking about them, and it felt good. I'm changing. Before I used to keep it all to myself and get depressed (III).

In the final stages of treatment, patients had a greater capacity to discriminate between bodily sensations and emotions, which implies the development of certain psychological resources.

Yes, yes, yes in fact now I realize that there are periods of time when I go 'I'm hungrier because I'm about to get my period!' and I realize I feel hungrier. Or I feel anxious, and of course, if I feel anxious I'll eat twenty thousand pieces of gum, you know? But yeah, I feel much more capable of telling the difference between the signals (XII).

Impulse Control

Another dimension of identity generated by the results was impulse control. At the beginning of treatment, patients' ambivalence was illustrated by the fact that despite the discomfort caused by their symptoms and the realisation that they were unable to stop them on their own, they were reluctant to ask for help, as they feared this could increase parental control, making it harder for them to freely engage in ED behaviours.

I thought about telling my dad I was unwell and I briefly thought that if I had their help they would watch me and it would be easy . . . but no, I continued with my obsession and I went on and on and on. Whereas before it was all so easy . . . everything would become so difficult, like if I wanted to throw up I would have to do a thousand things [to distract them], if I wanted to buy sweets I would have to do a million things [to not be noticed] . . . whereas before it was as simple as buying, eating and vomiting (IV).

Patients' accounts also revealed a fear of losing control, and keeping the symptoms hidden, which in turn seemed to provide a sense of organization and perfection. Before treatment and in the early stages, control of food intake was perceived as a sign of will power and a way of improving self-esteem. Patients described that when they lost control of food intake, they were deserving of harsh punishment.

Obsessed with vomiting, with not eating; I'd become aggressive, desperate, I'd lose control, I'd go crazy and I'd start screaming, cursing, hitting myself, breaking things, writing on the walls: bitch, fat, disgusting, pig (IV).

After treatment, patients described changes in the way they related to food and a greater ability to recognise personal attributes, which allowed them to develop a healthier sense of control over themselves and their eating behaviours. They also described changes in their

perception of the disorder; they realised the severity of it and how damaging it had been, and how much control it had over them.

. . . Now there are a lot of changes . . . because in the beginning, I would eat anything and then vomit . . . then I realized the things that triggered my vomiting, and I decided I had to avoid them [. . .] with time I started fearing food less . . . and now I can eat well . . . (VII).

Life Goals

The fourth dimension generated from participants' accounts involved the development of life goals. They described that in the initial phases of treatment, they were focused on living in the present, largely dealing with their ED symptoms. In effect, their lives revolved around food and weight.

During psychotherapeutic treatment, they gradually began creating life goals, which entailed making use of personal resources and new strategies, or strategies which had been set aside during their illness. They had to face the challenge necessitated by social reintegration, and develop social skills, assertiveness, and the capacity to set limits for themselves and others. Furthermore, the development of and the acting on life goals demanded an increase in autonomy, which was facilitated by the accomplishment of short-term tasks during treatment which promoted their sense of self-efficacy and confidence. The development of future projects such as having a career or starting a family were an important element of building personal identity and patients described the positive repercussions this had on their process of recovery.

One must have a goal in life in order to say: 'I want to be this or that, I want to be this person, but to do that I have to be OK'. And I need to be OK in several ways. No, things are not only about physical appearance, but also about the psychological aspects. I think that when you talk to a patient, you have to try to get them to have a goal, a purpose in life, which isn't only about what's going on at the moment, it's about something more remote, what they want for the future, for their life . . . do they want to continue like this, being sick, or do they want to have a family, do they want to become a mother, to have a career, what is it that they want . . . because I believe that when you achieve what you want, you feel good about yourself, and that's when you begin to realize that, maybe, what you were doing before was wrong (XI).

Discussion

The main objective of this article was to describe the themes that emerged through interviews with ED sufferers who underwent psychotherapeutic treatment, and in particular the descriptions of identity configuration that emerged from patients' testimonies.

Four main themes emerged from data. Transcending these themes was the central notion of identity and a shift in this identity from someone with an eating disorder towards a more expansive and authentic selfhood. Across all themes, patients described a broadening of the basis for self-concept, moving from an emphasis on physical appearance, weight, and control of food to knowledge of the complexities of the self, incorporating personality, and relationships.

The first theme was labeled "Self-Image" and described the transition from wishing to hide one's body at the beginning of therapy, to developing a more realistic understanding of one's own self and needs, similar to the concept of "finding me" proposed by Weaver et al. (2005). The second theme was identified as "Knowledge of the Inner World," whereby body image formed the basis for organising subjective experience and identity at the start of treatment, similar to the notion that ED patients are "trapped in the concreteness of body symbolism" (Skårderud, 2007, p. 173). However, through psychotherapy they developed the capacity for deeper level introspection and self-understanding. The third theme, "Impulse Control," reflected the belief at pretreatment that urges, impulses and associated lack of self-control are shameful and deserving of punishment, as compared with the acceptance of one's own emotions and needs that emerged during recovery. The fourth theme to emerge from the data was "Life Goals," which referred to the shift from an intensive present focus at the beginning of therapy, revolving around the eating disorder to a wider set of life goals that incorporated social, interpersonal, and other unique aspects of self.

In this study, the ED initially offered patients a form of "surrogate eating identity" (e.g., "I am anorexic"), since body shape was the main criteria by which they evaluated themselves, and their lives began to revolve around food and the ED. With the unfolding of an eating identity that is perceived as more acceptable than the authentic self, the compulsion to "disappear" may therefore serve the function of trying to resolve these issues at a pre-conscious level, through extinguishing or displacing desires associated with the underlying emotional, physical, and sexual "self" (Cordella, 2010). It seems feasible that this desire to "disappear" may be linked to the sufferer's sense of self and their emotions

as shameful (Keith, Gillanders, & Simpson, 2009; Simpson, 2012). Although not formally utilised in the conceptualisation of themes, it became clear in the second phase of coding that the themes emerging from the data naturally corresponded with those described in Erickson's (1968) theory of identity development, which describes the development of a coherent notion of self through time, integrating emotional, physiological, sexual, and social aspects of the self. He describes identity as "a feeling of being at home in one's body, a sense of knowing where one is going, and an inner assurance of anticipated recognition from those who count" (Erikson, 1968, p. 165).

The overarching theme that emerged from this investigation was the transformation of patient identity through psychotherapy. During the course of recovery, the "blanks" in patients' identity began to be filled by the ability to identify internal aspects of their experience such as emotions and thoughts and to discriminate them from bodily sensations. As the capacity to recognise, regulate, and express emotion improved, changes were observed in the way they managed food, and they began to accept themselves as unique and different from others.

This self-knowledge, self-acceptance, and self-comprehension made way for differentiation and the construction of an identity with better defined limits and with more personal content. Patient identities transformed into more complex structures which represented authentic experience and multiple facets of the self. Moreover, successful psychotherapeutic treatment appeared to facilitate the resolution of tensions of identity, which allowed the integration of patients' positive attributes with those that had been denied, rejected, or dissociated. This is congruent with the findings of Lamoureux and Botorff (2005), who described the central integrative process in the recovery of anorexia nervosa as "becoming the real me."

The recognition of the patient's own self became possible through consistent motivation for change, as well as a process of introspection undertaken within and outside of therapy, ultimately leading to an increase in self-awareness. Our findings suggest that it is this ability to think about oneself and feel oneself that finally generates the change from an eating identity based on rigid and poorly differentiated elements, to a biographical identity where past experiences are accepted and respected as instances of learning and growth, thereby allowing patients to resume their life projects in healthier ways.

Patients described the development of biographical or narrative identity as a feeling of self-integration, of getting to know their inner world. This implies an

opportunity to learn about themselves and identify their own psychic limits and the integration of their own internal narrative of the disorder as a part of their lives. This re-evaluation of the ED contributes to self-acceptance and leads to the path of forgiveness and reconciliation with the self. The importance of self-acceptance and self-determination in recovery from EDs is consistent with the findings of prior studies in this area (Espíndola & Blay, 2013; Redenbach & Lawler, 2003).

It also appears that effective psychotherapeutic treatment entails the collaborative creation of a life project for the patient. In parallel, an evaluation of how the ED has developed into a limiting, and in some cases, paralysing experience is undertaken by analysing how personal dreams and projects in the past and present have been sabotaged by the ED. This contributes to redefining the disorder as a negative state, which stands in the way of happiness and personal growth. The therapeutic process therefore appears to contribute to changing the focus of patients' lives from the ED to themselves as individuals on a broader level. These results are consistent with the findings of Dawson, Rhodes, and Touyz (2014) who described the externalisation and devaluation of AN as an important component of recovery.

Although this study has contributed to our understanding of recovery from an ED, certain limitations must be taken into consideration when interpreting results. In this study, the definition of participant recovery was dependent on a range of criteria as judged by qualified psychologists. Future studies would benefit from defining inclusion criteria in greater detail while including additional objective measurement of outcome data such as weight or body mass index, abstinence of ED behaviours and urges, in addition to therapist judgment. Furthermore, although the specific therapeutic models and their attendant characteristics were not treated as selection criteria in the present study, future studies may further contribute to the evidence base by collecting this information from the outset in order to facilitate the possibility of group comparisons. Although our study focused on similarities between ED subtypes in the recovery process, future studies should also investigate differences between ED subtypes. In particular, there is a need for future research to focus on developing our understanding of identity within bulimic disorders.

This study did not conform to the full grounded theory methodology by going on to develop a relational model. Although this was beyond the scope of the current study, it is recommended that future studies could further advance this area of investigation by including the next steps in the grounded theory methodology. Finally, future studies could be expanded by including both men and women from a range of cultural settings.

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