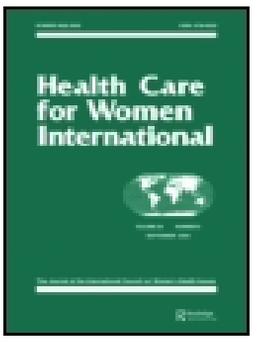

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The Patient's Perception of Having Recovered From an Eating Disorder

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Our aim in this study was to describe how patients perceive having recovered from eating disorders. A qualitative method with a phenomenographic approach was used to identify various ways of experiencing recovery. Four categories emerged, describing how the subjects now relate in a relaxed and accepting manner to food, the body, themselves as individuals, and their social environment. Some perceived recovery as coping with emotions, while others experienced themselves as healthier than people in general regarding food and weight. Different aspects were emphasized as important for recovery. As long as patients perceive themselves as recovered, it is not necessary that they fulfill all conceivable criteria for recovery.

Eating disorders are the third most common mental disorder among young women. These long-lasting disorders with disturbed eating or weight-controlling behavior seriously affect both physical health and psychosocial functioning (Fairburn, 2002; Lamoureux & Bottorff, 2005). In the literature, authors give an ambiguous picture of the long-term prognosis for eating disorders. In a review addressing short- and long-term course and outcome of anorexia nervosa (AN; the follow-up period ranging from less than 1 year to 29 years), researchers found that the recovery rate ranged from 0 to 92%. A higher recovery rate was seen with increased follow-up time.

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The same authors reported a mean of 20% chronicity and 5% mortality (Steinhausen, 2002). Even though the mortality is lower in bulimia nervosa (BN) than in AN, the chronicity shown in outcome reviews of BN is high as well. Approximately 25% of patients were still suffering from BN at a 10-year follow-up (Quadflieg & Fichter, 2003). There are also reports of spontaneous recovery where no treatment was involved (Woods, 2004). This warrants a critical examination of the long-term prognosis for eating disorders. Despite the considerable number of outcome studies, an established definition of recovery is lacking. Consequently, rates of recovery vary immensely depending on how improvement and recovery is measured (Jarman & Walsh, 1999).

When diagnostic criteria were used to define recovery, approximately 50% of patients with AN, 75% of patients with BN, and a majority of patients diagnosed as having a binge eating disorder (BED) had recovered by the time of the 5-year follow-up (Ben-Tovim et al., 2001). In previous follow-up studies regarding AN, researchers used resumption of menses and maintaining an acceptable weight as physical criteria of recovery (Pike, 1998). With regard to BN, the usual measure of recovery has been the absence of binge eating and purging, but the utility and sufficiency of physical and behavioral aspects of recovery has been questioned (Jarman & Walsh, 1999). Others suggest the inclusion of measures of psychological and cognitive aspects in a definition of recovery (Cogley & Keel, 2003; Norring & Sohlberg, 1993). Several researchers have begun by focusing on recovery from a patient perspective, to enable a deeper understanding of the process of recovery and patients' thoughts regarding the causes of eating disorders as well as factors important for recovery (Beresin, Gordon, & Herzog, 1989; C. J. Garrett, 1997; Hsu, Crisp, & Callender, 1992; Keski-Rahkonen & Tozzi, 2005; Lamoureux & Bottorff, 2005; Redenbach & Lawler, 2003; Rorty, Yager, & Rossotto, 1993; Tozzi, 2003). A majority of these authors investigated recovery from AN. Recovered patients considered, for example, overcoming self-loathing, body dissatisfaction, developmental stagnation, eating behavior problems, and detachment from other people as essential elements in the process of recovery (Garrett, 1997). This is consistent with the findings of Peters and Fallon (1994), who describe recovery as a process that involves a multidimensional change in relation to one's self, body, family, and culture. In an attempt to establish criteria of recovery from a patient perspective, some, researchers have focused on how patients perceive recovery (Noordenbos & Seubring, 2006; Pettersen & Rosenvinge, 2002). In a comparison between former patients' and therapists' opinions regarding criteria of recovery, Noordenbos and Seubring (2006) found a high degree of consensus but also divergences. Former patients accentuated self-esteem, a positive body attitude, and being able to express emotions as important criteria for recovery, while therapists accentuated physical recovery and normalized eating behavior. By using qualitative approaches researchers can

complement the concept of recovery on several dimensions that otherwise risk being lost in quantitative research (Beresin et al., 1989; Garrett, 1998; Pettersen & Rosenvinge, 2002). Therefore, our aim in this study is to describe how former patients perceive how it is to have recovered from an eating disorder.

METHOD

A qualitative phenomenographic approach was used to guide the interviews and analyses. When formulating the questions during the interviewing and when analyzing the data, the first author (TB) adopted the perspective of the participant and tried to observe the phenomena from her point of view and thereby experience the situation through her understanding (Marton & Booth, 1997). When using phenomenograpy, researchers potentially disclose similarities and differences in how people understand a specific phenomenon (Marton, 1981, 1992). By using this approach in the current study, the authors were able to identify and describe various ways in which former patients conceive of and experience recovery from eating disorders. Phenomenography can be seen as a complement to other approaches. With the focus on the description and analysis of people's experiences, the researcher deals with how a phenomenon is perceived and how it is lived as well as with individually developed ways of relating to the environment (Marton, 1981). Using phenomenography, one makes a distinction between what something *is*, the first-order perspective, and what it is *perceived to be*, the second-order perspective. In the first case, people learn about the environment and make statements about it; in the second, they orient themselves in relation to their experiences of the environment (Marton, 1981). The second-order perspective is the central focus in phenomenography (Marton & Booth, 1997). Phenomena can be perceived in a number of ways that are qualitatively different. The individual's different ways of experiencing a particular phenomenon are the central factor, but analyses generate a description on the collective level. In phenomenography, it is believed that phenomena, as an aspect of reality, are experienced in a restricted number of qualitatively different ways. The results deriving from this approach are a limited number of distinct descriptive categories that capture the variations within or between individuals (Marton, 1981). Since a researcher using a phenomenographic approach always derives the descriptive categories from a fairly small group of people, the sample has to represent a variation in the interview answers within the studied population to increase the ability to later apply the descriptive categories to other groups (Marton & Booth, 1997). The Regional Ethical Review Board in Uppsala approved the study (15 December 2004, D. no: M-433).

Participants

The setting of the study was a middle-sized Swedish town. The prevalence of eating disorders is estimated to be the same in Sweden as in other European countries (Hoek & van Hoeken, 2003; Nielsen, 2001; Rastam, Gillberg, & Garton, 1989). Usually patients with eating disorders are treated at special units run by public or private clinics. The participants were recruited from the special unit for eating disorders at the university hospital in the town. At the one-year follow-up the first author (TB) asked the patients whether they looked upon themselves as recovered. Those who felt recovered or markedly improved, had finished their treatment, and were 18 years old or older, were asked whether they were willing to take part in the study. Additionally, special attention was given to ensuring that all diagnostic groups were represented and that the participants represented a variation of illness duration and age. A letter of invitation was sent to those patients who fulfilled the inclusion criteria. The letter indicated the aim of the study, the voluntary nature of participation, and the freedom to exit the interview whenever they wanted, as well as gave an assurance that the data would be handled with secrecy. A total of 18 letters were sent. Within 10 days, the first author (TB) called them to further inform them about the study and to ask if they still wanted to participate. Two patients were inaccessible (phone numbers were not known). All but two of the contacted patients wanted to participate. Agreement was reached as to a place where the participant felt comfortable about being interviewed. Each of a total of 14 former eating disorder patients, females aged between 22 and 34 years (Md 27 years), participated in a face-to-face interview. Their duration of illness (i.e., from start of serious eating disorder problems until finishing treatment) ranged from 1.5 to 12 years (Md 5.5 years), and their earlier diagnoses according to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV;* American Psychiatric Association, 1994) were distributed as follows: four AN, four BN, and six eating disorder not otherwise specified (EDNOS). Marital status was as follows: seven were married or lived with a partner, four were on their own, and three had a boyfriend. On the occupational level, seven were working, four were studying, and three were on parental leave.

Interviews

Face-to-face interviews occurred 18 to 26 months after the end of treatment (Md 22.5 months) and were conducted in the patient's home (2), at the patient's work (1), or in an administrative center (11). The interviews were in conversational form and concerned how the patients experienced recovery from an eating disorder. A question about how they felt when they heard that someone had recovered from an eating disorder started the interview.

The ensuing questions concerned whether they perceived themselves as recovered, in what areas it was evident in their own lives, and in what way. If the participant did not spontaneously cover different dimensions of life, open-ended questions were asked about how recovery was physically, mentally, and socially evident. The interviews took 33 to 86 minutes (Md 52 min), were recorded on a mini-disc, and were transcribed verbatim.

Data Analysis

The data analysis was carried out in accordance with the phenomenographic approach (Marton, 1994). First, the text was verified by listening to the recorded interview. To obtain an overall impression of the content, the text was read several times in an open-minded manner. Thereafter, statements of essential content were identified in compliance with the author's aim in the study and coded in the data program NVivo (QSR-International, 2002). Second, conceptions were compared and grouped into preliminary nonoverlapping descriptive categories. Third, analyses of similarities and differences between the preliminary descriptive categories were performed, resulting in descriptive categories and conceptions about recovery. To assure trustworthiness of the results, the second author (GA) scrutinized the statements in relation to the conceptions and categories.

RESULTS

The participants were very willing to share their thoughts and feelings about being recovered. Most of them had a lot to tell, and a rich volume of material emerged. A few of them, though, answered more briefly. They just lived their new lives and did not devote much thought to recovery. All participants reported regular eating behavior. None reported dieting, using diuretics, or doing extreme workouts. One still reported binge eating and vomiting, but of rare occurrence (i.e., once a month) and not involving a feeling of loss of control. When the women were reminiscing, they thought about the eating disorder as a trauma they had overcome but that clearly had affected their entire existence. Even though they grieved about the loss of an important period in their lives, several women were thankful for the trauma in that it had caused a personal development that they considered would never have occurred otherwise. Regarding their present lives, the participants expressed hope, pleasure, and a sense of freedom. It was clear that they separated life in the present from life in the past. Recovery meant dealing with the eating disorder that earlier had filled their lives, rejecting disordered eating behavior, and no longer having the identity of a person with an eating disorder. They now felt they belonged to the healthy instead. Even though the participants realized that there was a risk of their relapsing, they did not

see themselves as going back to a life dominated by an eating disorder. The reason was that they now valued their new life very highly, as worth caring about.

The participants' 240 statements about recovery generated four descriptive categories containing 14 conceptions. Some of the women perceived recovery as being a question of being able to handle feelings, even if they still sometimes found themselves thinking in terms of an eating disorder. Others experienced themselves as healthier than ordinary people when it came to food and weight. They realized that they no longer thought the same way as they used to when they had an eating disorder.

Relaxed in Relation to Food

In this category the participants' new approach to eating is described, whereby the earlier irrational fear or compulsion had been replaced by a relaxed attitude. Now that the question of food was not dominant in their daily lives, they felt a sense of freedom. The category contains four conceptions: "eating everything," "having a regular eating pattern," "eating together with others," and "not relapsing into eating disorders."

Eating everything

This conception has to do with eating a variety of food in everyday life, without avoiding high-calorie ingredients. It also means being able to permit oneself to eat even unhealthy foods like candy, cookies, and rich desserts, or indeed whatever one fancies. This conception also includes eating normal-sized portions without counting calories or balancing the intake with purging or other compensational behavior:

> I feel healthy and feel I can eat anything at all and needn't be afraid to have whatever I fancy. Oh, it's lovely to just go and sit down and look at the menu and choose something without having to go and worry about how they've done it. Nowadays I can enjoy a proper meal—what a difference that makes! I believe in eating everything and in normal portions. (Amanda)

> Now I eat everything and I'm *very* interested in food—not special low-calorie but varied, with fruit and vegetables, and candy at the weekend. Not that I cut out fatty food so much—I have candy and I have a snack with my coffee and that, and I can handle it and I feel fine. (Lisa)

Having a regular eating pattern

This conception has to do with regular eating patterns, without removing any meals. It means usually eating breakfast, lunch, and dinner and additionally having something to eat between meals. A regular eating pattern also allows an opportunity for spontaneity, where the routines can be changed if necessary. If a meal is missed, it is because of practical circumstances and not a way of eating less:

> I suppose I hardly thought about anything except food and training. I was freezing cold and I was ever so hungry all the time. That's about how it was. But nowadays I think about completely different things, and food I have several times a day. It tastes really lovely—but sometimes not so lovely. I have about the same for breakfast every day, then I have lunch—and I think it's fun to cook too. (Sarah)

> I have breakfast, lunch, dinner, and two snacks in between, and it's always the food plate model. I eat very well—often *too* well, perhaps. . . . [Later in the interview:] A lot of times I feel this regular pattern of mine isn't healthy. It's not normal that it always has to be 12:00, 3:00, 6:00 or whatever—you need to be able to modify things a bit now and then, and I suppose that's what I'm working at most at the moment. When you have children, as I do, it's anyway very hard to say that at 3:00 I eat and everything else can wait, because it doesn't work like that. (Kim)

Eating Together With Others

This conception is about allowing eating to be a social function. Even if they cannot control what ingredients are included in the food when invited to friends' homes, they still can eat together with others. It also means a freedom to say no thanks, if they do not want to eat or are not hungry, because they do not have to prove that they have recovered by eating everything someone offers:

> Well, I've just had lunch with a pal of mine, and that was great. And I didn't have to pay the price by feeling bad after—I don't feel bad at all. (Alex)

> If you're offered something, it's okay to say no thanks just as much as it's okay to say yes please. You don't need to say yes please, eat up, and then leave as fast as hell. You can eat, you can enjoy eating, and you can eat a bit less, and you can see it as okay to enjoy your food. There doesn't have to be a frenzy when it comes to food, the way there used to

> be (and which was exceptionally dangerous), and there's no more need to worry a whole week if you've been invited somewhere and have no control over the food that's to be offered. (Amanda)

Not relapsing into eating disorders

By this conception former patients show a strong will to remain recovered, even if they at the same time have an insight into the risk of relapse. It also includes not having an identity as a person with an eating disorder, but as a recovered person. They now see eating disorders as a closed chapter in their lives. Some of the women were quite convinced that they were going to remain recovered: the healthy life was highly valued and they could not allow themselves to relapse. Others supposed they would remain recovered but said that crises in the future would show whether they could manage it or not:

> Once you've been in a bad state, you don't want to return to it for anything in the world. I don't want to land there again. Now it feels as if it can't happen, because it's all somehow a bit further away than it used to be. The only thing I think about when it comes to being ill again is what's going to happen when I start gaining weight. I certainly *shall*, some time, but I think somehow anyway that if I like myself—as indeed I do at the moment—I'll be able to handle it without too much trouble. (Sandra)

> No, I don't think that I'd go back to an eating disorder. I really can't be sure, but I don't *think* so, because I hope I'm clever enough, or that there are people around me that will help—at least it feels that way. It depends what happens in life. But . . . but, yes, I hope I have enough resources to see if I'm beginning to get myself in to something . . . If something really bad happens, I need people around that I can unload myself on, I need to be able to feel bad; otherwise I'd go crazy. Because I think a person can survive it without becoming self-destructive again. (Anne)

A Healthy Relationship to the Body

In this category, the participants revealed their new way to relate to their body. They have stopped criticizing or neglecting their bodies. Instead they accept their body size and take care of and enjoy their bodies and as a result experience bodily well-being. This category contains three conceptions: "accepting the body," "a relaxed relationship to weight" and "cooperating with the body".

Accepting the body

This conception concentrates on having an acceptable attitude toward the appearance of one's body, a feeling of looking good enough, without demanding any changes. It means accepting the size of one's body and buying clothes that fit. Some of the participants said that they could now accept their body, while others sometimes felt beautiful and could understand that people could be affectionate toward them:

> Yes, I've accepted my body. Not that I think I'm so fine—I wouldn't say I'm fine and pretty, but I've accepted it. My body works, and it's good enough. That's what I think. Well, I'm not a slender little person, but that's the way it is. So be it. (Lisa)

> But anyway, yes, I'm pretty satisfied with my body really, or at least I know I have a good *basis* in my body. It's my body and it's nice to me, it's adaptable again and so I think it's pretty fantastic. (Emma)

A relaxed relationship to weight

This conception has to do with no longer focusing on weight. Some women considered that weight had become less important, while others avoided weighing themselves. If they gained weight, they reacted with acceptance instead of fear and relapsing into an eating disorder. To have a relaxed relationship to weight also included a critical attitude toward the body ideal promoted by the media:

> You don't get fat just because you can't train, it's a question of your whole lifestyle. If your weight does go up, it's not the end of the world either. It's not so deadly serious. (Isabell)

> We don't have a scale at home now. It's banned anyway. But there's one at the public baths I can weigh myself on. My weight's been very steady, but now after Christmas I'd gone up more than 3 pounds, and it felt like it! But anyway I felt I was in very good health, because I don't intend to change, go on a diet—I think more, well, you eat, we're back to normal, you eat like a normal person and sooner or later it'll be as it's been before, I suppose. Let it take as long as it needs to. (Lisa)

Cooperating with the body

This conception has to do with valuing one's health and giving it priority, which is shown by listening to the signals of the body and taking care of it. The participants reported that their bodies felt strong and functioned normally, and that their weights were more stable. They had an insight into

their bodysize—knew where the body began and where it ended. They had a feeling of bodily well-being and felt that their bodies were reliable and strong enough to meet challenges. Sleeping well and having mental energy also was seen as a consequence of cooperating with the body and fulfilling the body's needs. Cooperating with the body includes allowing and enjoying intimacy:

> A very big difference is that I'm aware of my body. I hear signals. When I was ill I thought my head was completely separated from my body. I couldn't hear what it wanted—or I didn't listen. I was never aware of being tired or thirsty or hungry. There was something lacking in my basic instinct for survival. Now we're more of a piece, me and my body. We work as a team, quite simply, and I listen to how my body's feeling. (Helen)

> I can manage living with . . . having a boyfriend I love, sort of. It's as if I just enjoy being near him. It's been quite a process, learning to be like this, but I have a patient boyfriend, I really do—because I had a long way to go. I had so much self-contempt because of my body and. . . well, if I didn't feel at home in my own body, things were difficult. Nowadays I feel more at one with my body, if you can put it that way. (Anne)

Self-Esteem

In this category participants described a change in their way of relating to themselves as individuals that clearly influences their interaction with others. They now listen to their own wishes, give free play to different moods, give themselves space, and express their opinions without fear of criticism. This category contains four conceptions: "achieving self-acceptance," "thoughtful about oneself," "having self-respect" and "permitting and dealing with emotions."

Achieving self-acceptance

This conception has to do with the participants' acceptance of themselves as good enough. Some of them had come to accept their personality; others felt that they in fact liked themselves and did not want to be someone else. Accepting themselves also meant finding themselves, their personal style, and allowing themselves to be as they were. Even when they recognized their weaknesses, the participants did not blame themselves; instead, they either accepted these weaknesses or tried to change them. Accepting oneself also included asking less of oneself and accepting one's limitations. This was possible because they now felt loved and good enough as they were:

> Now I feel I'm an emotional person and it's just marvelous, really lovely. The glass is half-full now, or whatever they say. I'm aware of my shortcomings and I can handle them, and that's why I can feel esteem for who I am. I can appreciate—well, that this is the way I am. I'm intense, but I can keep it within certain limits. (Alex)

> In the past I wasn't aware of how much I disparaged myself. Nowadays I think I have more worth. I'm more satisfied with myself than I used to be. (Emma)

Thoughtful about oneself

This conception has to do with being kind-hearted and caring about oneself, with an attitude of approval toward spontaneity, pleasure, and happiness. It also has to do with permitting oneself to live here and now without stress or overactivity. It furthermore means a willingness to take responsibility for how life turns out, listening to one's own wishes and letting dreams direct choices. There is a determination to enjoy life, involving the courage to try new activities and interests:

> I have a new job now, for example, that I put a lot of energy into and that I feel very involved in and enjoy and all that. I don't think I would have had the self-confidence before. Now I know I fill a place I feel good about and . . . well, it's not just to do with this job: at home, too, I try to do things for my own sake in another way, I think. Not that I'm a superegoist and always put myself first and think I have a right to everything and so on. It's more like, say, "I don't feel like doing anything this Sunday, I'll just read a book in the bath." So that's what I do now and then, treat myself to a bit of relaxation in a way I couldn't before. (Elizabeth)

> It's a question of getting what I want, getting where I want to get in one way and another. More and more of what I want to accomplish has to do with work and a career and where I want to go with it. I want to raise new challenges, I've noticed, and want to try to meet them. I try to reach goals I've set up, try to make my dreams come true—and I work at it. When it comes to leisure, too—I try to have things the way I've wanted them on every level. (Susan)

Having self-respect

This conception involves setting boundaries. With self-respect the women can say no and do not feel forced to do what others want or need. When they have self-respect, they do no not allow people to disparage them. Instead, the self-respect gives them the courage to stand up for themselves

and express opinions and feelings. They are no longer frightened of conflicts, because they feel confidence, self-esteem, and an inner strength:

> I feel much more secure in myself. I'm not afraid to say no and I have the courage of my convictions. If I think one thing and another person thinks another thing, I just have to accept it, but I'm not afraid to stand up for my opinion. You've just got to accept that people think differently. So in this way I should think I'm tougher than I used to be. (Emilie)

> I used to find it hard to say what I thought to certain people, but I think I've become much better at it now. I do what I feel like doing a bit more, what I want to do myself. I pay a bit more attention to my own feelings. (Isabell)

Permitting and dealing with emotions

This conception has to do with handling emotions, thoughts, or problems. The participants perceived their feelings to be more noticeable and genuine. Now that they have recovered, they have the ability to recognize different kinds of emotions and can also find ways to handle unpleasant emotions without blaming themselves or starting to behave destructively, this as a result of accepting feelings and allowing them to come forth. Some of the participants considered their emotional life to be steadier. They have achieved an inner harmony and well-being. Other participants sometimes felt overwhelmed by feelings that earlier were repressed, experiencing a more rapid fluctuation of emotional level than before:

> I allow myself to be sad. I cry, and there's nothing dangerous about being sad anymore. There's that strong emotion and it's not dangerous because it doesn't have to be my fault. There doesn't have to be anything wrong with me because I feel sad. Or rather, . . . I can feel that of course it made me sad to hear him say what he did, or her say what she did, because I'd expected something different from that person. I'm allowed to feel sad—I suppose that's one of the big changes. It's lovely to see the difference—it wasn't very long ago I didn't allow myself to be sad. It's not self-destructive to be sad, it's natural—I can see that now. It's taken years of training, but I do cry, quite often. (Anne)

> It's as if your feelings go up and down, up and down all the time. I don't think it was ever really like that before, because I used to sort of turned my feelings off. So in a sense I could almost say I feel *worse* now. Maybe I feel in quite a good mood some morning, say, and then, "Bang!" I'm down in the dumps instead. So it can swing. (Linda)

Social Interaction

In this category, participants describe their new move toward social relations. Instead of withdrawing or just interacting in a superficial or tense way, they now feel natural and present and get pleasure from social relationships. This category contains three conceptions: "being active to create a social life," "attaching great importance to social relations" and "listening to others."

Being active to create a social life

This conception means both being open to others' suggestions and taking one's own initiatives for social interaction. It also means being active in making new friends. This implies an ability to give to and receive from others and not to let an earlier eating disorder be a hindrance to social intercourse. This conception includes a wish to have one's own family and have the courage to let someone be close to one:

> I'd say I have a social life. There are a few people I sometimes go and have a cup of coffee with or have lunch with or study with or something. I'm perhaps a bit more open to suggestions. I'm perhaps more ready to say something like, "Shall we meet and have a cup of coffee?" I perhaps wasn't quite like that before. A lot more effort was required for that sort of thing in the past. (Linda)

> Yes, it's easier to get in touch with new people, of course. I'm not afraid to let people get close to me, which I was before. Now I can arrange to meet somebody so that we can do something together. Before, I sort of just used to go to work and then go home and do keep-fit. I mean, there wasn't time for anything else. But now I *find* the time, spend it with friends and all that. (Amanda)

Attaching great importance to social relations

This conception has to do with not taking social relations for granted but giving them priority and being careful about them. It means feeling important to others and letting others be important to oneself. It also means sometimes keeping one's distance, when relationships do not fulfill one's expectations:

> Nowadays I can see that people mean an awful lot to me. I *see* them. I've come to understand, too, that I've neglected them—not in such a way that I have a bad conscience about it, but I do understand now that, God, they mean a lot to me. I hadn't seen it before, or anyway hadn't properly realized it. I hadn't realized how important it was, which I do now. (Helen)

> I value being important to people and having people I can let be important to me. It has to do with daring to believe in yourself. . . . I've never found it difficult to have close friends, it's just all that about not being afraid they're going to disappear. It's about being ready to take life as it comes, knowing you can cherish relationships but they can change. I mean, it's not something you can *own*, it's something it's a privilege to have. (Sandra)

Listening to others

This conception is about being able to join in a conversation, focusing on and being receptive to somebody's ideas or thoughts and evaluating what somebody is saying, instead of dismissing it. It also means feeling comfortable and relaxed when relating to others, because there is no feeling of inferiority in the social interaction. This conception also concerns acquiring an opportunity to adopt a wait-and-see attitude and just listen, without feeling any demand to entertain and make others happy:

> I reflect on what people say in another way. It sort of goes in now. There can be a dialogue. I feel a direct response arising in me, in contrast with how it used to be—it's got to do with my having the energy to take in the world around. I *see* the world around. I've got more focus, more concentration. I can take part in a conversation, I'm affected by what's said. (Anne)

> I used to be very much the stereotype of the anorexic girl, very clever and very cheerful. I used to joke and I was sort of always in top form. I saw it as my role, entertaining everybody around me and all that. Nowadays I leave it to others—they can get on with the talking for a bit now. I perhaps don't care as much what they think of me. I don't need to be amusing all the time. I don't have to have intelligent things to say; sometimes I just sit and listen. (Helen)

DISCUSSION

In the study we describe how former patients perceived recovery from eating disorders. Our results showed differences between the participants' conceptions of recovery, but several similarities as well. Statements with reference to recovery constituted four descriptive categories, which reflected how the former patients now related to food, to the body, to themselves as individuals, and to the social environment, in a relaxed and accepting manner. We verify, in our results, a number of aspects of recovery previously described in the literature. Factors found both in the present study and in earlier research—for instance having self-acceptance, accepting one's body,

having a relaxed attitude to food, having a functioning social life, and being in contact with and having the courage to express emotions—are all believed by former patients to be important manifestations of recovery (Lamoureux & Bottorff, 2005; Noordenbos & Seubring, 2006; Pettersen & Rosenvinge, 2002). Of particular interest, not generally reported in recovery studies, was a new thoughtful caring for themselves. They acquired greater well-being through kindness toward themselves and through allowing themselves to experience pleasure. As recovered persons, they wanted to make sure they were listening to the needs of the body as well as their innermost wishes or dreams. Participants described how a positive emotional relationship to themselves diminished the stress of trying to please others as well as achievement anxiety. It can perhaps be assumed that their recently acquired self-esteem had an influence on their entire life situation and that self-esteem offered a firm foundation for them to assume responsibility for their well-being and the shape of their lives.

Our results are in line with those of other researchers (Lamoureux & Bottorff, 2005) who have pointed out the unique characteristics of recovery from eating disorders, quite different from those of recovery from other mental disorders. To regard themselves as recovered, the former patients no longer acknowledged eating disorders as a part of their identity, while the opposite was true concerning recovery from other mental illnesses. An interestingly comparable pattern, however, has been reported in studies of chronically ill women with cancer or heart disease (Kearney, 1999). Even though these women remained ill, their way of coping with their trauma was very much like that which the recovered women in our study had used. It was a question of finding ways to accept and value themselves, by rediscovering their individuality on the basis of their persisting qualities. When the chronically ill women came to a point where they accepted the body as an essential part of themselves, they also became respectful of the demands of their bodies in a new way. Thus there are close points of similarity between how women seek to overcome eating disorders and how chronically ill women deal with their illness. It is therefore imaginable that part of the recovery from eating disorders implies an ability to cope with the previously experienced trauma of being seriously weakened in the body by these disorders.

One strength of our study is that all eating disorder diagnoses were represented, which resulted in a broadening of the previous picture of the patient's perspective on recovery. Our results corresponded to those of earlier studies on recovery from AN (Lamoureux & Bottorff, 2005), from BN (Rorty et al., 1993), and from either (Pettersen & Rosenvinge, 2002). This suggests that variations in patients' conceptions of recovery are not dependent on earlier diagnoses but on individual variations in how patients perceive recovery. A further strength of the study is the choice of a phenomenographic approach, where we gave an opportunity for the

participants to freely express themselves, not limited by questions formulated in advance. In a recently published study where participants were requested to fill in a preformulated criteria list for recovery, patients pointed out that some important criteria were lacking (Noordenbos & Seubring, 2006). The procedure used in our study admitted a certain guidance of the interview, but only if the participant did not spontaneously cover different dimensions. In our judgment this did not involve any influencing of the answers, but in some cases it helped the persons being interviewed to remember experiences of change since recovery. With a phenomenographic approach, the researchers have an opportunity to use different procedures and different ways of analyzing the material. It is the norm that the aim in a study and the content of the material determine how researchers organize the results. Some researchers focus on finding variation, others on finding the logical hierarchy of categories and conceptions (Fridlund & Hildingh, 2000). In accordance with our aim in this study, we chose to describe the variation in how former patients perceive recovery from an eating disorder. An additional strength of our study is that the interviews were carried out when roughly 2 years had passed since patients finished their treatment. Authors have shown in a previous study that significant improvement occurred up to 2 years after treatment and that some criteria for recovery (i.e., psychosocial functioning) took longer to evaluate in former patients with AN (Noordenbos & Seubring, 2006). There are limitations to our study as well. The recovery status was established only on the basis of what the participants themselves experienced, without objective measurement. At least the participants had verified improvement on the basis of the Eating Disorder Inventory scale (Garner, 1991) at their 1-year follow-up, and it may be assumed that the achieved progress was maintained up to the time of the study.

Some researchers have questioned whether former eating-disordered patients are able to fully recover (Noordenbos & Seubring, 2006) and if their extremely controlled cognitive patterns ever change (Redenbach & Lawler, 2003) or whether it is perhaps time for clinicians and researchers to modify their expectations of full recovery (Windauer, Lennerts, Talbot, Touyz, & Beumont, 1993). In contrast, other researchers claim that it is incorrect to say that patients never recover (Palmer, 2000), or that the variation of weight and food concerns seen in people in general must be accepted in recovered eating-disordered patients as well (Pettersen & Rosenvinge, 2002). It is indefensible to expect former eating-disordered patients to be less concerned about food and weight than people in general.

CONCLUSION

In the present study we suggest that it is possible to achieve recovery that includes changes in both behavioral and cognitive patterns. Nevertheless, as

the participants also described, an individual variation in the concern about food or weight should be admitted when assessing recovery, as long as patients see themselves as recovered in such a way that they can handle thoughts and feelings without resorting to eating-disordered behavior. One also can discuss whether the participants who perceived recovery as an ability to handle emotions even though they still had thoughts in line with an eating disorder, had reached the same level of recovery as those with no such thoughts. It is possible that these women still will progress in recovery. Certain researchers doing long-term studies indicate that recovered patients still report this kind of variation 20 years after onset (Hsu et al., 1992), while others indicate that patients' conceptions of recovery changed with their illness status (Keski-Rahkonen & Tozzi, 2005). Further qualitative research on the long-term recovered is necessary to gain a greater understanding of this issue and elucidate whether the pattern seems to remain in the case of the fully long-term recovered or if it is to be interpreted as a sign of an ongoing recovery process.

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