THE CELL KEYS ARE TURNING: SPIRITUAL INTEGRATION IN THE TREATMENT OF CHRISTIAN WOMEN WITH ANOREXIA NERVOSA

by

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Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

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A Dissertation Proposal

Submitted to the
Faculty of Liberty University
in partial fulfillment of
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ABSTRACT

This case study explored Christian spirituality, counseling practice, and recovery from anorexia nervosa. A spiritual integration model based on a comprehensive review of the literature was proposed. This model reflects a step care treatment approach, including the current standard of practice, spiritual integration, and Christian spiritual integration.

Next, a phenomenological analysis of document, interview, and observation data revealed several themes pertinent to counseling practice with Christian women suffering with anoexia nervosa. These themes were classified as (a) prior to treatment: spiritual disconnection, including suffering and brokenness, taking control of brokenness through anorexia nervosa, and her broken faith; (b) during treatment: reconnecting to the spiritual, including the person of the therapist, the mending of her faith, and the spiritual integration tools; and (c) after treatment: sustaining spiritual connection, including the battle continues and lessons from the suffering.

Implications of the findings for counseling practice with this population include the need for counselors to (a) understand the function of anorexia; (b) include a spiritual assessment in the comprehensive diagnostic evaluation; (c) utilize empirically based treatment strategies that recognize the biological, psychological, social, *and* spiritual needs of the Christian patient; and (d) include the ethical integration of empirically supported spiritual interventions as indicated, with special attention to the therapeutic relationship, Christian Cognitive Behavioral Therapy (CCBT) and the Christian perspective of "fighting the good fight." Suggestions for further research and closing comments from the researcher are provided.

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PREFACE

When I was first introduced to qualitative measurement over twenty years ago, I fell in love. Everything about it suited me perfectly. Although scientific and systematic, qualitative inquiries are also creative, personal, exploratory, interpersonal, unique, rich, narrative, and detailed. At that time I had the privilege of studying under a foremost authority on qualitative methods and my experience was deeply satisfying, both personally and professionally. So, when I had the opportunity to conduct research once again, I was thrilled to be encouraged to pursue my area of interest via qualitative methods. While pondering together with my advisor as to how best explore Christian spirituality, counseling practice, and recovery from anorexia nervosa, in light of the dearth of research in this area, he suggested considering a case study. After exploring the method in detail, it became apparent that it was the ideal approach.

Why the subject of Christian spirituality, counseling practice, and recovery from anorexia nervosa? Simply put, Christian spirituality is my life, clinical counseling is my calling, and anorexia nervosa comes to my office in a myriad of faces and symptoms every week. I have worn a similar mask and have been deeply touched by grace in my recovery. Now it is time to understand more.

CHAPTER ONE: INTRODUCTION

Overview

One assumption I bring to this research is the need to uphold the ethical mandate to "recognize spirituality as one type of diversity that mental health professionals are obligated to respect" (Richards & Bergin, 2000, p. 4). As such, there exists, at least for me and many others in the field, the commitment to explore the overlapping concerns of counseling and spirituality (Beck, 2003; Butman, 1997; Grams, Carlson, & McGeorge, 2007; Helmeke, 2007; Jones, 2001; Jones, 1994; McMinn, 1996; McMinn & Phillips, 2001; Worthington, Kurusu, McCullough, & Sanders, 1996) and to acknowledge that many people in treatment are presently searching for spiritually sensitive therapeutic models and paradigms (Miller & Thoresen, 1999; Richards & Bergin, 1997, 2000; Sperry, 2001).

Recent research and clinical experience suggest that clients are increasingly expecting that counseling will include the incorporation of spirituality (Sperry, 2003) and significant empirical evidence reveals that spiritual practices, when integrated with customary psychological and medical interventions, advance emotional and physical healing (Richards, Hardman, Frost, Berrett, Clark-Sly, et al., 1997). Because current research elaborates on the positive impact of religion and spirituality on mental health (Benson, 1996, Kelly, 1995; McCullough, 1995; Miller & Thoresen, 1999; Scafrankske, 1996; Smith, Richards, Fischer, & Hardman, 2003; Worthington et al., 1996) and scientific evaluation of diverse forms of spirituality in the treatment of eating disorders

has been encouraged (Richards, Hardman, & Berrett, 2007), I have chosen to focus this study on Christian spiritual integration in the treatment of anorexia nervosa. It is my hope that this work will add to the empirical literature on the impact of spirituality in recovery from anorexia nervosa and support colleagues laboring to help free individuals taken captive by this dangerous and destructive mental illness.

The need for increased understanding of spirituality in counseling individuals with eating disorders has recently been emphasized (Richards et al., 2007; Richards, Berrett, Hardman, & Eggett, 2006) and, in the case of anorexia nervosa, there is presently an urgent need for an improved understanding of the factors that facilitate recovery (Fairburn, 2005; Garret, 1997; Hsu, Crisp, & Callender, 1992; Le Grange & Lock, 2005; Jacobsen 2001; Jarman & Walsh, 1999; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003; Wilson & Fairburn, 2002; Woodside, 2005; Young & Ensing, 1999). Examining the statistics on anorexia nervosa and recovery from it demonstrates the need for empirical attention. Currently (a) anorexia nervosa has the highest mortality rate of any psychiatric disorder (Birmingham, Laird, Hlynsky, Goldner, & Gao 2005; Crisp, 2006; Sullivan, 1995); (b) it is the third most common psychiatric condition in adolescents (Hoel & Van Hoeken, 2003; Jarman et al., 1999); (c) there is an absence of empirically based treatment and recovery literature pertaining to it (Fairburn, 2005; Le Grange et al., 2005; Wilson et al., 2002; Woodside, 2005), and (d) the process of recovery from it remains poorly understood (Stern, 2006; Wilson, Grilo, & Vitousek, 2007; Yager, Devlin, Halmi, Herzog, Mitchell, et al. 2006).

In response to this crisis there has been encouragement for research attention to both spiritual integration and patients' perspectives via qualitative inquiry, the former due to preliminary evidence pointing to a relationship between spiritual issues and etiology, maintenance, and recovery from anorexia nervosa (Hardman, Berrett, & Richards, 2003; 2004; Richards, et al., 2007; Joughin, Crisp, Halek, & Humphrey, 1992; Richards et al., 2006; Richards, Hardman, & Berrett, 2001; Richards, et al., 1997; Smith, Richards, & Maglio, 2004; Smith et al., 2003) and the latter due to insights which have been forthcoming as a result of paying attention to patients' views of the factors influencing their recovery (Beresin, Gordon, & Herzog, 1989; D'Abundo & Chally, 2004; Hsu et al., 1992; Keski-Rahkonen & Tozzi, 2005; Lamoureux & Bottorff, 2005; Nilsson & Hagglof, 2006; Tozzi, et al., 2003; Weaver, Wuest, & Ciliska, 2005).

Purpose of the Study

The purpose of this study was to add to the empirical literature on spirituality in counseling practice by examining the role of Christian spirituality in the treatment of anorexia nervosa. Given that qualitative research methods are utilized to study human behavior in detail, are grounded in human experience, are apropos for exploratory inquiries (Creswell, 2003; Kazdin, 2003; Yin, 2003) and have been encouraged for the empirical exploration of recovery factors in anorexia nervosa, as noted above, a qualitative design was chosen for this investigation. The shortage of known information on this subject, one related study (Abel, 2005) and anecdotal evidence suggesting that there is a role for Christian spirituality in recovery, speaks to the need for a design choice

that involves the exploration of diverse forms of data. The case study method allows for such diversity.

Case study research is apt for discovery oriented, exploratory inquests (Hancock & Algozzine, 2006; Stake, 1995; Travers, 2001; Yin, 2003). Like other forms of qualitative research, the case study method has been encouraged as a means of delineating unexplored issues and processes which are multifaceted, challenging to measure, and most fruitfully depicted by focusing on patient outlooks (Mariano, 2001; Soy, 1997). The case study method, therefore, is the design I have chosen to explore the role of Christian spirituality in recovery from anorexia nervosa.

Research Questions

Given that the purpose of this study is to examine the role Christian spirituality may have in treatment and recovery from anorexia nervosa, the principal research questions framing this study are:

1. What role, if any, does Christian spirituality play in recovery from anorexia nervosa?
2. What specific Christian spiritual interventions, if any, support recovery from anorexia nervosa?

Definitions

In order to provide clarity regarding what is being explored in this study, the primary terms utilized in this research will now be operationally defined. These terms include anorexia nervosa, Christian spirituality, counseling practice, and recovery.

Anorexia Nervosa

In this study anorexia nervosa is operationally defined according to DSM-IV (APA, 2001) criteria. As such it entails

> (a) Refusal to maintain body weight at or above a minimally normal weight for age and height; (b) intense fear of gaining weight or becoming fat, even though underweight; (c) disturbance in the way in which one's body weight or shape is experienced, including undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight; (d) the absence of at least three consecutive menstrual cycles. (p. 251)

Additionally, although gender sensitivity is pertinent to all research, because more than 90% of the individuals suffering with anorexia nervosa are female (DMH, 2006), the use of the term and the recovered research sample in this study are limited to women. Individuals participating in this study consider themselves to be recovered from anorexia nervosa, as defined here, or as specializing in the treatment of anorexia nervosa as determined by credentials, interview and self report.

Christian Spirituality

Spirituality refers to the quality of being spiritual and is defined as "relating to, consisting of, or affecting the spirit; relating to sacred matters; concerning religious

values; and relating to supernatural beings or phenomena" (Merriam-Webster, 2006, on-line). The use of spirituality in this study refers to the aspect of persons that is transcendent, metaphysical and has the capacity to be "in the state of deep relationship to God "(Houston, 2001, p. 1138). The particular form of spirituality this research focuses on is Evangelical, Christian spirituality.

According to Milacci (2003) Evangelical Christianity "pertains to those Protestant groups or individuals that recognize revelation, the Bible, as the primary standard of faith and practice and that have maintained a loyalty to traditional, conservative theology" (p. 4). For the purposes of this study, Christian spirituality is operationally defined as spirituality that is (a) grounded in the evangelical, protestant religious tradition; (b) revealed in the Bible; and (c) deepened through the practice of the Christian disciplines explicated in the Bible (Anderson, 1979; 1997; Elmer & Lawrence, 2005; Elwell, 2001; Erickson, 1998, Hoekema, 1986; Packer, 1958; 1973; 2001, Rayburn, 2001). Individuals participating in this study consider themselves of the Christian faith, as defined in this broadly evangelical, protestant manner and as determined by interview and self report.

Additionally, consistent with the Christian faith, in this document God is referred to as "He." For further explication on Evangelical Christianity and its relation to counseling practice see Dougherty & Worthington (1983) and Thurston (2000).

Although Christian spirituality is just one of the many diverse and varied forms of spirituality worthy of exploring, the focus of this research is limited to Christian spirituality because (a) Richards et al. (2007) propose a research agenda for spiritual integration in the treatment of eating disorders that includes the exploration of specific

religious/spiritual orientations; (b) my own Christian faith and that of many of my clients; and (c) my desire to respond to the urging for further research-based integrative efforts from the Christian point of view (McMinn et al., 2001). Additionally, Thurston (2000) points out that evangelical Christian denominations consist of 77 million members in the United States, and therefore a "substantial market for psychologists, but one that they have traditionally been under-trained to serve" (p. 131). One objective of this study, therefore, is to support colleagues in providing ethically sensitive and empirically based, spiritually integrated counseling services to individuals from this population who suffer with anorexia nervosa.

Counseling Practice

The term counseling practice is operationalized as (a) mental health or psychological counseling that is (b) provided by trained and licensed professionals who (c) follow customary and ethical guidelines in their service as counseling practioners (ACA, 2005; Collins, 1991).

Recovery

The expression recovery refers to a "getting back, regaining, or reclaiming; a getting well again, coming or bringing back to consciousness, a revival of a person from weakness; a regaining of balance; a return to soundness" (Guralnik & Friend, 1968; p. 1216). For this research effort, recovery is defined operationally as (a) no longer meeting

the diagnostic criteria for anorexia nervosa and (b) personally considering oneself recovered from the disease.

Garrett (1996) emphasizes that recovery from anorexia nervosa is much more than a return to normal weight and menses. Restoration is demarcated by the features which the recovered themselves believe must be overcome, including "self-loathing and dissatisfaction with their bodies, developmental stagnation, ongoing difficulties with eating, detachment from other people, and unresolved questions about death" (p. 1490). In this study full recovery from anorexia nervosa relates to recovering from (a) the extreme need to control eating in order to organize one's internal world; (b) the tendency to judge one's self worth in terms of shape and weight; and (c) the pervasive sense of ineffectiveness, low self-esteem, and perfectionism that typify the disorder (Fairburn, Shafran, & Cooper, 1999). Recovery is characterized by the development of "healthy dependence and attachment and the replacement of inward-turning attempts at safety with interpersonal safety, which allows one to relinquish their anorexia nervosa without replacing it with other obsessional targets created to regulate anxiety" (Levenkron, 2000, p. 98).

Locating Myself as a Researcher

What is so exciting to me about qualitative research is that the researcher's empirical journey is often fueled by the very thing which impassions him or her (Moustakas, 1994). Personally, my heart is set aflame by the spiritual, and that fire finds its source in Jesus Christ. My vocation as a psychologist is one of the primary

expressions of my spirituality. It is there that I have the privilege of walking along side wounded individuals in treatment and the honor of ministering grace (in multifarious and diverse forms including empirically validated treatments and research supported spiritual interventions).

Like the individuals I counsel, I too am wounded. My wound is one of the gifts that enable me to understand some of the deepest pain lying just under the symptoms that bring folks to my office. And, like Nouwen (1979), I too am a wounded healer whose suffering is the aperture from which I humbly can enter with grace. My personal wound was predominantly born out of the death of my brother Stephen and the subsequent havoc that loss played on my family and attachment system. The protective shackles that grew around that emotional lesion resonate with the matrix of anorexia nervosa and found ultimate release within the context of my spirituality. Let me give you some personal history to place in the backdrop of this inquiry.

I have no memories of family connection, of secure and loving attachment in my childhood or adolescence. I do remember certain moments though. I see myself on my father's shoulders, walking to my bedroom singing. I remember thanksgiving at Aunt Rosie's house, again, singing. And there is a memory of walking up a wooded hill with my father, we were looking for salamanders. I can "see" other flashes of memory too. So, it wasn't that we didn't do much together as a family, because we did. It isn't that I don't have any happy memories, because I do. What it is though, is that there wasn't any sense of emotional connection between me and my other family members. In other

words, when I review the stores of my childhood family memories, I can find no sense of connectedness to a loving other; no awareness of protective security and belonging.

I have heard it said that infants developing in the womb and born into the death of a sibling generally do not bond with their families and never find an emotional home there (Clark, 1995). Additionally, it is common for these children to feel a deep sense of guilt, shame, and terror (Rowe, 2007), perhaps as a result of the normal egocentricity of infancy and childhood (Miller, 2002), and the internalization and personalization of an empty interpersonal milieu.

It certainly wasn't that my family lacked love, in fact, just the opposite. These were extraordinary, kind, loving and wise people; sensitive, creative, musical, educated, passionate people! My family was my kind of people. So why did I experience us as a group of disconnected aliens (Parrot, 1996)? Why? I can't say for sure, but I think that my internal world, as is common for the attachment deprived, was replete with the experience of inherent badness, ugliness, and aloneness (Ainsworth, 1989; Bowlby, 1988; Clinton & Sibcy, 2002); and, perhaps, even guilt over the death of my brother Stephen. Actually, though, it was the weight of their losses that separated my family from me.

A year before my six year old brother Stephen was diagnosed with leukemia my mom's dad, whom she loved dearly, also died of leukemia. Soon after that, their beloved Davey, my dad's closest brother, their confidante, and steadfast buddy of Stephen, also died. These monumental losses occurred in the wake of the Holocaust, just twenty years prior, when the massacre of all the family members on my father's side who were still in

the homeland, along with all they knew and loved, took place. However, I think it was Stephen's death that took them over the edge, psychologically speaking.

Six months into the torment of Stephen's cancer treatment, including hospital separations, chemotherapy-related hair loss, physical pain, and the knowledge of impending death, my mom awoke in the night to tell my father that they were supposed to have a little girl. Dad was shocked and said, "Why are you courting more trouble Nita?" But it was settled when she told him she "just knew."

My parents, both born to traditional, orthodox Jewish families who kept kosher homes, were not religious people. The losses completely changed their spiritual epistemology, with my dad migrating to the world of nature for meaning and my mom departing to the East. I can remember my mother telling me that her true spirituality was born on June 10. 1963.

In my mind's eye, I can see her sitting in Stephen's hospital room that night, eight months pregnant, with an anguish no mother should ever have to know. She had made it clear to the hospital staff that she wasn't leaving and although allowing parents to stay was not yet the practice in the early sixties, likely they did not have the heart to ask this grief-struck, tired, terrified and pregnant mother to leave. As she sat beside his bed Stephen roused for a moment, suddenly jovial and obviously excited. He looked into my mother's eyes with an eagerness she hadn't seen in many months and exclaimed, "Can I go mom? Can I go out with them and play?" (As a mother of sons my heart wrenches even as I write this down. What if it were I who had to travail such an agonizing journey

with my Tim, or Josh, or precious husband David? I think it would kill me. It did them, at least for many, many years to come).

"Yeah, Stephen, go out and play," she whispered. And out went my big brother into eternity. Four weeks later I was born to a shell-shocked, traumatized, and intensely sorrow-filled family. "Knock, knock, hello everybody, I'm here! Nope, no one is home…"

Soon after my son Tim was born, fifteen years ago, I found a Christian therapist who specialized in eating disorders. (It would take many, many pages for me to share how this little Jewish girl from New York came to believe in Jesus Christ. Although a beautiful story, it will need to await another dissertation). In counseling I learned that my symptoms (including emotional inhibition, control, perfectionism, isolation, external locus of orientation, and a strict dietary and exercise regimen) functioned to protect me from a scaffold-less interior and terrifying fear, shame, and emptiness. I had no sense of trust. She diagnosed me with obsessive-compulsive disorder (OCD). Two and a half years later I emerged with the ability to deeply connect with others, live more authentically and congruently, trust God, myself and others significantly more, eat normally and manage shame and fear with new skills and power. I was free.

About a year ago three events converged that triggered a relapse. Looking back now, I consider it grace; there was more work to do, including this research. First, my son Tim was to start high school the following fall and my husband David and I decided to fast and pray in order to gain clarity as to where to send him to school. Dave abstained from coffee and I, junk food. Second, I read a book that encouraged followers of Christ

to use food for fuel and to turn to God for emotional needs. I decided to abstain from eating beyond three meals a day. Third, a patient of mine with anorexia nervosa was unable, for financial reasons, to continue to see the nutritionist member of my eating disorder team. I decided to look around to see if I could find free options for nutrition tracking which could be used along with the eating plan that was already set up for this woman. I discovered mypyramid.gov (on-line), an obsessive compulsive's dream (and nightmare). In order to understand the computer program, I started using it. As a result of these dietary changes, weight began to shed. Over a period of several months I lost twenty pounds, bringing me ten pounds below the lowest suggested weight for someone my age and height (Tribole & Resch, 1995). Oh the tenacity of OCD!

It was also around this time that I needed to solidify my choice of research topic. Clarity came to me in the form of a reverie one evening while I was journaling:

I was standing alone as the light began to recede all around me and fear settled in like an ill-omened darkness. Soon it was painfully black, though after a time I was able to make out the outline of an odious structure before me. A thick haze surrounded the building and I felt as though an ominous presence was in the midst of it. "Not safe! NOT SAFE!" cried out from within me and a gripping fear ascended. My heart began to pound wildly and terror surged throughout my body. Oh to bolt away; yet I was frozen, a petrified, immobilized shape in the shadows.

Some moments later, the darkness began to wane and I saw a form materialize at the entrance of the medieval looking bastion before me. Concurrently, I heard the first moan. It was a deep and mournful groaning from some distance and it utterly wrenched

me. Even still, the presence of The Figure brought a surprising peace and softness to my body and being. An unearthly radiance framed the approaching apparition, the darkness repelling around Him as He drew closer and closer to me. When He finally arrived I collapsed into His arms and wept profoundly.

"What is this darkness and groaning?" I cried. "It is crushingly frightening and sorrowful."

"Yes," He said with longing. "It is this trepidation they experience so overwhelmingly, as if nothing undergirds them; no safety, no love, no grace or truth to scaffold them; no one driving the car of their lives. No trust in Me, in themselves, or in others. It makes them vulnerable to the illness which enters like a shepherd granting control, immunity, and exemption from the ravages of the world. Anorexia nervosa: the furtive friend, the cunning guest, promising sanctuary, protection and peace, even as it weaves a contemptible procession of defensive shackles and chains. Oh, but its promises are compelling in light of the devastating terror she experiences in the world. Faith in the shackles enlarges as any semblance of true security recedes; finally the guest is so wed to its host that there is no differentiation. Where is Lydia or Charlotte or Hannah? Safely hidden in the folds of anorexia nervosa where control and invulnerability abound and awareness of the choking manacles and impending death are suppressed. The deep and complex fear that is this darkness holds them captive."

"I can see why," I replied.

"Yes, but here I am; the True Shepherd, and they don't see or know me. Not even those who think they do." The haunting cry rang out again and I shuddered.

"What is that sound?" I cried.

"Come and I will show you."

He took my hand and led me through the entrance of the fearsome fortress and down a multitude of descending stairs; so many stairs and locked gates. It was that darkness again but infinitely tempered by His Hand in mine; and it was cold. We came to a gloomy, dank room and I lost my breath at the sight before me. The emaciated form of a child (she was actually 25 years old) chained and shackled to the dungeon wall filled me with horror. She could not see us.

"Notice how the hand cuffs are unlocked and open?" He finally asked.

"Oh, yes, they are. Yes." I was startled and confused; a deep sadness settling upon my heart and being.

"Doesn't she know that she is free to go?" I gasped.

"She does, but she is too scared to move. What we see as her chains and shackles she sees as her only refuge. She has more faith in those irons than she does in her ability to manage life outside of the dungeon."

"But why Lord, why?"

"Many reasons my beloved, many"

"But hasn't science revealed how to get her out?"

"There is a great need for research that delineates effective treatment components and few have explored the role of spirituality in recovery from anorexia."

"What can we do? We've got to do something!" I cried. I yearned to loose the woman and impart upon her a measure of His grace and truth.

"Yes, I have something I want you to do. Although science has made some strides, spirituality needs to be further explored as a resource in recovery…"

I awoke clearly knowing the focus and purpose of my dissertation research. The disturbing thing I discovered after recovering from my relapse was that, at least in a psychological sense, that chained up woman was me.

When it became apparent that I had relapsed, I went back to my Christian counselor. I sought out my spiritual mentor. I met with my pastor for theophostic counseling (Smith, 1999). I asked dear friends to pray for and with me. I rallied the support of my mother and brother, sharing with them the truth of my lifelong struggle with OCD for the first time. I began weekly meetings with an accountability partner with whom I shared my true feelings and thoughts in addition to the details of my daily food intake and exercise. As usual, my husband David displayed his love and devotion to me by "picking up his sword" and fighting alongside me. I have emerged out of this darkness with a deep sense of gratefulness and humility and can honestly say that the most significant moments of my recent recovery have related to my Christian faith.

With my counselor I discovered the reality that, among other things, this illness is a spiritual battle and I need to differentiate the truth from the cruel "voice" of anorexia (Claude-Pierre, 1997). I liken the arduousness of this undertaking to Frodo's journey in *Lord of the Rings* (Tolkein, 1954). Do I listen to the voice of fear and shame or do I listen closely to and believe the "Voice" of truth? My counselor's promise of being there to fight with me if and when I needed her gave me great courage and strength. She also

made herself available to me for supervision should my work with eating disorder patients suffer or cause me to stumble.

During one theophostic counseling session with my pastor, I experienced my shame as a black placenta that I had identified with. I believe that placenta represented the death of Stephen that I had fed off of, developed in, and was born into. I also saw an image of Jesus driving the car of my life, a car whose steering wheel I controlled so tightly, throwing that placenta out the window, running it over, and smiling at me saying, "Oh, that old thing? That was never you!"

With the support of my spiritual mentor, often in the role of counselor to me, I received a constant flow of nurturance and support whenever I was too weak to fight the "voice of anorexia" or felt myself drowning in a sea of fear, guilt or shame.

With my accountability partner at my side, functioning as counselor, sister, and friend, I received sharpening, challenge, truth, acceptance, love and consistency that continue to build a foundation of internal scaffolding that never grew in the famine of attachment available in my childhood home.

From meditation and breathing deep, with a focus on Scripture and God's presence, I regained the ability to reframe my mind, worship God, instead of avoid my feelings, and remain in the present moment with a real connection to God, myself and others. My identity has re-solidified in Christ in a deeper way, and my experience and true knowledge of Him is expanding at a rapid pace. What a joyous anguish this has been!

Perhaps the greatest gift that I have been given during this reversion has been a profound appreciation for the absolute terror that lies behind the inane symptoms of anorexia nervosa and the importance of spirituality as a recovery resource for those who consider themselves spiritual. I will gratefully utilize this option whenever it is ethically appropriate in my work with others.

So this is where this researcher locates herself. What an unexpected, yet pertinent, lapse! Although I can make no claims for objectivity, I do, somehow, feel specially equipped for and called to this research endeavor. I am ready to learn what others can teach us about Christian spirituality, counseling practice, and recovery from anorexia nervosa. I enter this realm with humility and eagerness, along with a deep commitment to present the research findings with the utmost veracity and trustworthiness.

Summary

This chapter introduced the interest and relevance of examining Christian spirituality, counseling practice, and recovery from anorexia nervosa. First, an overview of spiritual integration in the treatment of anorexia nervosa was provided. Next, the purpose of this study was presented along with a brief introduction to the case study method. Finally, the researcher was portrayed in reference to this investigation. The next chapter will provide a review of the literature and a proposed model of Christian spiritual integration that will be the focus of this study.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

In this chapter a detailed narrative review of the literatures related to Christian spirituality, counseling practice, and recovery from anorexia nervosa will be presented and related to a proposed model of Christian spiritual integration. First, the three literatures related to this inquiry will be presented. Next, the proposed model of spiritual integration will be introduced and related to the literature relevant to this study. Finally, the research project will be introduced and related to both the literature and the proposed model.

This appraisal began with an analysis of the literature on Christian spirituality in counseling practice in general (e.g. Abel, 2005; Abi-Hashem, 2006; Allender, 1995; Averbeck, 2006; Beck, 2003; Beck, 2006; Benner, 2002; Brokaw & Edwards, 1994; Cashwell, Bentley, & Yarborough, 2007; Cheon & DiBlaslo, 2007; Colbert, 1999; Crawford, 2003; Cumella, 2002; Eberly, 2005; Evans, 2005; Flannelly, Weaver, Smith, & Handzo, 2003; Garzon, 2005; Gubi, 2001; Hardy, 2000; Hill & Hall, 2002; Johnson, DeVries, Ridley, Pettorini, & Peterson, 1994; Jones, 2001; Jones & Butman, 1991; Langberg, 2006; Lish, Fitzsimmons, McMinn, & Root, 2003; McMinn et al., 2001; Ohlschlager, 2004; Peucher & Edwards, 1984; Poll, 2003; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Sartor, 2003; Sheilds & Bredfeldt, 2001; Sisemore, 2003; Sisemore & Moore, 2002; Tan, 1994, 2003; Tisdale, 2003; Tisdale, Key, Edwards, Brokow, Kemperman, et al., 1997; van Deusen Hunsinger, 1995; Watson, 2000; Weld & Erikson, 2007; Yarhouse & Tan, 2005; Worthington, Hook, Ripley, & Miller, 2007).

Next, the literature on counseling practice and recovery from anorexia nervosa was examined (e.g. Abel, 2005; Anderson, 2001; Anderson, Lundgreen, Shapiro, & Paulosky, 2004; Anderson & Maloney, 2001; Attia & Schroeder, 2005; Beresin et al., 1989; Birmingham & Beumont, 2004; Blake, Tumball, & Treasure, 1997; Bloom & Zaphirophodes, 1994; Button and Warren, 2001; Clarks, 1994; Collins, 2000; Corstorphine, 2006; Costin, 2007; Crisp, 2006; Cumella, 2005; D'Abundo et al., 2004; Eberly, 2005; Eckert, Halmi, Marchi, Grove, & Cosby, 1995; Fairburn, 1997; Fairburn, 2005; Fairburn, Shafran, & Cooper, 1999; Fisher, Golden, Katzman, Kreipe, Rees, Schebendach, et al., 1995; Foreyt, Postin, Winebarger, & McGavin, 1998; Garner, Rosen, & Barry, 1998; Garner, 1997; Garrett, 1996; Geller & Srikameswaran, 2006; Gusella, Gordon, Nichols, & Bird, 2003; Halmi, 2005a, 2005b; Hardin, 2003; Herzog, Durer, Keel, Selwyn, Ekebad et al., 1999; Hinz, 2006; Hsu, Kaye, & Weltzin, 1993; Hsu, et al., 1992; Johnson, 1991; Lamoureux et al., 2005; Kelly, 2001; Le Grange et al., 2005; Leung, Waller, & Thomas, 1999; Lock, LeGrange, Agras, & Dare, 2001; Lowe, Zipfel, Bucholz, Dupont, Reas et al., 2001; Manley & Leichner, 2003; Marsden, Karagianni, & Morgan, 2007; Milos, Splinder, & Schnyder, 2004; Morgan, Marsden, & Lacey, 2000; Natenshon, 1999; Nilson et al., 2006; Petrucelli & Stuart, 2001; Pike, 2005; Pike, Loeb, & Vitousek, 1996; Richards, Baldwin, Frost, Hardman, Berrett, et al., 2000; Rushford, 2006; Selwyn, Ekeblad, Flores, Greenwood, et al., 1999; Sharpe, Ryst, Hinshaw, & Steiner, 1998; Stern, 2006; Sullivan, 1995; Touyz, Thornton, & Rieger, 2003; Tozzi et al., 2003; Vitousek, Daly, & Heiser, 1991; Vitousek & Stumpf, 2005; Waller, Cordery, Corstorphine, Hendrichsen, Lawson, et al., 2007; Waller, Kennerly, & Ohanian, 2005; Wandler, 2003; Weaver et al., 2005; Williamson, White, York-Crowe, & Stewart, 2004;

Wilson et al., 2002; Wonderlich & Mitchell, 2001; Woodside, 2005; Yager, et al., 2006; Zaider, Johnson, & Cockell, 2000; Zerbe, 1993; Zuercher & Heffern, 2003).

Subsequently the literature on spirituality, counseling practice and recovery from anorexia nervosa was evaluated (e.g. Bell, 1985; Hall & Cohn, 1992; Hardman et al., 2003; Hardman et al., 2004; Jersild, 2001; Joughin et al., 1992; Marsden et al., 2007; Mitchell, Erlander, Pyle, & Fletcher, 1990; Morgan et al., 2000; Newmark, 2001; Richards et al., 1997; Richards, et al., 2001; Richards et al., 2006; Richards et al., 2007; Rorty, Yager, & Rosotto & 1993; Ruskay-Rabinor, 1999; Smith et al., 2003; 2004).

Finally, the literature on Christian spirituality, counseling practice, and recovery from anorexia nervosa was analyzed (e.g. Abel, 2005; Adams, 2004; Braem, 2004; Cumella, 2002; Darden, 2005; Eberly & Cumella, 2003; Grenfell, 2006; Griffeth, 2004; Rogers, 2004; Wall & Eberly, 2002; Wall, 2003; Wall, Cumella, & Darden, 2003; Wall, Eberly, & Cumella, 2005).

Although the focus of each of these literatures is different, a general pattern emerged in the process of the review leading to several conclusions and the formulation of a model for Christian spiritual integration in the treatment of anorexia nervosa. These conclusions, each containing several components, fall under the following categories (a) the current standard of practice in the treatment of anorexia nervosa; (b) the current recommendations for spiritual integration in the treatment of anorexia nervosa; and (c) the current status of Christian spiritual integration in the treatment of anorexia nervosa. This model and its application to the literature, along with the literature's prevailing themes and conclusions, will now be presented (Pan, 2004).

Christian Spiritual Integration in the Treatment of Anorexia Nervosa: A Proposed Model Based on the Literature

During the review and analysis of the literature on the treatment of anorexia nervosa, an integration model involving a step care approach to spiritual integration emerged. According to this formulation, treatment for anorexia nervosa begins with a foundation of the current standard of practice for eating disorders, including eight options of treatment that represent a bio-psycho-social approach to intervention. The addition of a spiritual assessment to the current recommended practices, as suggested in the literature on spirituality in the treatment of eating disorders, adds another level of intervention options, building on the first, with seven additional treatment opportunities for the patient who desires to integrate spirituality (and consents to do so) in her treatment. Finally, where a patient is Christian and desires (and consents to) spiritual integration, a third level of intervention options opens up, built upon the first two, with five additional options to support recovery in treatment. This formulation (depicted in Figure 1) provides a foundation on which to present the prevailing conclusions from the literature.

The Current Standard of Practice for Treatment of Anorexia Nervosa

The literature reveals that anorexia nervosa is a devastating, often chronic, condition that wrecks havoc on the academic, developmental, occupational, physical, sexual, and social functioning of sufferers (Birmingham et al., 2004; Garner, 1997; Lamoureux et al., 2005; Lowe et al., 2001; Sharpe et al., 1998). Anorexia nervosa's mortality rate is approximately16-20% (Birmingham, et al., 2005; Crisp, 2006; Eckert et al., 1995; Sullivan, 1995) and it is greatly resistant to treatment (Halmi, 2005b; Rushford;

Figure 1. Spiritual integration in the treatment of Christian women with anorexia: A step care model based on the literature.

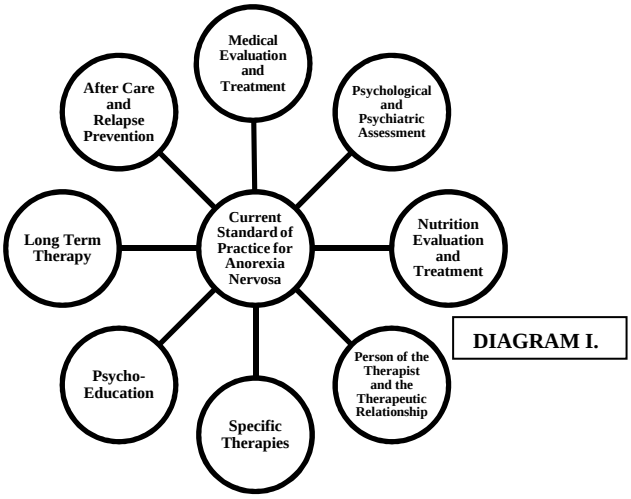


DIAGRAM I.

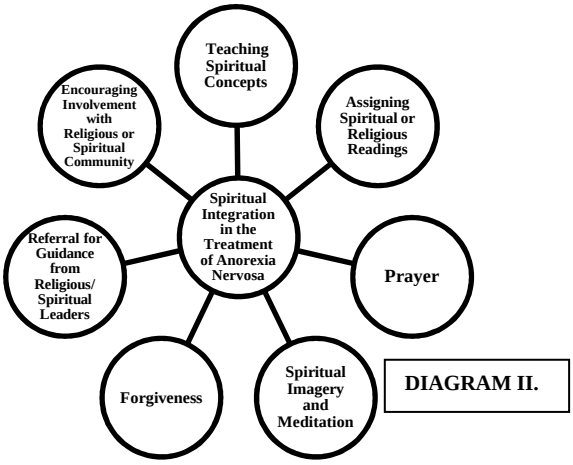


DIAGRAM II.

I. If religious/spiritual issues are not present during assessment and the patient does not want to integrate spirituality into treatment, include appropriate treatment elements from diagram I only.

II. If religious/spiritual issues are present during the assessment and the patient wants to integrate spirituality into treatment, include appropriate elements from diagrams I and II.

III. If the patient considers herself Christian, religious/spiritual issues are present during the assessment, and the patient wants to integrate Christian spirituality into treatment, include appropriate elements from diagrams I, II, and III.

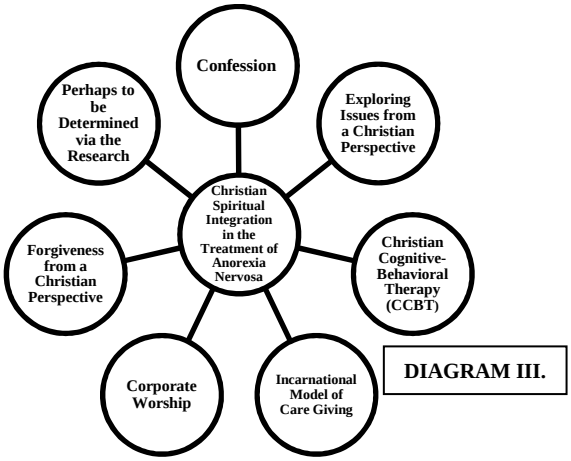


DIAGRAM III.

2006; Wilson, et al., 2002) with only 30-40% fully recovering, 20-30% improving, and the rest chronically suffering (Herzog et al., 1999; Richards et al., 2000). In terms of treatment efficacy, the literature establishes that there currently is a pressing need to explore and develop additional treatments (Fairburn, 2005; Weaver et al., 2005; Woodside, 2005; Yager et al., 2006), to determine the efficaciousness of present treatments (Halmi, 2005a; Le Grange et al., 2005; Selwyn, et al., 1999; Stern, 2006; Woodside, 2005), and to further understand the process of recovery (Hsu et al., 1992; Tozzi et al., 2003; Wilson et al., 2007).

Although controlled studies have yet to be done to evaluate effectiveness, the literature reveals clinical consensus regarding the current standard of treatment for anorexia nervosa. The major tenets of this treatment are summarized below and appear in the proposed model in Figure 1, Diagram I. They include (a) medical evaluation and treatment; (b) psychological assessment; (c) nutrition evaluation and treatment; (d) the person of the therapist and the therapeutic relationship; (e) specific therapies; (f) psycho-education; (g) long term therapy; and (h) after care and relapse prevention. These treatment constituents are the essential foundation of the proposed Christian spiritual integration model presented in this document.

Assessment

According to the literature, treatment for anorexia nervosa begins with a complete, standardized medical and psychological assessment, the foundation of the personalized treatment formulation and plan involving a team of intervening professionals (Anderson, et al., 2004; Anderson, et al., 2001; Fairburn et al., 1999; Lock,

et al., 2001; Hsu et al., 1993; Milos et al., 2004; Pike, 2005, Vitousek et al., 1991; Vitousek et al., 2005; Wonderlich et al., 2001). This team includes medical, psychiatric, psychological, nutritional, counseling, and sometimes academic specialists (Fairburn, 1997; Manley et al., 2003; Natenshon, 1999; Touyz et al., 2003; Wilson et al., 2002; Yager et al., 2006). Because of the extant medical dangers inherent in this population, counselors working with anorexic patients are ethically obliged to work on a treatment team.

Medical Evaluation and Treatment

Medical care involves a full medical evaluation, medical stabilization and emergency management, re-feeding and monitoring through the weight restoration process, treatment of medical co-morbidities, and patient education regarding medical complications of eating disorders. Throughout the course of treatment, medical status must continually be assessed and responded to (Birmingham et al., 2004; 2005; Cumella, 2005; Fisher, et al., 1995; Garner, Rosen, & Barry, 1998; Lock, et al., 2001; Mehler, 2001; Pritts & Sussman, 2003; Schulke, 2007; Wilson et al., 2007). There is consent in the literature that the effects of psycho-social treatments, including therapy, are limited until weight is within 85% of normal weight range (Yager, et al., 2006).

Psychiatric Evaluation

Psychiatric care, one aspect of the medical treatment component, includes a thorough psychiatric evaluation, assessment for substance abuse needs, assurance of psychiatric safety, and patient education regarding psychotropic medications. The

literature is clear that medications are not indicated for anorexia nervosa, but are important in the treatment of co-morbid conditions once normal weight has been stabilized. This is because, to a large extent, the obsessive-compulsive symptoms related to anorexia nervosa are the primary effects of starvation (Attia et al., 2005; Waller, et al., 2007; Wandler, 2003; Zaider et al., 2000).

Psychological Evaluation

According to the literature, reliable and valid diagnostic and outcome assessment of anorexia nervosa is imperative:

> Standardized assessments provide consistent and comprehensive diagnosis, facilitate reliable monitoring of course and outcome for an individual, provide for comparison of clinical status and severity, and are often a source of self learning for the individual. In both clinical practice and research, a comprehensive battery for anorexia nervosa should generate both the requisite information for categorical diagnosis as well as descriptive, continuous data with sufficient clinical sensitivity to capture changes that occur along the multiple dimensions that comprise anorexia nervosa (Pike, 2005, p. 21).

Effective psychological assessment involves several phases, the foundation of which is the structured, clinical interview (Anderson et al., 2004; Groth-Marnat, 2003; Milos et al., 2004; Pike, 2005; Vitousek et al., 2005; Wonderlich et al., 2001). In addition to the interview, a full battery of psychological tests is recommended in order to get a multi-axial picture of the patient's psychological functioning (Wall, 2007). When treatment commences it is important to include the appropriate management of co-morbid conditions which are usually present with the diagnosis of eating disorders (Anderson et al., 2001; Fairburn et al., 1999; Hsu et al., 1993; Milos et al., 2004; Vitousek et al., 2005; Wonderlich et al., 2001).

Clinicians exploring spiritual integration in working with this population have recommended that a spiritual assessment take place during the psychological evaluation (Darden, 2005; Griffeth & Griggs, 2001; Hardman, et al., 2004; Hartz, 2005; Richards, et al., 2000; Richards, et al., 2007; Richards & Potts, 1995; Sperry, 2001, 2003; Weld & Eriksen, 2007). The proposed model introduced in this document incorporates this practice as it gives the opportunity to determine if spiritual/religious issues are related to the maintenance of the anorexia nervosa and if spiritual integration may be an option in the treatment. Wall et al. (2003) recommends *The R SAQ*, which is available in interfaith and Christian versions. The 41 question survey assesses total spirituality, current spiritual wellness, experiences of shame and judgment and past spiritual experiences (See also Darden, 2005).

Nutrition Evaluation and Treatment

The nutrition evaluation is used to determine patients' understanding of good nutrition and its effects on health. Medical and nutritional rehabilitation during the treatment phase focuses on reestablishment of normal menstruation and weight, normal eating and exercise, and psycho-education about these issues (Cumella, 2005; Zuercher et al., 2003).

The Person of the Therapist and the Therapeutic Relationship

The literature clarifies that anorexia nervosa emerges as an alternative option, or coping mechanism, when healthy attachment and the ability to trust people has gone awry (Levenkron, 1997/2000). Because human relationship and the ability to trust is the

foundation of normal development (Ainsworth, 1989; Bowlby, 1988; Cichetti & Toth, 1995; Clinton & Sibcy, 2002; Erikson, 1950; Miller, 2002), in order for health to be restored, the ability to attach and to trust others must be developed (or re-formed). Herein lies the import of the therapeutic relationship, it is the learning environment in which attachment and trust can be nurtured and formed (Bruch, 1978; Clark, 1995; Claude-Pierre, 1992; Cooper, 2006).

In the context of a "nurturant-authoritative" relationship (Levenkron, 2000, p. 223), something which the anorexic individual may never have had or has lost during the process of development or trauma, true identity development can begin to occur. As a trusting attachment is formed between the patient and therapist, the anorexic individual begins a process of coming to understand her anorexia as a "security-controlling obsession" which can never really produce true security. Over time genuine security can develop as the therapist structures the relationship (and often the family) to address unmet developmental needs and the security operations inherent in the pseudo identity of anorexia nervosa. This occurs through the therapist providing support and coaching, very much as a healthy parent would.

In order to provide the kind of relationship necessary to facilitate hope and change for persons in treatment, the therapist must have specialized training in eating disorders, be able to tolerate the fears and frustrations associated with working with this population, provide consistent nurturance, assistance, belonging, emotional encouragement, feedback, information, and relief; and remain a firm and strong authority in terms of boundaries and patient needs (Anderson, 2001; Beresin et al., 1989; Berrett, 2003; Button, 2001; Cooper, 2006; Geller et al., 2006; Hsu, et al., 1992; Kelley, 2001;

Lamoureux, et al., 2005; Levenkron, 1997/2000; Manley et al., 2003; Santucci, 2007; Weaver et al., 2005; Wonderlich et al., 2001; Yager, et al., 2006). There is evidence in the literature that recovered individuals highlight the therapist-patient relationship and the identity development that occurs therein, as the most important factor associated with recovery (Anderson, 2001; Beresin et al., 1989; Button, 2001; Hsu et al., 1992; Kelly, 2001; LaMoureux et al., 2005; Weaver et al., 2005).

Specific Therapies

As indicated in figure I, Diagram I, several specific therapies are utilized in the treatment of anorexia nervosa. In many cases a combination of these treatments are applied according to the individual needs of each patient. Treatment settings include out-patient, partial residential, or inpatient (Fairburn, 1997; Manley et al., 2003; Richards, et al., 2007; Touyz et al., 2003; Waller, et al., 2007; Wilson et al., 2002; Yager, et al., 2006), depending on severity, and involve behavioral, cognitive and cognitive-behavioral therapies and techniques, psychodynamic and interpersonal conceptualizations and interventions, family therapy, group therapy and creative/expressive therapies. Each of these will now briefly be discussed.

Cognitive-Behavioral Therapy

Of the specific therapies utilized in treating eating disorders, cognitive-behavioral therapy has received the most research attention and positive outcomes (Anderson et al., 2001; Corstorphine, 2006; Eberly et al., 2003; Eberly, 2005; Fairburn, 2005; Foreyt, et al., 1998; Garner, 1997; Geller et al., 2006; Leung et al., 1999; Manley et al., 2003; Wall,

2003; Waller et al., 2005; Williamson et al., 2004; Wilson et al., 2007). Waller and associates (2007) provides a comprehensive and up to date treatment model that includes (a) engaging the patient, and family when appropriate, via the development of a caring and trusting relationship, (b) completion of a thorough assessment, (c) explanation of treatment and treatment parameters, (d) collaboration with the patient to create a comprehensive formulation of the anorexic mechanisms, (e) collaboration with the patient to create a treatment plan, (f) the use of motivational enhancement, (g) the use of psycho-education, (h) provision of structure to dietary intake, (i) addressing central themes and issues utilizing cognitive-behavioral methods, (j) weight gain/stabilization, (k) addressing co-morbidity and other difficulties, (l) developing further conceptualizations utilizing schema therapy if cognitive-behavioral therapy is not successful, (m) developing a relapse prevention plan, (n) and terminating treatment with an after care plan.

Interpersonal Therapy and Psychodynamic Therapy

Interpersonal and psychodynamic therapies and conceptualizations are often indicated in the treatment of anorexia nervosa. Interpersonal therapy is a brief and highly structured psychotherapy that addresses issues related to attachment and interpersonal relationships within the context of the therapeutic relationship (Fairburn, Jones, Peveler, Hope, & O'Connor, 1993). Psychodynamic therapy focuses on understanding unconscious meanings and motivations and understanding and resolving conflicts that may have formed during the developmental process (Bloom et al., 1994; Johnson, 1991; Petrucelli et al., 2001; Zerbe, 1993).

Family Therapy

Preliminary research suggests that family work is indicated, whenever possible, and involves helping the family emotionally connect with one another, meet the patient's needs, develop healthy communication skills, address structural issues, increase mutual understanding, warmth, and compassion, and support individuation (Beresin, et al., 1989; Braem, 2004; Cooper, 2006; Hardman et al., 2005; Hsu, et al., 1992; Lock et al., 2001; Yager, et al., 2006). Adults in treatment appear to benefit from family of origin work and, when appropriate, may benefit from family therapy as well.

Group Therapy

Group therapy provides several unique opportunities for growth and healing. Members often experience increases in self-esteem as they realize they are not alone in what they are suffering. They find support and acceptance, learn to identify feelings and how to appropriately express them interpersonally, develop friendships, benefit from giving and receiving constructive feedback, and gain help from a variety of educational, experiential, psychodynamic and cognitive-behavioral interventions (Costin, 2007). Therapists must carefully screen and prepare (educate) members to insure readiness and the ability to respect and follow group norms. Members who agree to participate need to be willing to be involved in group process, be non-judgmental and accepting, be self-disclosing, desire self-understanding and change, and avoid discussing eating disorder behaviors as these promote competition rather than connection (Costin, 2007; Garner, 1997; Wilson et al., 2002).

Creative/Expressive Therapies

The creative-expressive therapies include art, drama, and physical challenge. These can facilitate emotional and verbal expression, cut through defenses, support the giving up of passivity and avoidance, facilitate risk taking, present opportunities for authentic identity awareness and development, help suspend a negative self focus, increase self-acceptance and connection to others, shift mood, and give patients unique and different ways of "having a voice and making a stand" (Hardman & Berrett, 2005, p. 4). The younger the patient the more activity-based the therapy should be (Berrett, 2002; Hardman et al., 2005; Gusella, et al., 2003; Hinz, 2006; Yager, 2006).

Psycho-Education

Psycho-education consists of "education used to help the patient evaluate their own relationship with their eating disorder" (Waller, et al., 2007, p. 140) and generally includes empirically based facts about nutrition, bodily processes, and medical repercussions of eating disorder symptoms (Eivers & Nisbett, 2005; Garner, 1997; Hardin, 2003; Yager, et al., 2006).

Long-Term Therapy

Extensive therapy is often indicated for the treatment of anorexia nervosa, especially chronic conditions. Treatment involves addressing issues related to abuse, developmental disturbance, personality disorder and trauma (Allen, 2001; Blake et al., 1997; Bloom et al., 1994; Cooper, 2006; Johnson, 1991; Levenkron, 1997; 2000; Milos et al., 2004; Petrucelli et al., 2001; Vitousek et al., 2005; Yager, et al., 2006).

After Care and Relapse Prevention

The literature suggests that 30-50% of all patients successfully treated for anorexia nervosa relapse within one year and 20% remain in treatment failure (Solitis, 2001). Factors which have been associated with relapse and poorer outcomes include long duration of the illness, starting treatment at an extremely low weight, older age at time of treatment, and the presence of purging (Deter & Herzog, 1994; Lowe, Zipfel et al., 2001; Pike, 1998; Solitis, 2001; Steinhausen, Seidel, & Winkler, 2000).

Therapists working with this population must understand the often chronic, long-term nature of the illness and the intermittent and ongoing type of support that is often necessary to maintain recovery (Yager, et al., 2006). When termination is imminent, therefore, it is important to create an aftercare/relapse plan. Waller et al. (2007) suggest that therapist and patient work together to create a "relapse prevention file" (p. 350) which includes cognitive-behavioral tools and activities to encourage recovery maintenance, maintenance diaries for recording food intake and emotions, a list of support persons and phone numbers, and writing pieces created in treatment that highlight what helped during treatment, what got in the way of recovery during treatment and how to overcome these, and what brought on and maintained the illness in the first place.

As shown in Figure I, the Christian spiritual integration model proposed in this document incorporates all of the current modes of treatment discussed above (Figure I, Diagram I), as indicated by each patient's individualized assessment. When a spiritual assessment is added to this foundation, as proposed in this model, spiritual integration

provides additional therapeutic options when appropriate. Details about these options, as illustrated in Figure I, Diagram II, will now be described.

Spiritual Integration in the Treatment of Anorexia Nervosa

As previously stated, the mental health field currently espouses the role of faith, religion, and spirituality in the etiology, treatment, and prevention of physical (Matthews, 2000; Newmark, 2001) and mental illness (Benson, 1996; Craigie, Larson, & Lyons, 1988; Jones, 1994; Laurencelle, Abell, & Schwartz, 2002; Miller et al., 1999; Richards et al., 2000; Shafranske, 1996) and the prevailing bio-psycho-social model of mental health and illness embraces spirituality as a fundamental factor (Cumella, 2002; Gunderson, 2000). In this section, spiritual interventions presently used in counseling practice will first be described. A discussion of ethical spiritual intervention follows. Next, spiritual issues common in the eating disordered will be presented. Finally, the current status of spiritual interventions in the treatment of eating disorders, including anorexia nervosa, will be explained. Concurrently, how these interventions fit into the proposed model presented in this document will be clarified.

Spiritual interventions recommended as useful in counseling practice include mindfulness and meditation, prayer, spiritual surrender, spiritually informed imagery and visualization, forgiveness, collaboration with and/or referral to clergy, participation in a healthy religious/spiritual community, biblio-therapy, and the encouragement of the use of particular spiritual disciplines related to one's faith (e.g., Grenfell, 2006; Hardman et al., 2003; 2004; 2005; Helminiak, 1996; Joughin et al., 1992; Lelwica, 1999; Marsden, et al., 2007; Miller et al., 1999; Mitchell, et al., 1990; Newmark, 2001; Richards et al. 1997;

2000; 2001; 2004; 2006; 2007; Smith et al., 2002; 2003; Ruskay & Rabinor, 1999; Shafranske, 1996). Spiritual interventions and how they relate to the treatment of anorexia nervosa will be described later in this chapter after a brief presentation regarding the importance of utilizing these interventions only as ethically indicated.

A review of the literature on the ethical use of spirituality in counseling practice reveals that spiritual interventions are indicated only in the context of (a) informed consent; (b) promoting patient's well being; (c) addressing thoughts and affect that are incongruent with the patient's faith; (d) the patient's religious/spiritual belief system, as opposed to the counselors'; (e) a prior full spiritual assessment; (f) appropriate counselor training in cultural, ethnic, and religious/spiritual diversity and spiritual integration; (g) supervision, if indicated; (h) a multi-modal treatment formulation that includes customary medical and psychological methods; (i) a trusting, empathic therapeutic bond; (j) assurance that the patient is not psychotic or delusional; (k) relevancy to patient's issues and concerns; (l) prior description and evaluation of patient comfort and desire; and (m) proper training in the use of specific interventions (Butman, 1997; Collins, 1991; Garzon, 2005; Gubi, 2001; Hardman et al., 2004; Jersild, 2001; Kelley, 1995; Martines, Smith, Barlow, 2007; McMinn, 1996; Miller et al., 1999; Ohlschlager, 2004; Richards et al., 1997; Richards et al., 2000; Richards et al., 2007; Scafranske, 1996; Sperry 2001;2003). In relation to the use of spiritual interventions in the treatment of anorexia nervosa, these same standards apply.

In terms of spiritual issues related to eating disorders, the literature reveals that many individuals who suffer with anorexia nervosa also experience profound spiritual struggles and benefit from addressing these in treatment (Jersild, 2001; Joughin et al.,

1992; Marsden et al., 2007; Morgan, 2000; Newmark, 2001; Richards et al., 1997; Richards et al., 2007). Additionally, the literature clarifies that for individuals who consider themselves religious or spiritual, spiritual integration may support recovery from eating disorders (Abel, 2005; D'Abundo et al., 2004; Garrett, 1996; Hall et al., 1992; Hardman et al., 2003;2004; Hsu et al., 1992; Jersild, 2000; Jough et al., 1992; Marsden et al., 2007; Mitchell et al., 1990; Morgan et al., 2000; Newmark, 2001; Nilson et al., 2006; Richards et al., 1997; Richards et al., 2006; Richards et al., 2007; Smith et al., 2003; Tozzi et al., 2003; Weaver at al., 2005).

Empirical investigation of the role of religious and spiritual issues in the development and treatment of eating disorders began a decade ago by Richards and colleagues at the Center for Change in Orem, Utah (Hardman et al., 2000; Hardman et al., 2003; Hardman et al., 2004; Hardman et al., 2005; Richards et al., 1997; Richards et al., 2000; Richards et al., 2001; Richards et al., 2006; Richards et al., 2007; Smith & Richards, 2002; Smith et al., 2003; Smith et al., 2004; Taylor et al., 2003). An outcome of this empirical work was the creation of a research agenda that includes the exploration of specific faiths in the development and treatment of eating disorders (and this research project is a response to that agenda item). An additional outcome was the emergence of several conclusions about spiritual integration in the treatment of eating disorders.

One important conclusion made as a result of their research was the finding that there are common spiritual/religious issues that eating disordered patients struggle with and particular spiritual interventions that support recovery. These spiritual issues include "negative images of God, feelings of spiritual unworthiness and shame, fear of abandonment by God, guilt and shame about sexuality, reduced capacity to love and

serve, difficulty surrendering and having faith, and dishonesty and deception" (Richards et al., 1997; p. 264).

As a means of addressing these spiritual concerns, which often exacerbate and/or fuel eating disorder symptoms and hinder successful treatment if left unaddressed, Richards and colleagues developed a repertoire of spiritual interventions which have been incorporated into the proposed model (See Figure I, Diagram II), as they are researched based and clinically supported. These include (a) education about spiritual principles and ideas; (b) spiritual/religious readings; (c) prayer; (d) spiritual imagery and meditation exercises; (e) forgiveness; (f) seeking spiritual guidance from religious leaders; and (g) encouraging involvement in a religious community (Hardman & Berrett, 2000; Hardman et al., 2003; Hardman, et al., 2004; Richards et al., 1997; Richards et al., 2007). These interventions, which make up the second tier in the integration model proposed in this document, will now be described. Examples of the use of these interventions and fuller explication regarding them can be found in the literature notated in this section. Additionally, the use of these interventions is discussed at much greater length in the literature on spiritual integration in general. Therefore in this section, and the following one on Christian spiritual integration, references are provided for further exploration of literature that expounds on and provides examples of the use of these interventions from the integration literature at large. Although this literature is not specific to treatment with anorexic individuals, it is both pertinent and easily transferred to use with this population.

Direct Education about Religious/ Spiritual Principles and Ideas

Utilizing spirituality as a resource for recovery in the treatment of anorexia nervosa requires counselors to be well trained and versed in ethnic, cultural, religious and spiritual diversity (Miller et al., 1999; Richards et al., 1997; Sperry, 2001). Because patients with eating disorders are often undeveloped in terms of identity, respectful exploration of what is spiritually authentic for the patient is especially necessary (Richards et al., 2007). As dystonic and harmful religious/spiritual beliefs (incongruent with patient's own faith) are often present, exploring issues, which can be gleaned from the spiritual assessment, may be helpful. The goal of this process is to help patients correct dysfunctional thinking and subsequent affect that have emerged from faulty beliefs about God, self and others. This practice makes use of scripture and religious writings to help transform mistaken beliefs into ones that are consistent with patient's actual faith and which promote spiritual health (Miller et al., 1999). Although reference to this process in treatment with anorexic individuals is limited (Richards, et al, 1997; 2007) applicable resources are available in the literature at large (e.g., Benner, 2002; Evans, 2005; Garzon, 2005; Hardman et al., 2005; Pargament, Kennell, Hathaway, Grevengoes, Newman et al., 1988; Pargament, 1996; Pargament & Brant, 1998).

Assigning Spiritual or Religious Readings

The use of spiritual/religious bibliotherapy is common in spiritually integrative psychotherapy (Azhar, Varma, & Dharap, 1994; Bearon & Koenig, 1990; Byrd, 1988; Finney & Malony, 1985; Miller et al., 1999; Sperry, 2001; 2003; Tan, 2003). In the treatment of eating disorders, Richards et al. (1997) report the successful use of religious-

spiritual readings to facilitate healing and understanding about topics such as "forgiveness, love, guilt, trust, spiritual identity and worth, and the role of suffering and pain" (p. 271). Readings are used to correct misunderstandings, inspire, teach, comfort, strengthen, provide meaning, support differentiation from eating disorder identity and symptoms, and aid in the development of an authentic and solid personal identity (Hardman et al., 2000; 2004; Richards et al., 2000; 2007).

Prayer

There are many varieties and forms of prayer that can be utilized in counseling (McCullough & Larson, 1999, McMinn, 2001; Garzon, 2005) and the effective and ethical use of prayer in treatment is addressed well in the literature (e.g. Ashby & Lenhart, 1994; Gubi, 2001; Hardman et al., 2005; Hurding, 1995; Matthews, 2000; McCullough, 1995; McCullough & Larson, 1999; Miller et al., 1999; Poloma & Pendlleton, 1991; Richards, 1991; Sperry, 2001; 2003; Tan, 2003; Walker, Tonigan, Miller, Comer, & Kahlich, 1997; Weld, 2007).

Counselors working with religious/spiritual individuals who have anorexia nervosa can personally pray for their patients, encourage patients to pray in a manner congruent with their beliefs and in keeping with their comfort level, pray directly with patients during sessions, and/or encourage patients to request prayer from supportive others. Prayer themes may relate directly to eating disorder symptoms and/or any of the patient's other life issues.

Spiritual Imagery and Meditation Exercises

Spiritually grounded meditation, relaxation training, and imagery are commonly used in spiritually integrated psychotherapy (e.g., Carlson, Bacaseta, & Siamton, 1988; Elkins, Anchor, & Sandler, 1979; Garzon, 2005; Marlatt & Kristeller, 1999). Detailed instructions about the use of these strategies in treatment can be found in this literature. In terms of their use with anorexic patients, Richards and associates have found that many of their eating disorder patients "have experienced powerful affirmations and flashes of insight into their spiritual identity and worth" (Richards, et al., 1997, p. 272) as a result of the use of spiritual imagery and meditation in counseling. The use of visualization and meditation, for example, may involve revisiting traumatic experiences that relate to the development of the eating disorder and visualizing God bringing comfort and healing to those memories. Therapists can utilize these tools in their work with anorexic individuals to address body image issues, identity, self esteem, and the ability to receive God's acceptance, comfort, and love in traumatic memory and present circumstances (Richards et al., 2007).

Examples of the use of spiritual imagery and meditation in the literature at large can help counselors grasp the process of their use (e.g., Cecero, 2002; Garzon, Witherspoon, Garver, Wu, Burkett et al., 2002; Garzon, 2005; Hurding, 1995; Smith, 1999). However, it is important to note that there is some controversy about the use of such interventions in treatment. For a further information see Garzon, 2005 and Entwhistle, 2004.

Forgiveness

Currently there is much integration literature on the topic of forgiveness in counseling (e.g., Cheon et al., 2007; Coyle & Enright, 1997; Enright, 1996; Enright, Freedman, & Risque, 1988; Hardman et al., 2005; McCullough & Worthington, 1994; 1998; Worthington et al., 1996), all of which can be related to working with this population. According to Sanderson and Linehan (1999), "forgiveness means to give up or give away anger and the actions associated with it, retribution and revenge" (p. 207). Richards and associates encourage therapists to help eating disorder patients consider forgiveness as a gift they can choose to give to themselves, others and God.

Forgiveness work is considered a process that is not to be hurried as

> intense feelings of hurt, disappointment, anger, and rage must often be acknowledged, re-experienced, and worked through before patients are ready to forgive. To foreclose on these emotions and prematurely forgive often gets many patients into trouble emotionally, as they must deny their feelings of hurt, disappointment, resentment, and anger over what they have suffered. As many of our eating disorder patients are already repressing their emotions, prematurely encouraging them to forgive others would exacerbate this problem (Richards et al., 1997; p. 274).

Seeking Spiritual Guidance from Religious Leaders

When patients' religious/spiritual leaders are healthy people who are available to support patients in treatment who consent for collaboration, a resource of caring, support, wisdom, guidance, and comfort can emerge as therapist and spiritual leader work together on behalf of and directly with the patient (Hardman et al., 2005; Richards et al., 1997; 2007). Although the literature is limited in terms of how collaboration with leaders relates directly to the treatment of anorexia nervosa, relevant information about such collaboration can be found in Berrett, 2003, Evans, 2005; Gorusch and Maylink, 1988;

Sperry, 2003; Tan, 2003; Weaver, Koenig, and Larson, 1997; Weaver, Sanford, Kline, Lucus, Larson et al., 1997; and Winger and Hunsberger, 1988.

Encouraging Involvement with Their Religious/Spiritual Community

Involvement with a healthy religious community has been shown to promote health and well-being (Arteburn & Felton, 2001; Berrett, 2003; Eberly, 2005; Griffeth et al., 2001; Vorhees, Stillman, Swank, Heagerty, Levine et al., 1996). Individuals with anorexia nervosa are often extremely isolated people. Counselors utilizing spiritual integration can promote involvement with their patient's religious community once they are made ready for healthy participation and connection. Patients in treatment who wish to participate in their religious/spiritual community may need help moving from being greatly extrinsically oriented, that is, concerned about outward appearance and pleasing others, to a more intrinsic orientation, which involves being more "internal, devout, service, and worship oriented" (Richards, et al., 1997, p. 276) (Smith et al., 2003;2004). When ready, such involvement offers opportunities for healthy interpersonal experiences which can help patients mature and more fully recover.

In terms of the integration model introduced in this document, the seven integration options described above may be utilized in treatment as indicated, in accordance with the ethical guidelines previously presented, once the treatment plan incorporating customary practices in the treatment of anorexia nervosa is in place, and when a full spiritual assessment is completed (See Figure I, Diagram I). As previously noted, *The RSAQ* (Wall et al., 2003) is suggested. Although several spiritual measures are notated in the literature, it has been reported that many of these have

theoretical/psychometric weaknesses (Darden, 2005; Hall, Tisdale, & Brokaw, 1994) or are not as comprehensive as the *RSAQ* (Darden, 2005). Additionally the *RSAQ* was specifically formulated for use with an eating disordered population. According to Darden (2005)

> The *RSAQ* represents a broad spectrum of clinically meaningful spiritual beliefs and experiences, fully addresses psychometric considerations in design features and in demonstration of instrument reliability and validity, and can be used to assess spiritual growth and change through repeated administrations during the course of treatment. It is also relatively short to administer: 41 questions, taking 10-15 minutes for the average patient to complete, and not requiring clinician involvement to administer. Scoring and interpretation are automated. (p. 14)

Level two (Figure I, Diagram II) of the proposed model utilizes the spiritual interventions described in this section. If a patient desires to utilize specifically Christian spiritual integration in her treatment, the third level in the proposed model (See Figure I, Diagram III), which will now be described, opens up additional options to support recovery from anorexia nervosa.

Christian Spiritual Integration in the Treatment of Anorexia Nervosa

In this section the present status of Christian spiritual integration in the treatment of anorexia nervosa, as revealed in the literature, will be presented. Although some discourse on this subject is available (Braem, 2004; Cooper, 2006; Cumella, 2002; Darden, 2005; Eberly et al., 2003; Eberly, 2005; Rogers, 2004; Wall, 2003; Wall, et al., 2002; Wall et al., 2003; Wall et al., 2005), only one research study (Abel, 2005) was found. Fortunately, there is a growing body of literature about Christian spiritual integration in general that relates to the treatment of individuals with anorexia nervosa.

Where relevant, these references are also provided. The Christian spiritual interventions utilized in the treatment of eating disorders found in the literature will first be described. These will then be placed in the context of the proposed model (See Figure I, Diagram III). These interventions include (a) confession and reconciliation; (b) exploring spiritual issues from a biblical perspective; (c) Christian cognitive-behavioral therapy; (d) an "incarnational" model of care giving; (e) corporate worship; and (f) forgiveness from a Christian perspective.

The integration tools described here comprise the third tier, built upon the first two, in the proposed model. In this model, Christian spiritual interventions become options in the treatment of anorexia nervosa in a step care process, once the current standard of practice in the treatment of eating disorders (as outlined in Figure I, Diagram I) are firmly in place, a full spiritual assessment is completed, in accordance with the ethical standards outlined in this document, and in addition to the general spiritual interventions depicted in Figure I, Diagram II (See Figure I). As previously stated, prior to the use of these interventions, assessment for appropriateness is essential. Garzon (2005) presents a situation in which it was made clear to the counselor that Christian spiritual integration was indicated,

> Careful assessment of George revealed a man utilizing his Christian faith as a main support in his life. He was very open to discussing spiritual issues and having spiritual techniques incorporated as a part of his care. He had a positive view on the inclusion of the Bible as a part of his treatment, so some interventions applying this resource were used. (p. 115)

Confession and Reconciliation

In the Christian faith the concept of confession entails the

> acknowledgement and praise of God's character and glorious works, often with expression of man's confession of faith in God and in his Son, Jesus Christ; also man's admission to God of his sins and wicked works. Confession of sin is emphasized in the New Testament and with it is connected the promise of forgiveness of sins, a forgiveness based solely on the death of Christ. (Mare, 2001, p. 285)

Christians who utilize confession and accept the unconditional love and forgiveness of God (reconciliation) report experiencing deep joy, freedom and security (Davis, 2001).

For the Christian individual with anorexia nervosa who desires to integrate her faith in her recovery, confession entails personally understanding and sharing the truth about one's eating disorder with God and with significant others, receiving forgiveness, and accepting God's love (Cooper, 2006). This process involves working in therapy to become prepared to share in fullness about personal experiences and issues related to the development and maintenance of the eating disorder including specific eating disorder behaviors and the underlying thoughts, feelings and needs behind them, with treatment providers, other patients, and ultimately with families and loved ones. Confession allows patients to face their shame and to let go of the painful belief that God could and would not love them because of their eating disorder behaviors (Wall et al., 2005).

According to Wall et al. (2002; 2005), when Christian patients come to understand, through the use of Scriptures and experiencing grace-filled therapeutic relationships, that God loves them completely no matter what their behavior, they can come out of hiding and begin the work of recovery, not because of condemnation and fear but "because we are loved and have been granted infinite worth by God" (Wall et al., p. 9). Confession to others about the reality of one's eating disorder denotes coming out of denial, motivation for recovery, interest in utilizing spirituality as a resource in

treatment, and a desire to engage directly with God as part of the recovery process (Cooper, 2006; Rogers, 2004). Other clinicians, researchers and theorists writing about the Christian process of confession in counseling in general include Allender, 1995; Braem, 2004; Foster, 1988; Monroe, 2001; Smith, 1999; and Tan, 1996.

Exploring Spiritual Issues from a Christian Perspective

Although not written specifically for the treatment of anorexia nervosa, the integration literature has many relevant resources for clinicians who want to learn how to ethically integrate biblical perspectives into counseling (e.g., Adams, 2004; Averbeck, 2006; Benner, 2002; Cloud and Townsend, 1994; Collins, 2001; Cumella, 2002; Foster, 1988; Gruner, 1985; Powlison, 2001; Roberts, 2001; Sheilds, et al., 2001; Tan, 2003; van Deusen Hunsinger, 2001). Incorporating a Christian perspective in treatment with individuals with anorexia nervosa, according to Wall (2002), entails helping patients understand that eating disorders "result from a combination of five Biblical factors" (p. 6) that relate directly to Christian theology (see Wall, 2002 for a full explication of this view). Once patients are educated about how these factors contribute to the development and maintenance of their eating disorder, spiritual health can be promoted. Wall reports that this occurs as the counselor helps patients to

> understand the concept of grace, to grow beyond a legalistic and judgmental perception of God, and to embrace a Christian life walking in God's beneficent love. From this context of grace, acceptance, and forgiveness, repentance can occur. Patients can embrace truth, rather than denial about past ineffective choices and actions, and they can take responsibility for recovery. The process is assisted by understanding that eating disorders are almost always unhealthy ways of meeting rational, human needs, such as the needs for love and acceptance. These underlying needs can be validated while patients are encouraged at the same time to take responsibility for choosing healthier methods to meet their needs. (Wall, 2002, p. 9)

Utilizing Christian perspectives in treatment for anorexia nervosa, according to Cumella (2002), Eberly (2005), and Wall et al. (2005), occurs best not through direct instruction, but via respectful questions that facilitate introspection, thought, and growth in the understanding of and trust in God's love.

Christian Cognitive-Behavioral Therapy

As noted in this chapter, cognitive-behavioral interventions in the treatment of anorexia nervosa are empirically supported. Additionally, spiritually informed cognitive-behavioral therapy has been utilized in the treatment of both anxiety and depressive disorders and there is growing empirical evidence for its efficacy (e.g., Abel, 2005; Eberly, 2005; Eberly et al., 2003; Hardy, 2000; Hawkins, Tan, & Turk, 1999; Jones, 2001; Johnson, 2001; Kaiser, 1991; Miller, 1988; Propst, 1996; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Tan & Ortberg, 1995;).

Christian Cognitive-Behavioral Therapy (CCBT) utilizes the basic premises of CBT to combat faulty or irrational thinking in conjunction with Christian spiritual principles and Scripture. According to Eberly (2003; 2005), Scripture can help Christian eating disordered individuals transform thoughts that fuel symptoms. Christian CBT, including schema work for deeply held beliefs about the world, self, and others, is utilized to help transform the obsessive and dysfunctional thinking that sustains the eating disorder. The Bible, a source of authority for most Christians, acknowledges the significance of thinking and urges man to "think on those things that are true, noble, right, pure, lovely, admirable, excellent and praiseworthy" (Philippians 4: 8). According to Wall (2005)

> The transformation to which the Bible refers involves changing from a schema derived from the fallen world to God's schema or God's way of seeing things. God's schema involves no distortions, misperceptions, denial, or lies. It is truth. In Christian CBT with eating disorder patients, mental renewal occurs when patients are offered and build a self-schema from Gospel truths. (p. 7)

In their work with Christians suffering with anorexia nervosa, Wall and his colleagues utilize several Christian principles in their application of CBT. Their goal is to encourage the development of thinking that is congruent with biblical truth and is differentiated from the harsh and perfectionistic thinking that is at the heart of anorexia nervosa. Self image, value of self, purpose, legitimate need meeting, the cost of the eating disorder, ability to fight the eating disorder, and the transformation of the mind are themes which are directly addressed with Scripture in CCBT. Wall and colleagues have found that "by assisting patients to renew the mind, CCBT promotes a therapeutic transformation: from irrational to rational schemas, emoting, and behaviors that are consistent with God's plan for each person whom he has lovingly made" (Wall, 2005, p. 8).

"Incarnational" Model of Care Giving

In Christian counseling, incarnational modeling entails facilitating knowledge about the attributes and character of God via the qualities inherent in the counselor. As previously noted in this chapter, the therapeutic relationship and the person of the therapist are vitally important in recovery from eating disorders. As a result of experiencing a healthy and developmentally supportive relationship, growth and healing are promoted.

For anorexic individuals who are Christian but lack an understanding of God's character as evidenced in the Bible, experiencing the attributes of God's grace and mercy via the kindness, warmth, and gentleness of the therapist, provides a corrective emotional experience both psychologically and spiritually. Over time, the nurturing therapeutic relationship may impact the internal world of the patient (as cited in section one), correct distortions in faith, increase the likelihood of faith becoming a resource in treatment, and facilitate the healing of trust and the development of deep and meaningful interpersonal relationships (Cumella, 2002).

In addition to the limited amount of literature on this theme in relation to eating disorder treatment (Cumella, 2002; Eberly, 2005; Wall et al., 2005), the integration literature at large presents the character and person of the therapist as one of the primary healing factors of spiritual dysfunction and mental/emotional disorder (e.g., Anderson, 1997, Anderson, 2007; Benner, 1983; Cheon et al., 2007; Hardy, 2000; Langberg, 2006; White, 1984).

Grace, in the form of patience, kindness and interest; and truth, in the form of consistent limits, boundaries, and rules, are emotional and developmental needs that many anorexic individuals have never been privileged to have. Those who are Christian and who have been deprived of this nurturing tend to project this neglect and disinterest onto their image of God and cower from Him at worst or make little use of Him at best. According to the literature, counselors working with this population can do much to facilitate recovery and faith as a resource when they give their Christian patients the experience of Christ-likeness within the context of the therapeutic relationship.

Daily Corporate Praise/Worship

For many individuals in residential treatment for eating disorders, daily praise and worship experiences were reported as helpful to recovery (Wall, 2005). Such experiences entail community meetings during which prayer and worship singing takes place, and a Christian spiritual message is given. Anecdotal evidence suggests that residents in treatment have found these gatherings encouraging, inspiring, and supportive of recovery (Cooper, 2006; Eberly, 2005; Wall, 2005).

Forgiveness from a Christian Perspective

Although forgiveness was already presented as an intervention option in the proposed model (See Figure I, Diagram II), forgiveness from a Christian perspective is different in that it is rooted in the Christian's belief in God's immeasurable love for mankind, as demonstrated by the forgiveness He has provided through His Son. Here the focus is on God's forgiveness and love toward humankind as the motivator for forgiveness and love toward self and others.

The exploration of forgiveness in psychotherapy with Christian people can be found in the general integration literature (e.g., Cheon, et al., 2007; McCullough, Worthington, & Rachal, 1997; Sartor, 2003; Seibold, 2001; Worthington, et al., 1996; Worthington, 1998) with many applicable insights for therapeutic work with this population. Of particular importance to therapeutic work with anorexic women, who are often laden with guilt and shame, is forgiveness as a manifestation of God's acceptance, compassion, understanding and love. Seibold (2001) captures this here,

When we have been deeply wounded, someone has acted unlovingly toward us.

> The antidote is to be bathed in love until we are so filled up with love that we can begin to imagine letting some love flow out into forgiveness. Forgiving must flow from love, and forgiving is a form of loving. When we are sufficiently full of love-love that we are receiving and love that we are giving-we will naturally be drawn to offer forgiveness. However, we start not by loving the offender, but by loving people and receiving love from people who will rebuild the broken self, people who are safe and trustworthy. There is no need to force love toward the offender or to will forgiveness. The love, and hence the forgiving, will come with time, gently, the way winter melts into spring. This love flows from the soul. (p. 307)

For the anorexic individual who is Christian yet feels disconnected, unloved, unwanted, shameful, terrified and alone, due to her eating disorder and the history behind it, understanding the love and forgiveness of God provides a foundation of lasting and unchanging security, attachment and identity that can be the basis of true and lasting recovery (Cooper, 2006; Cumella, 2002; Eberly et al., 2003; Eberly, 2005; Wall, 2005; Wall, et al., 2005). Indeed, it appears that facilitating awareness and experience of the love of God is the cornerstone of Christian spiritual integration in the treatment of anorexia nervosa.

The Relationship between the Literature and the Present Study

The preceding review has clarified that (a) there is an urgent need for research that further delineates recovery factors for anorexia nervosa, (b) research exploring spirituality and recovery from anorexia nervosa has been encouraged, and (c) research exploring specific religious/spiritual orientations and recovery from anorexia nervosa has been recommended. As only one research study related to the topic of Christian spirituality and recovery from anorexia nervosa has been found, the present study exploring Christian spirituality and recovery from anorexia nervosa is warranted.

Summary

This chapter provided a review of the literatures relevant to this study. In the first section, the literature related to counseling practice and the treatment of anorexia nervosa was presented and the current standard of practice became the basis of the model of Christian spiritual integration proposed in this document. This foundation, as illustrated in Figure I, Diagram I, includes (a) medical evaluation and treatment; (b) psychological assessment; (c) nutrition evaluation and treatment; (d) the person of the therapist and the therapeutic relationship; (e) specific therapies; (f) psycho-education; (g) long term therapy; and (h) after care and relapse prevention. In the proposed model, a spiritual assessment is added in order to determine if spiritual interventions may offer additional opportunities in the treatment process. This section also highlighted the fact that research in the area of anorexia nervosa has been strongly encouraged (Fairburn, 2005; Halmi, 2005a; Hsu et al., 1992; Le Grange et al., 2005; Selwyn, et al., 1999; Stern, 2006; Tozzi et al., 2003; Weaver et al., 2005; Wilson et al., 2007; Woodside, 2005; Yager et al., 2006).

In the second section of this chapter, the literature on spirituality in the treatment of anorexia nervosa was presented and recommended spiritual interventions were integrated into the proposed model (Figure I, Diagram II). This second tier of the model includes (a) education about spiritual principles and ideas; (b) spiritual/religious readings; (c) prayer; (d) spiritual imagery and meditation exercises; (e) forgiveness; (f) seeking spiritual guidance from religious leaders; and (g) encouraging involvement in religious community. This section also clarified that research further exploring spirituality in the treatment of eating disorders has been strongly encouraged (Hardman et al., 2000; 2003;

2004; 2005; Richards et al., 1997; 2000; 2001; 2006; 2007; Smith et al., 2002; 2003; 2004; Taylor et al., 2003), including the call for research exploring specific faiths in the treatment of eating disorders (Richards, et al., 2007).

In the final section of this chapter, the literature on Christian spirituality and recovery from anorexia nervosa was reviewed, and the specific interventions highlighted were presented and integrated into the proposed model. These include (a) confession and reconciliation; (2) exploring spiritual issues from a biblical perspective; (3) Christ-centered cognitive-behavioral therapy; (4) an "incarnational" model of care giving; (5) corporate worship; and (6) forgiveness from a Christ-centered perspective. Although some discourse on the subject of Christian spiritual integration in the treatment of anorexia nervosa exists, only one research study related to this topic was found (Abel, 2005). In response to the call for further research on this topic, this study was done. In the next chapter the research study is introduced and the research method elucidated.

CHAPTER THREE: RESEARCH METHOD

Introduction

The preceding chapters clarified that there presently exists a pressing need for research in the area of recovery from and treatment of anorexia nervosa and that qualitative research and spirituality have both been encouraged for exploring this. This research endeavor was selected as one response to this need. In this chapter the qualitative case study research method that was utilized in this study, along with the rationale for its use, will first be provided. Next, the case is defined and details regarding the research questions, data collection procedures, and methods of data analysis are given. Finally, procedures that were used to confirm the trustworthiness of the research findings will be described.

The Case Study Method

The disciplinary orientation and design selected for this inquiry was the psychological case study, a qualitative research method used to study human behavior in detail and grounded in personal experience (Yin, 2004). Case study research involves the intense analysis and description of a multi-faceted "case" (an individual, group, or event) with the hope of gaining an in-depth understanding of the situations and meanings for those involved (Hancock et al., 2006). The case study method is an empirically grounded approach for exploring complex subject matter and can enlarge upon the understanding of what is already known about a phenomenon from preceding research (Stake, 1995).

Case study research involves detailed contextual investigation of events or conditions and their relationships (Soy, 1997). Researchers have effectively utilized case study methods across a multiplicity of fields successfully illuminating complex phenomena while "retaining the holistic and meaningful characteristics of real-life events" (Yin, 2003, p. 2) and richly depicting multifarious data. Case studies are used to develop, construct, and contest theory, to elucidate situations, to provide a foundation for applying remedies to problems, and to richly depict an entity or an experience. A principal benefit of case study research is relevance to current human circumstances and ease of access through user-friendly and comprehensibly written reports (Soy, 1997).

Case study designs share the elements of other forms of qualitative measurement including the study of experiences in their inherent settings, the use of manifold processes that are interrelated, recursive and person-centered, the upholding of a perspective that is principally exploratory, developmental and inductive, the use of data processing procedures that involve narrative, interpretation and explanation, the viewing of social experiences and events holistically, and the inclusion of the introspective reflection of the researcher (Creswell, 2007; Davidson, Sells, Sangster, & O'Connell, 2005; Denzin & Lincoln, 1994; Patton, 2001).

Researchers engaged in case studies approach the data with a desire to enter fully into the realm of consideration, to submerge themselves through deep attentiveness, disciplined listening, and careful observation with the goal of grasping the true experience and perceptions of the person's related to the situation being studied (Yin, 2003). Because the case study method is discovery oriented, exploratory, personal, non-deterministic and constructivistic (Stake, 1995) it is a fitting design choice when there is

anticipation that what is being explored is complex and that conceptualization necessitates delving into many contexts with an eye to meaningfully conserve the whole.

The qualitative orientation of this particular case study is heuristic and phenomenological. The term heuristic means to discern, ascertain, realize and uncover via a progression of inward and outward exploration of experience (Moustakas, 1990). Heuristic research is fueled by a query that is beckoning the researcher to an arduous journey involving deeply personal encounter, thorough and precise characterization, scrupulous data collecting, and comprehensive examination. According to Moustakas (1990),

> The heuristic research process demands the total presence, honesty, maturity, and integrity of a researcher who not only strongly desires to know and understand but is willing to commit endless hours of sustained immersion and focused concentration on one central question, to risk the opening of wounds and passionate concerns, and to undergo the personal transformation that exists as a possibility in every heuristic journey. (p. 14)

The term phenomenological means "from the point of view of the behaving organism itself" (Giorgi & Giorgi, 2003, p. 243) and denotes the desire to obtain, directly from individuals involved, descriptions of human experience that are accurate and faithful. The fundamental end of phenomenological analysis is an understanding of the structure of an experience and knowledge of what is genuinely psychologically essential about it (Giorgi & Giorgi, 2003). For those engaged in heuristic, phenomenological investigation, the research question holds the avid interest of the examiner and also possesses critical social and civil relevance (Merriam, 2001). It is both deeply connected to the identity and personhood of the researcher while concurrently addressing a void in the empirical field.

Why a Case Study?

In light of the preceding description of case study research and the fact that so little has been empirically investigated in the area of Christian spirituality, counseling practice, and recovery from anorexia nervosa, the case study method was particularly fitting for this research. The openly inquisitive, non-pre-determined epistemology of the approach anticipated answers that are elaborate and co-related and its method of analyzing multiple forms of data was apropos in terms of the extent and depth of information hoped for. Case studies aspire to capture a sense of the complex developmental processes, the personal meanings, the rich, personal experiences, and the specific nuances related to inquiry topics to as great an extent as possible. In light of this, the case study method was chosen for this research.

Now that the case study method has been introduced, along with the rationale for its use in this inquiry, the case itself will next be delineated.

Defining the Case

The case in this study was Christian spirituality, counseling practice, and recovery from anorexia nervosa. The primary question being addressed was, "What can selected recovered individuals and those who work with them teach us about Christian spirituality, counseling practice, and recovery from anorexia nervosa?" In other words, can spiritual integration play a part in overcoming self-starvation for the Christian woman?

The Research Questions

Case study research begins with the selection of a clear research focus to which the investigator continually refers to throughout the inquiry. This focal point is founded upon the formation of a question or questions about the condition, circumstance or issue being studied related to the objective of the research. Manifold and diverse sources of data including existing documents, interviews, and observations, are then utilized to yield information leading to a conceptualization of the case and answers to the research question(s) (Soy, 1997). The investigatory process culminates with an exposition of answers to the research question(s) grounded in a methodical analysis of the collected data using appropriate qualitative procedures (Hancock et al., 2006).

The principal research questions binding this case were:

1. What role, if any, does Christian spirituality play in recovery from anorexia nervosa?
2. What specific Christian spiritual interventions, if any, support recovery from anorexia nervosa?

Data Collection Procedures

In this study, the research questions were addressed by collecting and analyzing data from carefully selected documents, interviews and observations. The particular "purposeful sample" (Patton, 2001) of sources were selected because of their potential to bring forth the richest amount of pertinent information relevant to the study.

Existing Documents

Even though little empirical research has explored Christian spirituality, counseling practice and recovery from anorexia nervosa, documentation of integration exists in diverse forms. The following documents were collected and analyzed:

- Documents recommended by and collected from colleagues who have specialized in treating eating disorders from a Christian perspective.
- Documents recommended by and collected from the observation site, including all the back copies of the facility's periodical (which was introduced in 2003), their based on facts novel, written for the express purpose of delineating their Christian treatment approach, and several other documents related to their facility and its treatment protocols.
- Outlines and other documents (including journals, poems, stories, books or professional texts that document recovery from anorexia nervosa) from interview participants.

Interviews

In order to prevent excessive data build up (Creswell, 2007; vanManen, 1990) there was a limit of eight research participants (Hancock et al., 2006). This number was chosen because, according to Boyd (2001) and Groenewald (2004), it provides ample enough data to promote "saturation," or full compilation (Creswell, 2007). Purposeful criterion sampling was used to insure that participants would have knowledge and insight that would provide important information regarding the research questions (Babbie, 1995; Greig & Taylor, 1999; Schwandt, 1997). Additional participants were found by

using “snowball sampling, a method of expanding the sample by asking one informant or participant to recommend others for interviewing” (Grownewald, 2004, p.9). The interviewed sample was volunteers who were either recovered from or specialized in treating anorexia nervosa.

At the time of recruitment the researcher screened potential participants to determine if their qualifications fit with the purposes of this study. Demographic information was also collected at that time. The screening entailed directly asking potential participants if they (a) were Christian, as broadly defined in this document; (b) were recovered from or specializing in treating anorexia nervosa; and (c) if their faith related to their recovery or work with patients. Because it was anticipated that the recovered would have especially relevant data to contribute, five interviews were with recovered individuals and three were with doctoral level clinicians. This combination sample was chosen based on the believe that it would yield the most pertinent information (Hancock et al., 2006). In terms of prior relationship, two of the recovered participants had previously been in treatment with two of the clinicians two to four years prior to the research.

Participants were asked to read, discuss, and sign a consent form which delineated the purposes, procedures, risks, benefits, and confidential/voluntary nature of participation in the project and were given the opportunity to ask questions prior to signing the consent form (Appendix A). Participants were also encouraged to withdraw from partaking if at any point they changed their mind about their involvement in the study and they received a copy of the consent form for their own records.

Because ethical research involves protecting subjects from the potential risks involved in human research (Creswell, 2003; Denzin et al., 1994; Kazdin, 2003), volunteers were also notified that participation in this study could include feelings of discomfort, including anxiety, shame, and sadness. The steps taken to minimize these risks included researcher empathy and therapeutic skill, preparatory outline writing, the encouragement of thoughtful consideration prior to participation, confidentiality, informed consent, the availability of debriefing with the researcher after the interview, referral back to the referring therapist for debriefing or treatment, and the ability to revoke participation at any time.

Once the sample of eight participants was established, the researcher followed the guidelines articulated in the interview protocol (Appendix B). Participants were asked to write a detailed outline describing their experience of Christian spirituality, counseling practice, and recovery from anorexia nervosa. This outline served as a means to prepare for and prompt during the interview.

The interview was an "informal conversation," in which "questions were derived from the ongoing context and asked during the course of the interview without predetermined questions, topics, or wording" (Hancock et al., 2006, p. 43). The researcher entered the world of each interviewee with a deep desire to fully understand communicated experience. Her stance was very much in keeping with Moustakas (1994),

> I do not select, interpret, advise or direct. Being in the world of the other is a way of going wide open, entering in as if for the first time, hearing just what is, leaving out my own thoughts, feelings, theories, biases. I enter with the intention of understanding and accepting perceptions and not presenting my view or reactions, I only want to encourage and support the other person's expression, what and how it is, how it came to be and where it is going. (p. 82)

This approach considers participants "co-researchers" and was characterized by

> accurate, empathic listening; being open to oneself and to the co-researcher; being flexible, and free to vary procedures to respond to what is required in the flow of dialogue; and being skillful in creating a climate that encourages the co-researcher to respond comfortably, accurately, comprehensively, and honestly in elucidating the phenomenon. (Moustakas, 1990, p. 48)

During the interview, if prompting for information was needed, co-researchers were encouraged to utilize their outline to organize their explication. The researcher also asked open ended questions to keep the focus on their experience of Christian spirituality, counseling practice, and recovery from anorexia nervosa.

Volunteers met individually with the researcher for one 60 to 90 minute audio taped interview. For co-researchers living out of state, the interview occurred via telephone. Instead of taping these interviews, the researcher wrote detailed notes during the conversation and then e-mailed these to participants to confirm their accuracy. Transcripts of interviews were mailed to participants to verify correctness and to have participants add anything pertinent they may have missed during the interview. Additionally, follow up interviews, phone contacts, and e-mails occurred, as needed, in order to clarify the research data and to have co-researchers review their interview transcript to insure accuracy or add to their content.

To complement and "triangulate" (Kazdin, 2003) the interview data, personal documents volunteered by participants were also collected. These included journal entries, academic papers, published articles, presentation notes, and documents written by former patients of the clinician co-researchers.

Observation

In case study research ethically informed and responsible observation of an appropriate research related setting is often utilized (Hancock et al., 2006). In this study descriptive and reflective observational data were collected during a two day visit to a residential eating disorder facility that provides

> (a) treatment exclusively for girls/women suffering from eating disorders; (b) treatment grounded in Christianity; (c) multi-disciplinary treatment teams; (d) specialized therapies including art, equine, body image, trauma, and challenge course; (e) individualized treatment based on multi-phase assessments; (f) longer-term, intensive treatment (45 to 90 days); (g) a total staff to patient ratio of 3.5 to 1; (h) non-institutional settings; (i) ongoing outcome research; (j) intensive family week; (k) treatment of co-occurring disorders; (l) state licensed and accredited programs; (m) a history of treating over 6,500 women and girls; and (n) comprehensive aftercare and follow-up. (treatment center information packet)

The observation period consisted of collecting relevant documents, exploring the facilities, and meeting with and hearing presentations from the staff. An overview of the facility's programs for eating disorders was first gained. Next, meetings with and presentations from a program specialist, recovered patient, psychiatric provider, nurse, medical doctor, nutritionist, psychotherapist, psychologist, director of performance management (treatment outcomes), and chaplain occurred. Finally, a tour of the facilities and a demonstration of experiential interventions occurred. Additionally, the facility's published book depicting the process of treatment (Cooper, 2006), along with their journal were collected and then carefully assessed for additional information relevant to this study. During the visit observation data were methodically chronicled for subsequent appraisal and analysis.

Data Analysis

Because case study research entails collecting information from multiple sources, a copious amount of data was engendered and methodical organization became imperative (Soy, 1997). Taped material was transcribed verbatim. Document and observation data were carefully labeled and stored in files along with preliminary elucidations of the information to be utilized later in order to triangulate interview data and expand on the findings.

Moustakas' (1994) method of phenomenological analysis was used as the structure for processing the interview data. This entailed listing every expression relevant to the experience, determining the primary constituents, clustering information, discerning and labeling core themes, validating themes, constructing textural descriptions, and, finally, developing a composite description of the meanings and essences imbued in the data relative to Christian spirituality, counseling practice and recovery from anorexia nervosa.

The organized, categorized and analyzed data were then synthesized into a written reporting of significant and meaningful research findings. The underlying goal in this process was to present a report of the outcomes that was comprehensible, that meaningfully conveyed the research topic, was well organized, staid and scholarly, was replicable, narrative, and experiential, was replete with excerpts, was reliable and valid, and amply imparted information that sanctioned the research findings and conclusions (Hancock et al., 2006).

Trustworthiness and Validity of the Research Findings

Triangulation refers to the protocols that provide validity to case study research data and addresses the investigator's ethical responsibility to control misapprehension and misinterpretation (Hancock et al., 2006; Kazdin, 2003; Stake, 1995). Because of its use of diverse forms of data collection, which were compared and contrasted, this research allowed for built in forms of triangulation and validation.

In terms of descriptive validity, the narratives and accounts found in this document were reported as accurate by the co-researchers. Additionally, the interpretations of the data (interpretive validity) were reported to be accurate and credible by research participants and others not involved with this study. Then too, the inferences from the data (theoretical validity) were reported to be plausible by the research participants and the readers who were not involved in the study. Also, triangulation between document, observation, and interview data, the literature, and feedback from external readers confirmed the credibility of the research findings (internal validity) and controlled for bias and artifact.

The generality of the findings to diverse populations, circumstances, and situations (external validity) is found in the relation of the specific findings to the field of counseling in general. In the case of this study, applicability lies in the template the model provides for further research on diverse disorders, faiths and populations. Although the findings from this study relate to a finely circumscribed population (Christian, anorexic, Caucasian women between the ages of 22 and 50 who found that their faith substantially supported them in recovery) the experiences of the sample have general and universal meaning. As Kazdin said (2003), "placing a microscope on

experience has value in deepening our understanding" (p. 341). This study not only deepens our understanding of the importance of spirituality in the treatment of anorexia nervosa, but the value of spirituality in clinical practice in general, and the need for research that delineates spirituality in the treatment of the various disorders and populations as well.

This section has discussed the trustworthiness and validity of the findings. Findings from this study appear to be valid, reliable, and credible.

Summary

This chapter presented an overview of the case study method and the *raison d'être* for utilizing it in this study. The case was demarcated, and details regarding the research questions, data collection, data analysis, and data confirmation procedures were provided. The next chapter will present the research findings including a description of the co-researchers and the themes that emerged as a result of the phenomenological analysis of the collected case study data.

CHAPTER FOUR: FINDINGS

Overview

The purpose of this research was to add to the empirical literature on spirituality in counseling practice by exploring spirituality and recovery from anorexia nervosa. In particular, this study, in keeping with the recommendations made by Richards and associates (2007), sought to expand the knowledge base of health promoting spiritual integration in counseling practice with anorexic, Christian women. During the process of evaluating, interpreting, and presenting the relevant literature on this subject, a spiritual integration model for use with this population emerged (See Figure I). This model reflects the researcher's personal, interpretive and inferential experience with the data within the literature (Eisner, 1991).

The focus of this document now shifts from presenting the literature and what is known about this subject to the collected data and the objective of creative synthesis (Moustakas, 1994); or creating the phenomenological text (van Manen, 1990). In this process of sense construction (Eisner, 1991), the researcher has the responsibility of choosing how to proceed, not based on objective standards, but on the demands and needs of the empirical situation (Milacci, 2003) and the desire to accurately portray the phenomena under investigation (Crabtree & Miller, 1992; Hammersley, 2000; Mouton & Marais, 1990). In this chapter, descriptions of the co-researchers will first be provided. Subsequently, the themes that emerged from a phenomenological analysis of the data will be given.

An Introduction to the Co-researchers

In this section the eight interview participants, Paige, Jennifer, Sondra, Caitlin, Rosalind, Dr. Jessie, Dr. Carmen and Dr. Benjamin (all pseudonyms) will be described in terms of their experience of Christianity and either recovering from (referred to as "the recovered") or treating (referred to as clinicians) anorexia nervosa. A general description of the group will first be given followed by a brief portrayal of each individual co-researcher.

The Co-researchers in General

As a whole, the co-researchers had several things in common outside of the inclusion requirements. All, for example, were interested in participating for the purpose of helping people who suffer with this illness and each gave of their time, energy, and resources honestly, openly, and generously.

Demographically, all of the co-researchers were born and currently reside in the United States and are Caucasian. The recovered grew up in intact, albeit some troubled, middle to upper class families that they identified as Christian, with varying degrees of faith and practice. In terms of marital status, five of the eight co-researchers were married, including all of the clinicians. Regarding age, the recovered ranged from the mid-twenties to mid-forties, with two to fifteen years of recovery; clinicians from the mid-thirties to early sixties, with seven to twenty two years of experience treating eating disorders.

Additionally, prior to the development of anorexia nervosa, all of the recovered had experiences, often multiple, wherein they felt scared, out of control, isolated,

neglected, lonely, sad, or traumatized. Sondra, for example, faced several distressing incidents that "wrecked havoc on my sense of security:"

> My mother had an affair with a neighbor and I felt abandoned by both she and my father at that time. I was painfully alone, both at home and with my peers. I didn't know where to go with all that was happening. Not to mention that two really scary things, sexual things, happened with boys and there was the constant sexual innuendos from my school headmaster too. Everything was out of control.

The experience of life "feeling out of control" and "unbearably painful" was commonly expressed by the recovered, and the clinicians, as well, pointed these factors out as primary to the etiology of the disorder.

Then too, the recovered reported struggling with their Christian faith and having a distorted understanding of its primary tenets. Dr. Jessie, for example, shared that for her Christian patients,

> God is really viewed as just another possible source that would want to come in and make them something that they would not want to be. They are as suspect of God as they are of all others. So with the anorexic patient, perhaps you have a history of maybe a mother or a father, who wants them to be a certain way, wants them to look a certain way, wants them to act a certain way. When other people have been in their lives, those people wanted them to be different than themselves. So usually when we get them, they really have never been themselves. They have fitted into whatever cookie cutters other people expected them to fit into.

Paige put it simply, "blah, blah, blah about God in my house and in my church. I wasn't a solid enough person to focus on God or believe that anything I heard about Him applied to me at all. Love me? Nope, that never got near my heart."

Finally, the most notable and significant commonality, relative to this study, was that each of the eight co-researchers was passionate about their belief that Christian spirituality can play a central role in recovery from anorexia nervosa for the Christian. Jennifer captures the perspective shared by all the participants,

> For four years I believed anorexia was part of who I was; that it was here to stay. But through the tender guidance, support, and accountability I found in treatment, I realized that I can choose to be free, to believe the truth. I saw the hope and I determined I was going to conquer this illness; and through the Lord's love I truly was freed from this obsessive disorder.

The Co-Researchers as Individuals

In this section individual portrayals of the eight co-researchers, in reference to Christian spirituality and recovery from anorexia nervosa, will be provided. The recovered participants will first be described, followed by the clinicians.

One important detail to note about the recovered co-researchers' stories is that words on paper fail to capture the depth of emotion and expression behind them. Residing beneath the words is the reality of the inexplicable pain and suffering that preceded self-starvation. These women did not choose anorexia nervosa without reason; they were not foolish or lacking intelligence in any way. Rather, the illness was akin to a raft of refuge they clung to in order to escape a sea of terror. As Dr. Jessie put it, "the anorexic is like someone who found a lifeboat on a sinking ship and it is keeping them from drowning, it is keeping them alive, and it is very important to them." These courageous, determined, and remarkable women, for the purpose of helping others, chose to relive their excruciating journeys and openly share about how their Christian faith impacted their recovery from anorexia nervosa.

Paige, at the time of her interview, was working part time as a school nurse, raising her nine year old son, and "having the busy, crazy life of a doctor's wife." Her husband, who has had intermittent bouts with his own eating disorder and "can be

emotionally abusive at times," had three young boys from a previous marriage, now grown, whom she also participated in raising.

Professionally, Paige is trained as an obstetrical nurse but admits that her real passion is her love for animals. She shared that "one of my favorite things in life is riding my horse Ellie. It just all comes together on a horse."

Presently in her forties, Paige developed anorexia nervosa at the age of 14 and suffered with the illness for almost 20 years. "Puberty was just too painful, and kids are so mean. Anorexia was my way of determining to never be hurt again."

While in her twenties, a crisis in Paige's marriage brought her into counseling. She sought out a Christian counselor because of her religious beliefs, but, looking back, feels that "I wasn't at all walking close to God" at the time. "I had no sense of my faith during the illness, no sense of my faith or myself at all really. At such a low weight there is no sense of anything or anyone at all."

Paige considers herself "completely recovered from anorexia for about ten years now." She attributes her recovery to the focus on faith that occurred in treatment with a Christian counselor. Like the other recovered co-researchers she can "feel the pull sometimes back to the old familiar ways" but knows that "I will never go back to that starving madness again."

Jennifer, now in her early twenties, single, and a recent college graduate, was contemplating further education at the time of her interview. She shared that her present passion and "earnest desire is to expose the truth that freedom [from anorexia nervosa] is attainable!" Whenever she can, she speaks publically about the hope for recovery she has found through her Christian faith.

Jennifer developed anorexia nervosa during her sophomore year of high school when she felt "cut off from everyone and painfully alone." She spoke of how "a tormenting and demanding voice from within me that I thought I needed to obey" emerged out of the vacuum of attachment she found herself in. Jennifer finally lost interest in everything that was good and real to her and devoted her entire being to following the dictates of "the voice."

When Jennifer's weight dropped dangerously low, at the insistence of her parents, she entered out-patient counseling, which included medical and nutritional monitoring. Like the other co-researchers, she remembers seeking out a Christian counselor because of her faith, even though she believed that she was "constantly letting God down and He couldn't help but be disgusted with me." In counseling, Jennifer was introduced to the idea that "the voice of anorexia" was an influence that she had no obligation to obey; and she began to consider the fight against anorexia nervosa as representing a "spiritual battle." She shared that through the four years of struggling to recover, "it was never over until I began radically incorporating the truths of my Christian faith." She reported that she has been recovered from anorexia nervosa for more than four years now.

Rosalind, like Jennifer, is also single and in her twenties. A recent graduate of nursing school, she was looking for a professional nursing position at the time of her interview. She shared that as a result of applying her faith in recovery, "I want more than anything to work as a nurse at the Christian, inpatient facility I was a patient at." She believes that her greatest joy is co-facilitating a Christian eating disorder support group at the church she is presently attending.

Rosalind's ten year struggle with anorexia nervosa began when she was 12. A move abroad, dealing with a painful physical condition, isolation from peers, and feeling "completely controlled by my mother" were a few of the factors that preceded the development of the illness.

Rosalind's experience in treatment began with in-patient hospitalization due to her extremely low weight. Her anorexic and bulimic practices put her in great danger of death. She remarked,

> At that time, my physical body had finally begun to give up after nearly seven years of starving and then binging and purging. When my body started to give up on me I had to be hospitalized numerous times. I had acute dehydration and related symptoms and a life-threatening low potassium level. I was at death's door, and I honestly didn't care anymore…

After several hospitalizations near her home, Rosalind entered a residential treatment facility that provided eating disorder treatment from a Christian perspective. She and her parents chose this option because of their Christian faith and the positive reports they had heard about the facility. After six months of residential treatment occurring in three separate intervals, "I finally gave up control and began my journey of recovery with my treatment team and God. It took me that long to trust enough to let go and believe there was a better way to meet my needs." Rosalind has been recovered from anorexia nervosa for two years.

Like Rosalind, Sondra, a college graduate, developed anorexia nervosa when she was 12 years old. She is now in her thirties and enjoying her life as a "wife and stay at home mom, especially being mama to my two girls and doing just about anything with them. Cuddling and reading is probably first and foremost on the list."

Sondra remembers always "being extra sensitive growing up and an extreme perfectionist." She reported that after feeling "isolated from and rejected by peers and hounded by the constant pressure to be flawless in every way," the anorexia nervosa emerged just after the transition from elementary to junior high school.

From the ages of 12-29 Sondra saw various counselors, but found that "nothing was really helpful. Nothing stuck." She was deceptive about the treatment plans and "never really got on board." She just couldn't give up "the security and control of anorexia." During her last stint in treatment Sondra sought out a counselor who was Christian and who specialized in eating disorders. According to Sondra, over a two year period in treatment "I found my faith and my recovery." She has been recovered for more than three years.

Caitlin, a single fitness instructor in her late twenties, considers herself passionate about two things: "God and fitness." Presently she is also enrolled in a master's program in Christian counseling and hopes to utilize her training to help others recover from eating disorders in the future. She shared that what she really wants most is to be married to "an awesome guy who loves the Lord and is crazy about me." Second to helping people take care of their bodies, Caitlin loves "traipsing about with my two big dogs who have loved me through recovery."

Caitlin developed anorexia nervosa at age 22, when she graduated from college and had to make a decision about what she was going to do with her life. Unable to manage the tumult of insecurity and panic, she chose to focus instead on losing weight. Before long she weighed 80 lbs.

Caitlin's recovery story is unique because it occurred outside of the context of formal counseling. Because of her training in nutrition and fitness, and her avid reading on the subject, she led herself through a process of self-directed recovery that included all the empirically based treatment components for anorexia nervosa, only personally applied. Although she did not have a trained counselor, she had the support of her pastor, spiritual community, and family for accountability and direction. Caitlin remained in the sample because her recovery journey can teach us much about Christian spirituality and recovery from anorexia nervosa that directly apply to counseling.

Caitlin has been recovered from anorexia nervosa for ten years now. She commented, "I know I am fully recovered from anorexia, totally; I consider myself a fully recovered control freak."

In addition to the five recovered co-researchers, three clinicians who specialize in treating eating disorders were also part of the sample. Drs. Benjamin, Jessie, and Carmen, storehouses of knowledge and experience regarding Christian spiritual integration in the treatment of anorexia nervosa, gained their positions of authority by walking in the trenches with countless suffering women, women who were privileged to lean on these stalwart resources of compassion and expertise.

Dr. Benjamin, a clinical psychologist, overseer of the psychological services at a residential eating disorder facility, and specialist in treating eating disorders for almost two decades, is a psychotherapist, presenter, researcher, writer, and diagnostician. Dr. Benjamin has devoted his life to treating women with eating disorders from a "bio-psycho-social-spiritual perspective."

Dr. Benjamin, who is married and in his fifties, has treated countless women suffering from anorexia nervosa who have benefitted from an integration of their Christian faith into their treatment. He believes this is because "the Christian worldview addresses the primary needs and concerns of the human heart, needs that directly relate to the development and maintenance of anorexia."

Dr. Carmen holds a PhD in counseling and has worked with Christian anorexic women since 2001. Like Dr. Benjamin, she is passionate about Christian spiritual integration in the treatment of anorexia nervosa, because "I have seen remarkable results."

Dr. Carmen, who is married and in her thirties, provides individual and group counseling services at a university counseling center. She is also adjunct professor for a Masters in counseling program at a state university. Additionally, Dr. Carmen teaches doctoral counseling students as adjunct professor at another university, and she presents lectures and seminars on eating disorders on campus and at other local universities.

Dr. Jessie has treated anorexic patients from a Christian perspective for over 20 years as a clinical psychologist. Akin to Drs Benjamin and Carmen, she has a tremendous amount of wisdom to impart regarding Christian spiritual integration.

Dr. Jessie, who is married and in her early sixties, is the Associate Director of a counseling center and specializes in the treatment of eating disorders and women's issues. She has presented research and clinical papers on eating disorders to national and international professional organizations, and conducts in-service programs at clinics, hospitals, dental and medical conferences, and schools. Additionally, Dr. Jessie is a former director and international board member of a Christian counseling association and

has received awards for her exceptional work in the area of counseling women with eating disorders. Like Drs. Benjamin and Carmen, she believes that her "Christian faith is the most important and powerful resource" she brings to the clinical relationship.

The preceding vignettes have been given in order to impart a sense of the individuals behind this study, the eight co-researchers whose narratives are the foundation of the research findings. In the next section, my interpretation of their accounts will be presented as the themes derived from a phenomenological analysis of the collected research data.

Christian Spirituality and Recovery from Anorexia Nervosa: Themes Found in the Data

This section of the findings presents the three main themes and eight sub-themes that emerged from the co-researcher narratives.

Theme One: Prior to Treatment: Spiritual Disconnection

The Suffering and Brokenness

The recovered co-researchers described their pre-treatment existence as entailing intense suffering and brokenness, as Dr. Benjamin put it, "in every aspect of their humanity: body, soul, spirit, and interpersonal relations." Their accounts portrayed a period of uncontrollable and unbearable emotional pain that came just before the development of the anorexia nervosa. For many, this pain was typified by an agonizing sense of aloneness and shame, including spiritual disconnection and feelings of unworthiness (as described in the third sub-theme) and the entry of what was experienced as a cruel and unyielding internal construct demanding perfection and obedient control.

Paige, for example, said that the physical symptoms of anorexia nervosa, "the hunger, the absence of energy, constantly being cold, and the obsessive need for control" were secondary to the torment that preceded the illness.

> I had been mercilessly teased for being chubby and I can't describe how horrible that was. It was so humiliating and scary and I hated it; I felt like a disgusting nothing of a person. I was going to the lunch room and sitting with people I didn't know and felt really uncomfortable with, so I just started skipping lunch. I didn't feel like I was good enough. I tried to pull myself up by my bootstraps, but I just couldn't. My dad was really athletic and he would make comments about my weight. He didn't mean it but it really hurt. I buried all of my feelings and lost myself in an endless striving to be perfect in every way.

Paige described this intense drive for perfection as emanating from an internal proclamation that she be beyond reproach in every way. She never questioned the demands of this "voice," which eventually impounded so much of her life that there was "nothing left but the rules and rituals of anorexia." One by one, Paige let go of her interests; and as her world constricted, so did her body. At 70 lbs., she was hanging on by a thread, a shadow of the vibrant teenager she once was.

Jennifer, like Paige, also experienced an intense isolation from others, which she found insufferable, as well as a forceful, severe pressure from within to be perfect.

> I went to the same private school from pre-school through eighth grade and had the same friends for all those years. But for high school, my parents moved me to an all-girls private school. My freshman year there was terrible; I had no friends. I couldn't seem to make any close friends at school, church, or youth group.

Jennifer remembers that during this period of isolation "my mind turned against me."

> I plunged into negative thought patterns, becoming extremely hard on myself. Whenever I made a mistake, even something trivial, I sent myself down a spiral of insults that had nothing to do with the original mistake. It seemed the only way to climb back up was to not eat, to make up for the mistake. I would repeat this cycle over and over; it was my own fault I didn't have friends, I didn't do well enough in school because I was lazy, I was constantly letting my family down, troubling them with anorexia, letting God down, wasn't making anyone proud of me.

For Jennifer, the relentless internal critique demanded a perfection that was unattainable but required.

Rosalind's ten year ordeal with anorexia nervosa also emerged out of a deep sense of isolation and with it, trauma. The unbearable emotional pain that ensued led to a subjective state of despair and anxiety which were the forerunners of what she considered a compulsion "to gain control through dieting." During her interview, Rosalind, like the others, spoke about a relentless pressure from within, whose dictates eventually had "complete control over me;" leaving her with no sense of herself or functioning apart from anorexia nervosa.

Eventually, years of living in a state of disassociation and starvation led to severe mental, emotional, and physical deterioration. When she could no longer starve herself she engaged in binging and purging. Rosalind gave up hope of ever recovering.

> I wanted to fight, I really did, but my mind was already convinced that I could not win- that there was no chance, no glimmer of hope. I hated how I would be driving, reading, watching T.V., surfing the net, working or doing anything else, and out of nowhere the urge, the idea, the "demand" that I "needed" to binge and purge would come over me and there was nothing I believed that I could do about it, nothing! I tried to distract, I tried to sleep; I tried anything that I thought would or could possibly work.

Caitlin also experienced brokenness. Her suffering related to a deep sense of unworthiness and disgrace that haunted her "ever since I was a little, little girl."

> I put up a front, but inside was all covering up the fact that I didn't feel worthy. I felt like I had to be perfect, I had to have control over things because I had no value, I had no worth. I was a nothing, an insignificant no one.

This shame kept Caitlin from connecting with others and led to years of isolation and despair. She felt condemned by those in her outside world and condemned by a "voice" from within.

Like Caitlin, Sondra's suffering was also connected to an agonizing feeling of unworthiness and ignominy that constantly hounded her beginning at puberty.

> I think my illness started when I hit puberty. It was very, very uncomfortable for me; I was having issues of where I fit in with my friends; that whole junior high thing. My parents did not realize how hard it was, how deep the pain was. I felt out of control in my life. It was summer and I was 12 and there were issues with boys [and abuse]. It really was more than I could bear. I wish I could have talked to my parents, but I didn't come from a real open home. My parents said I should be friends with everyone, make everyone happy. They couldn't hear me. My dad became distant with me when I started puberty and my mom and dad were having problems. My mom had an affair. It was hard because my parents had prominent places in church and I couldn't talk to anyone about it. I overheard them talking about the affair. Instead of ministering to me, they worried about me telling others. It was my next door neighbor and his daughter who had been my best friend. I lost her. My mom finally broke up the relationship with my neighbor, my neighbor built a fence, and they became mean. I really had no one and nowhere to go with all of the emotional pain, it all felt completely out of my control.

In addition to the recovered co-researcher discourse, the clinicians also brought up the theme of suffering and brokenness during their interviews. At the observation site where I met Dr. Benjamin, I witnessed starving girls and women with nasal-gastric feeding tubes and emaciated bodies; their anguish apparent in their vacant eyes, their torment emanating from their corpse-like figures. Dr. Benjamin spoke about the illness being complex and multi-determined, and related it to his Christian view of the suffering embedded in "a broken world," which he elaborated on in a document from the observation site,

> We experience this brokenness within our very organisms. This brokenness is often referred to as the fallen or sinful condition of the world. As a condition, it is not the same as the committing of individual, personal sins. Confusing the two can be the source of hurtful ideas that emphasize judgment and condemnation instead of God's loving redemption. The fallen or broken condition of the world creates vulnerabilities in every aspect of our humanity: body, soul, spirit, and interpersonal relations.

Dr. Carmen echoed this view of multi-determinism when she shared that prior to the development of anorexia nervosa several problems are usually present that have caused untold suffering for the patient. These include "family/systemic problems, parental control, enmeshment, disengagement, abuse, a child-like mindset, perfectionism, dichotomous thinking, low self-esteem, and spiritual influences."

Finally, Dr. Jessie spoke of the suffering that arises from an internal world that is void of basic trust and the internalized attachment figures which are normally the foundation of healthy development and identity. Consistent with the conclusions of Levenkron (1997; 2000), Bruch (1978; 1995) and others (e.g. Bloom, Zaphirophodes, 1994; Waller, 2007; Walle et al., 2007), Dr. Jessie has found that in lieu of healthy attachment, anorexic individuals possess an internal abyss that is comprised of "dystonic and abusive internalized objects" and voices. As a result, intolerable psychological suffering ensues which is defended against via the psychological mechanisms of anorexia nervosa. Dr. Jessie spent much time elaborating on the clinical importance of understanding anorexia nervosa as literally "holding the patient psychologically together." She believes that clinicians must fully appreciate the level of brokenness behind the disorder if they are to work successfully with this population. I saw a sign on Dr. Jessie's office wall that reads, "What we call their symptoms, they call their salvation." After my interviews with her, it was clear why.

Taking Control of Brokenness through Anorexia Nervosa

As was seen in the previous section, behind the development of anorexia nervosa there is a trail of multi-determined suffering and uncontrollable, unbearable emotional

states. Additionally there is a famine of interpersonal resources available to help cope with the pain. According to the co-researchers, out of the experience of disconnection, confusion, and suffering anorexia nervosa transpired, functioning as distraction, hoped for means of meeting unmet needs, expressive metaphor of the brokenness of her being and, primarily, as a means of feeling some semblance of control.

For Paige, the obsessive and compulsive behaviors of anorexia nervosa distracted her from the emotional suffering and granted her "some crumbs of attention." Like the rest of the recovered co-researchers, the anorexia nervosa's provision of control was primary.

> Then I found a calorie counting book. Suddenly it became a game to see how much weight I could lose over the winter. In spring I had gotten so much positive feedback about the weight loss that I decided not to eat at all. I also started to exercise compulsively. I kept losing and losing. When it got hard to not eat any longer I stumbled into purging and using laxatives. My relentless pursuit of bodily perfection completely distracted me from the former pain I had been feeling. I had traded one kind of pain for another; but in this one I had complete control. My mind was totally consumed.

Sondra, like Paige, also felt "completely out of control" prior to the development of anorexia nervosa. She said that she could not control the way others treated her or viewed her and she could find no means of terminating the pain from within. When she started dieting, however, Sondra felt a sense of power, control, self-esteem, and even invincibility. With every pound of weight loss, came more hope, approval, peace, excitement, attention, admiration, and confidence. She recalled,

> I finally had control and could become beyond the reproach of others. I had the power to keep them from hurting me. My life became so focused on what I was eating and not eating and I was getting a lot of attention from my parents for it. Everything was about weight and food, everything. All the other issues and problems receded. Soon my weight got very low… and I felt glorified.

Rosalind also talked at length about how the anorexia nervosa provided her with the feeling of control that she “desperately needed and wanted.”

> At the beginning of the anorexia, I believed I was in complete control over it. I decided when and how I would engage in it. I had the "power" when I would find myself bending my head over a porcelain bowl, a bush, a garbage can, a bucket, or anywhere I was, forcing my body to purge of its contents. In hindsight, I find it ridiculous and sad at the extremes I would go to in order to feel a sense of control, over anything, anything at all. But soon, the control shifted. I lost the firm grasp I believed I had over it and it began to control me more and more. Anorexia grew and became stronger and stronger; in the end it completely controlled me.

Things felt out of control for Jennifer too. She spoke of how badly her self esteem was affected by her inability to make any friends. In the following excerpt her final remark echoes precisely what Rosalind said, above.

> No matter what I did no one let me in, no one wanted me for a friend. I really was trying hard too. I couldn’t understand what was wrong with me that no one reciprocated my efforts at friendship. Since I couldn’t force friendship, I turned to something I could force, I could control: eating. I was so pleased I had control over something; it made me feel so good. And I needed that, to feel good. The problem was that it required more and more of me; I mean when it started I had the control, but before long, it had complete control over me.

Caitlin, the last of the co-researchers, felt similarly to the others:

> My thinking was I don’t have value, I don’t have purpose. Those were the voices; I didn’t think there was purpose in my being here. I was all cut off from any love. I didn’t know how to get it, the love, the acceptance, the worth, the closeness. I didn’t know how to get control over my life. I struggled to figure out what I was going to do career wise, job wise. I was never supported in developing my passions, my identity. I didn’t know who I was. And it was so scary, like there was no security in anything for me. So, I would get on the scale and I had control over something. It wasn’t that I was deathly afraid of facing life on my own any longer, it was that I was deathly afraid of gaining a pound. I needed to have control so desperately. I couldn’t get control over anything else.

As can be seen from these excerpts, for the recovered co-researchers anorexia nervosa emerged as a means of coping with and controlling suffering. The clinician co-

researchers also spoke about the function of anorexia nervosa in the lives of the sufferer, and addressed the central place of control.

According to Dr. Jessie,

> With anorexia, their feelings of power and security and control and identity all come from keeping things out. They keep food out, they keep people out, and they keep life out. They keep feelings and needs out; everything is kept out because everything is suspect. If I let any of this in it will do something to me that I won't be in control of; like if I eat it will make me fat. If I let someone in my life they will end up controlling me, and want to shape me into something I don't want to be. So, the anorexia is a total metaphor on all those levels.

Dr. Carmen also addressed the issue of control in the life of the sufferer. Her experience has been that the anorexic is looking for control via anorexia nervosa, but has actually completely lost true control over herself. She said,

> Control is one of the biggest issues. They have come in for treatment because they have lost control. I help them to identify who and what is in control. They must come to recognize that they have lost control and the joy of life but that they can find what they need in a source apart from anorexia. That is when they are ready to really begin working. They must come to realize, "I am being controlled by this."

Dr. Carmen believes that Christian anorexics are "looking for an existential source of hope beyond themselves" and until they can secure it "will not be able to change because they still need the secondary benefits of anorexia."

Finally, Dr. Benjamin also discussed control as being related to one of the functions anorexia nervosa may be filling in the life of the individual with the illness. He said,

> It is important to identify why she has anorexia. What factors led to it, what is her motivation? We must remember that likely she is motivated to get rid of it and to keep it; it gives her things she needs. We must look for the function of it and then we can help her replace it with healthy ways to meet her needs. We can assist patients by understanding that anorexia is an unhealthy and irrational way of meeting rational, basic human needs. These underlying needs can be validated,

> while patients are encouraged at the same time to take responsibility for choosing healthier methods to meet their needs.

Dr. Benjamin believes that although their Christian faith has the potential to function as a significant resource to them, the anorexic is unable to tap into it for means of support.

Her Broken Faith

Although, as Dr. Benjamin explained, "the most basic and essential tenet of the Christian faith is that God is love," Christian individuals with anorexia nervosa are "not able to apply this love to themselves." This is because "she believes that she has so disappointed God that He has withdrawn his grace, love, and help from her and that in order to receive God's love again, she must earn it back."

Dr. Benjamin's words reverbrated in the voices of the other co-researchers as well. Similar to their experience of insecure attachment with the significant people in their lives and central to their suffering was their experience of inconsistent access to God's love and acceptance; to feel secure in relationship with Him. This failure of secure attachment in the spiritual realm prevented the recovered co-researchers from using their Christian faith as a resource to them in recovery. Caitlin expressed it this way,

> Even though I was a Christian, I didn't know God loved me. I knew He saved me and didn't want me to go to hell, but I didn't grow up understanding that I could have a relationship with this Father. I grew up in a strict Baptist church and it was all fire and brimstone. You'll go to hell if you don't do this, this and this. I guess I assumed God felt toward me the way everyone else seemed to, like I was a nobody and a nuisance.

Paige's words resonated with Caitlin's, "I grew up in a Christian home and I attended a Christian youth group, but I still didn't know the love of God. I didn't apply and receive His love or His perspective of me."

Rosalind associated the perfectionistic, cruel and dictator-like voice she heard from within with God's voice, assuming that He too expected perfection, was revolted by her, and could never love or protect her unless she flawlessly obeyed Him. She, like the other recovered co-researchers, was therefore unable to turn to Him in order to meet her needs for love and security.

As well, Jennifer and Sondra both were tormented with shame regarding their spirituality. Jennifer said that she thought God thought she was a bad person who "kept letting Him down, not doing anything to make Him proud of me." Sondra too, felt a constant sense of guilt and disgrace. She felt too unworthy to turn to God.

> I was a Christian and I was trying to have a relationship with God. I had a lot of guilt about the whole eating thing. Plus, my preacher's son had sexually assaulted me and the headmaster of my Christian school would call me into his office and cuddle with and kiss me (later he got fired). He would also send me notes that said he loved me. "I like your short skirts" type of thing.

Sondra was ashamed and confused and thought God was ashamed of her too.

Dr. Carmen explained that Christians in treatment experience God the way they have experienced the important people in their lives. She said,

> Usually when [Christian] anorexic clients come in I hear "God is distant; God doesn't love me; I don't know how to have a relationship with God; I don't know how real God is." The concept of God is so skewed: distant, uninvolved, "He is displeased with me." Their view of God is a complete distortion.

Dr. Jessie, as well, reported that for this population their failure to develop a basic sense of trust with people has transferred onto God. She said, "So, where does their spirituality come in? If they have a Christian faith, if they know God, if they have accepted Christ as their savior, all of that is still in the suspect category. They still don't want anything or anybody running their lives except themselves." Dr. Jessie has found

that these patients can't let go of anorexia nervosa until their frightening internal world becomes filled with some semblance of security, a security they cannot yet find in their faith.

Dr. Benjamin, as evidenced by this excerpt he and two colleagues wrote from the observation site, has found that Christian anorexics feel like they have been "forsaken by God" because of their disgracefulness.

> Feeling as though one has been forsaken by one's Maker is a crushing, even terrifying experience. Many patients with this belief are desperately trying to get God's love back; they believe that in order to receive God's love again, they must earn it back. According to the Christian Scriptures, this approach cannot succeed. It is, in fact, completely antithetical to Christianity. If there is one thing that distinguishes Christianity from other religious perspectives, one thing that so many Christians stumble over and struggle with, it is the belief that God's love, forgiveness, and spiritual restoration come not by our own efforts but from God's free unmerited grace.

Theme Two: During Treatment: Reconnecting with the Spiritual

The Person of the Therapist

Once in treatment, the recovered co-researchers reported that the therapist and their relationship with him or her was a primary factor in their recovery. According to the clinicians, the therapeutic relationship offers the opportunity for patients in treatment to redress the developmental disturbances, attachment failures, and interpersonal trauma that preceded the development of anorexia nervosa. In the context of the therapeutic relationship, emotional needs are redressed, new internal models of self and others are developed, and developmental impasses are resolved. Additionally, the therapeutic relationship has the potential to impact the Christian patient's inability to utilize her faith as resource in recovery.

From the perspective of Dr. Jessie, anorexic patients are not able to draw on their faith for the love and security it can provide because they have projected upon God the painful attachment experiences they have had with the significant people in their lives. One means of correcting these distortions is for patients to experience, within the context of the therapeutic relationship, a loving and secure attachment. She shared,

> What I have found to be true is, and this may sound arrogant but I don't think it is, is that we have to model God to them. The love, the acceptance, the mercy, the unconditional acceptance, the affirmation of them being a unique person; they have never experienced these. To affirm their unique personhood and to give them unconditional acceptance, trust; we have to model that, we have to be that for them.

Dr. Benjamin spoke at length about this, referring to it as the provision of "an incarnational relationship" wherein patients learn their true identity, receive what they are really hungry for via the therapeutic relationship, and are exposed to what the God of their faith is like. Although there are times when these are explicitly taught by comparing their sense of self with what is written in the Bible, Dr. Benjamin believes that the insight is best learned in the context of how they are viewed and treated in treatment. Once the patient is regarded this way "by someone with skin on" she can begin to believe that the God of her faith just might consider her that way too. He shared this during the interview and also wrote about it in a document from the observation site:

> We teach patients, via an incarnational relationship, that their need to be unique and special is God given, that they are special, not because they are better than other people, but because they are *irreplaceable*. They have to come to see that it is their irreplacableness and not their thinness that makes them special. Food has become dangerous because it threatens to stop the love, specialness, perfection, and adequacy. It has all become cockeyed. They must learn that the love isn't through the body it is because of who they are. The body is not the primary reason they are loved, respected, and special. God making you irreplaceable is where the love, respect and specialness come from. You are not your body or your performance.

In the context of the therapeutic relationship, Dr. Benjamin teaches people they are irreplaceable by perceiving and treating them that way.

Along the same lines, Dr. Carmen spoke about the need to help Christians in treatment come to see themselves as God does. She focuses on giving patients the experience of God's love while also explicitly using scripture to correct a faulty self image. She calls this using the "power of God's Word to help create a new framework for her to find her identity and value through God, and not in some quest for perfection." She models this by seeing and treating her patients in a manner in keeping with the Christian faith, that is, with the honor and dignity they are due as image bearers of God, and helping them to see themselves and treat themselves this way too.

The recovered referred a great deal to the impact the relationship with their counselor had on their recovery. Sondra, for example, shared that her counselor, through a patient modeling of God's character and love, brought her back to her faith, which then, "became the pivotal factor in my ultimate recovery." She said,

> Then I met my counselor, and she saved my life. She helped me figure out why I was feeling what I was feeling. She helped me feel loved, just talking to her. She never made me weigh in [the nutritionist was responsible for that part of the treatment]. She focused on symptoms yes, but she mainly focused on the real issues underneath. Why I wanted to hurt myself, why I was so unhappy with the way I was. She had a real gift of letting me look into the issues that were so hard. From ages 12-29 I dealt with a lot of counselors who dealt with symptoms and they weren't Christians. But just talking with my counselor made me feel loved, strong, and filled. It was like she was Jesus reaching out to me in love; consistent, patient, strong.

This sense of being cared about and understood by the therapist and its subsequent effect on recovery and faith is also captured in this journal entry from one of Dr. Jessie's recovered patients,

> She listened; she cared deeply about what I cared about. She often shed tears of sadness with me. Looking back I can see that I had no sense of who I was; I was very chameleon-like and full of fear. But who she was in my life made a place for me to come to know myself in a different way, a solid way, if that makes sense. It's like I became substantial in her presence, a person in my own right, not just a reflection of what others wanted or thought of me. I remember I used to drive home from her office feeling like once again the universe had clicked back into safeness and hope that I really could be my own person. Her patient kindness and steadfastness, it's truly what gave me the possibility of thinking of God as He says He is and not as my mind had made Him to be: mad at me, disgusted with me, thinking I was never enough. That's just what I felt at home and at school; never enough. But with my counselor I was always enough and after two years with her, my sense of faith had turned around. My sense of who I was did too.

Rosalind, as well, conveyed that it was in the context of relationship that healing took root. During inpatient treatment the whole treatment team provided her with the experience of nurture and support she desperately needed.

> The treatment team at the facility really cared about me. I was really bonded with people for the first time. I had to get to the point of trusting enough to get real with them, to be honest and let them into my mind and into this battlefield. I couldn't fight it alone, but before them, I didn't trust anyone enough to let them in.

Jennifer and Paige also discussed the qualities they found in their relationship with their therapists and how these impacted their recovery and the healing of their faith. Jennifer, who was used to living in the midst of a constantly cruel and exacting internal world, was released from internal torment within the nurture of the therapeutic relationship. She disclosed,

> My therapist was never in my face, never harsh, she was consistently kind, yet sharing incredible truths, giving helpful, patient direction; respecting not controlling me. It was an attitude I found in her, that basically she was saying, "I can provide you with counseling, a place to be vulnerable and real, accountability, acceptance, but in the end you must decide what you are going to think, the attitude you take and the perspective you take." It was like suddenly I have some choices, I can take control in a different kind of way. There was light at the end of the tunnel. No longer did I think this is just part of who I am, no, my counselor showed me I could choose to believe the lies that anorexia is part of who I am or I can believe that freedom from this is attainable. She gave me hope, in the way

> she treated me and the truth she taught me, that freedom from this prison was within my grasp.

Paige had a similar experience:

> When I started in counseling, spiritually, I was just not there. I couldn't see myself the way God did. I didn't have any sense of Him as loving father, protector, meeter of my needs. I was just filled with all kinds of shame. It wasn't until this disconnect between my beliefs and who He was in the Word was brought up in counseling; I hadn't even really thought about it. I certainly wasn't turning to Him as a refuge of comfort. I didn't even know He could be that for me. Before my counselor, I didn't know anyone could or would. He not only taught me I could find this in God, I mean, he not only told me this, I mean with His words and with Scripture, it was kind of the way I felt when I was with him; like I was someone who was worth this kind of love, this kind of being special to someone.

Not surprisingly Caitlin, who obtained recovery outside of formal treatment, did not discuss the significance of the therapeutic relationship. However, she did experience "redemptive" (McMinn, 1996) relationships in her church community and reported the significant impact these had on her recovery.

The Mending of Her Faith

Also prominent in the recovered co-researchers descriptions was the significant place faith came to have in recovery, once they were given the opportunity to explore and correct spiritual perspectives that were not congruent with the actual tenets of their Christian faith. One key factor in assessing these incongruencies was gaining a greater understanding and application of God's love.

According to the co-researchers, one function of Christian spirituality in recovery from anorexia nervosa is its provision of this love and security. Per Dr. Benjamin from an observation site document, Christian integration in the treatment of anorexia nervosa

> Supports the judicious use of scientifically-valid treatment methods while also offering a personal relationship with Jesus Christ that can renew the mind through scriptural truth and restore the soul through a covenant of continual forgiveness and unconditional love. Patients often need to examine their [spiritual] beliefs and the social context in which they arose in order to change unhealthy beliefs to those that are consistent with scripture. A cultural worldview sees the person merely as a body and teaches that one's primary value comes from appearance or ability to perform. Therapists may offer a biblical worldview that values who the person was created uniquely to be by a loving God, helping the Christian patient to establish her true identity in Christ.

The impact of receiving and applying God's love was frequently brought up by the recovered co-researchers as pivotal in their recovery. Rosalind, for example, shared that "if it weren't for a growing awareness of God's love, I wouldn't be able to… even now I may not be getting anywhere. If I didn't keep reminding myself that God loves me, I wouldn't have been able to replace those old coping methods."

Sondra found that when a Christian perspective of God was introduced and explored in counseling, it was like "a light turned on" for her. She remarked,

> As soon as it clicked, I made the decision that I am going to kick anorexia, and I clung to the reality that God loves me, He is with me, and He will lovingly help me. I found Him so willing to help, to provide the strength and the perspective I needed whenever I called out to Him.

Paige was also empowered in her recovery by exploring her faith in treatment:

> It (recovery) all came down to Jesus Christ providing me with the love and truth I had been looking for anorexia to provide. I just needed to train myself to go to Him instead and really believe it was for the taking. Not by how I felt, at first, but by choosing to believe what He promised me in his Word.

Caitlin found that when she came to understand what her faith actually taught about God's view of and love for her she was transformed. It was then that she was able "to start saying no to the brutal voice of anorexia" and start having internal dialog that was kinder and more self supporting. She said,

> So, I didn't really understand. It came down to the fact that I couldn't love myself because I didn't know the Father's love for me. I didn't realize that no matter who I was or what I do, if I am His, it doesn't matter if I'm perfect, if I have control of things. It took me a while to get that. The realization came to me over time. So, I had to start unbelieving a lot of lies. And then I had to deal with anger against my parents. I had to deal with the fact that I do have value, I do have worth.

She concluded, "I had to know my identity in Christ. That's what it came down to."

Dr. Benjamin's words resonate with Caitlin's. He shared that, "the biggest problem with eating disorder patients is that they don't love themselves; they are not committed to their own well-being. One of the big hurdles in treatment is for patients to understand their value and to treat themselves in keeping with their faith."

This recognition of having value, of being loved that is provided through faith, is captured in the following narrative written by one of Dr. Jessie's former patients,

> I realized that my safety and worth had nothing to do with my size or my ability to be what everyone else wanted of me. I didn't need to be seen by others a certain way because I knew how God saw me. I continue to need to hold on to that truth through various spiritual disciplines; that I am God's treasured and beloved possession. I don't have to earn this place through thinness, I don't have to protect myself through thinness, I don't have to deal with my rage at abusers through thinness and turning the anger against myself. I have learned to speak the truth in love, to say no when I need and want to. I am a person now, worthy of love and respect. If that is so, I can learn to love myself, I can be myself, I can know that no matter my size I am safe and never again to be abandoned. I will not rely on thinness to give me what it never can. I still get scared and when I do my mind reverts to the old path of protection. What a false savior, what a broken, empty cistern! I might hear it, but I no longer obey! One day my mind will be completely redeemed. Until then, I will trust Him, even when my heart fails me.

Jennifer reminisced about the transformation of her faith while she was in treatment. She let out a gleeful laugh in the middle of relaying the following,

> About my relationship with the Lord: It was very interesting. Before that I didn't understand God's perspective of me, how He sees me. That He loves me and supports me and gives me the strength, accountability, people. It was so

> refreshing, enlightening, and very different. I felt like I had a whole new relationship with the Lord, it is absolutely beautiful.

Dr. Benjamin wrote these words which echo Jennifer's,

> For Christians, healing, growth, and wholeness begin with this realization: We are loved unconditionally and irrevocably by God. God loves us! This is the foundation of our self-worth and ultimate healing. Not our actions, achievements, successes, appearance, talents, or intelligence-but the fact that the Creator of the universe made us in an act of love and loves us as we are. When individuals with anorexia really get this, it is a eureka experience: I am valuable because I am loved by God himself!

As do Dr. Carmen's,

> Their view of God is a complete distortion. It is such a joy to reintroduce to them who God says He is: "no condemnation for those in Christ." They have felt condemned forever. Tears come when they get this. This is freedom. I take them to Eph 1 and 2: chosen and co-heirs with Christ, this is who they are in God's eyes, no matter what sin is in their life. God himself is not holding them to the standard they are holding themselves to. We do not have to be perfect and righteous: He covers us with His righteousness.

Based on the experience of the co-researchers, a role that spirituality may play in recovery from anorexia nervosa is the imparting of an identity in which she is loved, unfathomably valued, and vigilantly guarded over; a far cry from the cloak of shame, worthlessness and terror that the anorexic previously identified with and has turned to anorexia nervosa to cope with. An understanding and awareness of God's unconditional love appears to directly impact the patient's ability to move out of the self abuse of anorexia nervosa and into loving self care. According to Thurston (2000) one common psycho-spiritual issue seen in conservative Christians is feelings of guilt related to meeting one's own needs or caring for the self. One effect of the internalization of God's love appears to be decreases in self-loathing and self-abuse. As per Dr. Benjamin,

> Knowing that we are all loved by God as his unique creations is a powerful unifying experience. When we discover that God loves us, seeks relationship

> with us, and above all wants to know us intimately, we recognize that we are not objects to him and we cease to objectify ourselves and other people.

The Tools

According to the co-researchers, Christian spiritual interventions (tools) are beneficial in the process of recovery from anorexia nervosa and correcting distortions in, and promoting the use of, faith as a resource in recovery. These methods were part of a multi-modal treatment plan that also addressed the bio-psycho-social aspects of the illness. Dr. Benjamin referred to such a plan as a "bio-psycho-social-spiritual" treatment strategy. The Christian interventions mentioned most frequently were Christian Cognitive-Behavioral Therapy (CCBT) and the application of the Christian perspective "Fighting the Good Fight."

Christian Cognitive-Behavioral Therapy (CCBT)

Cognitive-Behavioral Therapy (CBT) is presently considered the most empirically supported psychotherapeutic approach to treating eating disorders (e.g., Anderson et al., 2001; Corstorphine, 2006; Eberly et al., 2003; Eberly, 2005; Fairburn, 2005; Foreyt, et al., 1998; Garner, 1997; Geller et al., 2006; Leung et al., 1999; Manley et al., 2003; Wall, 2003; Waller et al., 2005, 2007; Williamson et al., 2004; Wilson et al., 2007). The primary focus of CBT is to teach patients how to determine if their thoughts, ideas, beliefs, and behaviors are true, rational and appropriate responses to situations and to change those that are not. Deeply held beliefs about the self and the world (schemas) are the most difficult to change and are often the foundation of eating disorder symptoms (Waller, 2004).

The clinician co-researchers reported that they utilize Christian perspectives in conjunction with CBT (CCBT). According to Dr. Benjamin, anorexia nervosa is an "irrational, unhealthy way of meeting normal, rational, and healthy goals." His experience has been that CBT, with the utilization of scripture and Christian principles to replace anorexic thinking, has been extremely beneficial with this population. As an example of its use, Dr. Benjamin and two of his colleagues wrote this from the observation site,

> In Christian CBT (CCBT) with eating disorder patients, mental renewal occurs when patients are offered and build a self-schema from Gospel truths. Key truths include: (a) You were created by a loving God with intrinsic value apart from your appearance, gifts, talents, or willingness to do for others (Matthew 10:30-31; Psalm 130:14; 1 John 4; (b) Nothing you have done in the past can change your great worth and value today (Lamentations 3:22-23; Romans 8:1; 1 John 1:9); (c) Your life has meaning, value, and purpose (Jeremiah 29:11); (d) What you are attempting to achieve through the eating disorder is a legitimate and appropriate need. It is not necessary for you to let go of this need; in fact, God intends to fulfill this need in a life giving way (Philippians 4:19; John 10:10); (e) The eating disorder may have worked to some extent in meeting your legitimate needs, but it is costing you much and is killing you (Proverbs 16:25); (f) You are not a powerless victim over the eating disorder or difficult experiences from your past. There is a way out (Romans 8:37; 2 Timothy 1:7; 1 Corinthians 10:13); and (g) the way out includes an examination of your beliefs and usual ways of perceiving the world, a new schema (Romans 12:2; 2 Corinthians 10:5).
> By assisting patients to renew the mind, Christian CBT promotes a therapeutic transformation: from irrational to rational schemas, emoting, and behaviors that are consistent with God's plan for each person whom he has lovingly made.

Like Dr. Benjamin, Dr. Carmen also makes extensive use of CCBT in treatment and reported significant positive results from its utilization with this population. She shared that she especially sees excellent effects with

> (a) Scripture flash cards: teaching patients to write specific truths about what they want to focus on when they are triggered to remind them of their goal. Reading and re-reading the cards helps them learn to fixate on the truth instead of the anorexic thoughts and behaviors. I encourage them to take the flash cards everywhere and to read them before, for instance, they purge. They need to see that they have a choice.

(b) Cognitive restructuring exercises: teaching them to write down the situation, the thoughts that are triggered (the lies), and the truth that can be chosen instead. For instance, if they think "I need to exercise for three hours." We then focus on the fact that they have a choice, that the thought, the situation/temptation is not in their control and it is not their fault. We look at the lies that work to make them give in to this situation/temptation. Then they draw two arrows, one goes to the lies, the other to the truth. In this example, one arrow goes to giving in to running for three hours and the lies that support it; the other arrow goes to facts and God's Word. After reflecting on these they can either believe the truth or give in to the lie side. I encourage them to fill out the sheet before they give in to the anorectic thinking or behavior.

(c) Keeping a prayer journal: teaching them to reflect on paper about God and about anorexia. I especially encourage using this tool when they don't really know who God is in truth. They put their thoughts down and then they write down what they think Jesus says based on the Word. This helps them begin to have conversation with God. It helps them ground it in God's Word. Just talking and conversing with him about their feelings and struggles with anorexia is new and freeing. The prayer journal also becomes a catalyst for conversation in the sessions.

Dr. Jessie also discussed the importance of helping patients differentiate from distorted, irrational thinking and uses Christian perspectives toward that end. Her experience has been that the therapeutic relationship needs to be solidified, including internalization of the therapist's voice and the healing of dystonic faith, before patients can really make good use of CCBT interventions.

The recovered co-researchers also discussed the significance of "taking thoughts captive" in their recovery. Rosalind provides an example of the primacy of relational security in the treatment context prior to the ability to use cognitive tools in recovery:

> That Saturday was the first day for as long as I can remember during which I had not engaged my anorexia in any way whatsoever since it took up residence in my body and mind nearly a decade ago. I am certain that this was because I finally trusted the team enough to give up control to them. For the first time, my anorexia's efforts to triumph over me proved to be in vain. It could not control me anymore because I had no control to give it. As I stated before, I had given control to my treatment team. I remember telling my therapist that Tuesday how out of control I felt, but at the same time how I felt more in control than I had in a

> really long time. I told him how ironic it was that control came when I let go of control to my treatment team. If I was the only one who could make that decision and follow it, I was actually in control. It was around then that I started to be able to use the truth from the word instead of listening to the anorexia. The tools I thought would never work began to work. They had never worked before only because the option of using my eating disorder behaviors was still there. I was frightened, terribly frightened, because I had never known to rely on anything other than my anorexia. My life preserver took the form of the staff at the facility. I clung to them like superglue because it was a life or death manner, I was beginning to allow my mind to engage in the prospect of being alive. That I, Rosalind, had the right to live. They held me afloat as I began to swim ashore. Slowly, as I began to build strength of my own, their hold on me lessened, until I was able to swim along side of them on my own.

After Rosalind developed secure attachment with her treatment team, she was able to replace the lies that maintained the anorexia nervosa with the truth provided by the treatment team and later on with her own perspectives in keeping with her faith.

Once Jennifer was able and ready to turn to her faith to help support her in recovery she made use of her faith and CBT principles in her recovery as well.

> Mid-semester was when I really decided that this has been going on for four years, counting calories, it was always a lingering thought: I need to watch my weight, I need to count calories. I made the decision this is not going to be part of my life, period. This is going to be done. I am not going to be scared or run from this, I am going to be free from this. No matter what I am not turning back, I have no other choice. It was not easy or comfortable, it was uphill. It was an uncomfortable process; this insight and resolve, this steely determination, it was mental. From there it was a combination of focusing on practical truth, simple practical truth. We had surveys on how we rated certain lies. Much of my negative spiral was that I was repeating to myself these lies. I had to force myself to remember the meetings and force myself to repeat and believe these practical things: I don't have to be perfect; I don't have to have everybody's love and approval. I have the Lord's love and approval. I had to believe positive things and reiterate them again and again. I had to pray and pray for strength and perspective. I would pray, "Lord give me the mental strength to believe the truth, give me perspective on my life." I have so much blessing; I started being thankful instead of focusing on lies. It was a constant repetition of the truth. Repeating the truth was a monumental aid to my recovery. Whenever I would feel negative thoughts or urges to control my eating creep up, I would repeat over and over [what Jesus said], "Come to me all you who are weary and burdened, and I will give you rest. Take my yoke upon you and learn from me, for I am gentle and

> humble in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light."

Jennifer's recovery sparked into a fire when she began to forcefully, consistently and persistently use Scriptures to combat the demands of the anorexia nervosa.

Caitlin had a similar experience.

> I read self help books forever, I love the psychology section. I knew the mind had to start being reprogrammed. And I thought, "Oh God, you are going to have to help me with that too, because I don't even know where to start." I have always believed in the power of the mind and the danger of believing lies; where that will get you. I started to go back to my earliest memory I ever had. I was probably two, sitting on the kitchen floor of my parent's house, banging pots and pans, and I had to start here and reframe everything based on the truth. I went through my whole history.

Over a period of twelve months, Caitlin actively used a process of writing out her thoughts and replacing negative thoughts with scriptural truth. This practice "paved the way to my recovery."

Lastly, both Sondra and Paige were introduced to forms of CCBT in their treatment. Their experience, similar to the other co-researchers, was that once they addressed the distortions in their faith in the therapeutic context, they too benefited from using scripture and Christian perspectives in a process of cognitive restructuring. It was clear from their interviews, as evidenced in previously mentioned excerpts in this chapter, that the effectiveness of these interventions related to the experiences they had in relationship with their therapist. Sondra and Paige both reported that they had experienced what God is like for the first time in Christian counseling. As a result of a process of internalization, thoughts and images they held about themselves shifted. Dr. Jessie had some pertinent comments related to this:

> As a patient experiences the reality of God's love and protection in the therapist, she is drawn to Him, and the truth, not by the therapist's use of skilled techniques

> but by the Holy Spirit Himself working through the relationship. I think the more we are connected to the Holy Spirit, the more we pray for our patients in the morning and we ask God to be with us and to be in the room with us, the better. I know that I need to do that because I can get insight that way that I might not get just from using clinical skills. It's a huge responsibility, and it's sacred.

Fighting the Good Fight

The co-researchers made reference to the experience of recovery as entailing a journey that necessitated frequent combat against a devious adversary. Using the Christian perspective of battling lies, darkness, and evil as metaphor for this process validated the extent of the campaign and provided a narrative of hope and help for the passage. Seven of the eight co-researchers referred to this experience with the Christian concept of "spiritual battle," and discussed the hard work and diligent watchfulness required to "fight the good fight" and win. Caitlin captured what was generally relayed in the following,

> I wrote verses down about His strength and His power. I actively fought back thoughts that denied what was said about God's power over fear, over lies, over darkness. One I used a lot was 2 Timothy where it says that God has not given us a spirit of fear but of power and a sound mind. I had to choose to trust Him and not what anorexia was telling me. I would pray, saying, "Father don't let me be deceived." I had to trust Him. I chose to trust Him. I would ask Him to help me to see, and I would tell Him that I knew that I could not do it by myself. He guided me. In spite of me, I know this presence of grace, this power and authority that became available to me; it was not me. He gave me what I needed. I did a lot of straight out fighting using scriptures right out of the Bible. I had to know my identity in Christ. That's what it came down to. Reading, tapes, listening to Christian speakers; these gave me great encouragement. I had to push and push and push and not give up.

Rosalind relayed that through a process of continually calling out to God for help and running to her treatment team for support, she learned that God and her treatment team were more trustworthy and reliable authorities than the cruel voice of anorexia

nervosa. She shared how hard she had to work to reject the internal "screams and torments of anorexia when I obeyed the treatment team instead of its voice." But each time she did, she was more and more certain it was the right thing to do and began to find a peace and security she had never known.

Jennifer reported that for four years she struggled between doing what she knew was right and following the dictates of anorexia nervosa:

> I had good spells and then relapse, again and again. It was never over until I began calling out to God. Radical obedience to what He said was the key. It was like an addiction that I consider sinful. I didn't feel loathed by the Lord because of it though. I felt His compassion, "We are going to get over this together," I felt from Him. He wasn't saying, "Get over this." It was more like, "You are so much more special than this. You don't need to do this because I am here with what you need." I got a different kind of security from Him; what I had been putting in anorexia, I learned to transfer to Him.

Dr. Carmen's experience has been that it is effective to explicitly teach anorexic, Christian patients that anorexia nervosa has taken control over them and has become their authority. One of Dr. Carmen's goals is to facilitate an awareness of the Christian view that the patient has power and freedom to choose whose authority to be under. She comes along side sufferers in the grueling fight to take their lives back from anorexia and to trust and obey what God says in the Scriptures, instead of the lies of anorexia nervosa. She relayed,

> What has helped the most in terms of feedback I have received is the cognitive renewing structuring exercises. They see from these that there is really another way of thinking. When introduced to what God says about it, they learn that they have a choice [about whose authority to come under]. They have felt condemned to only one way of thinking. According to Romans they have the capacity to give in to the Spirit nature instead of the sin nature. [I ask them] which one are you going to surrender to most? Who are you going to turn to meet your needs?

Dr. Carmen finds group work, wherein sufferers can band together in the fight, especially productive.

Dr. Benjamin and his colleagues, like Dr. Carmen, utilize the Christian perspective of spiritual battle and encourage patients to take up the sword against the dictates of anorexia nervosa. He believes that patients need to be monitored in treatment for ability, readiness and motivation to fight. When they feel the patient is ready, they discuss the choice to fight the anorexia nervosa and to meet their needs in healthy and life promoting ways:

> We accept them, care, give empathy and understanding; this helps motivate them. We ask them, "What's *your* vision? What would *you* like your life to look like?" Help me understand how *you* are going to get there? (Instead of this is what you need to do…). There is often a control/power struggle with patients. I let them know that it is not freedom to do the opposite of what one is told. If you really want to be free, *you* have to decide whose authority you are going to come under.

Sondra captured the sense of empowerment that occurred when she realized she could make a choice to fight the tyrannical dictates of anorexia nervosa:

> For four years I told myself that anorexia is just part of my life, but through the support I received in counseling I realized that's not the way life has to be, I can choose to believe the truth! I can choose to walk in freedom. Once I saw this hope, how inviting it was, I was set. I determined in my mind that I was going to get better, I was going to conquer this, through the Lord's love; I was going to be free of this obsessive disorder. During one of the first group meetings, we all wrote ourselves a letter stating our goals for the semester. I wrote, when a stressful situation arises, I will be able to have a broader perspective and overcome the control eating has over me. I will be ready to follow what the Lord has for me to do. I will be completely free. I will be completely free. I will be completely free. And now I am free, I'm living in victory.

According to Dr. Jessie, much of what occurs in treatment is supporting the patient in becoming a solid person who clearly knows who she is and who is able to discern truth from falsehood. She has found it fruitful to provide metaphors and parables that help patients recognize that they have the right to respond to controlling or abusive internal and external influences from their own center and values. The safety of the

therapeutic relationship provides the secure attachment from which to practice these undone developmental tasks. Per example, she shared this metaphor about recognizing and honoring one's emotional barometer in relation to others,

> Their recovery might also entail changing their relationships with their parents or siblings. Often they end up even changing friends, because other friends were in that mode of wanting to control them. We can encourage new friendships that are reciprocal and balanced, that "taste good," and to sense for herself when she feels safe. I like to use a lot of metaphors. I suggest that developing relationships is a lot like checking out the ice on a lake to see if it is safe to go skating. I say, you don't run to the middle to see if the ice is safe, you start from the edge and you take a step and you see if it feels safe. And then maybe at step 14 you feel a crack. Then you step back and that is far as it is going to go. You don't have to throw the person out if the ice cracks, but that is as far as it is going to go. That's where your trust and your safety level with that person are going to go. And that's ok because you're in charge, and that's authentic control. That's driving the boat and taking it where you want to go.

Boundaries, assertiveness training, identity solidification, discerning truth from falsehood, healthy relationships, etc., these are some of the concepts that Dr. Jessie addresses in treatment in order to equip her patients to "fight the good fight" and let go of anorexia nervosa as a method of meeting her needs. According to Dr. Jessie, until she can replace the anorexia nervosa with an authentic identity, she will not have the ability to win the battle against it.

Finally, Paige shared that she sees her recovery as akin to a spiritual battle that requires constant "feeding off the truth and fighting off this darkness."

Theme Three: After Treatment: Sustaining Spiritual Connection

The Battle Continues

Beyond the intense "battle" that occurs during treatment, the co-researchers also expressed the continued nature of the battle after treatment was formally done. What

they found particularly important, as Paige put it, was "not letting the guard down or getting lazy about keeping watch over my mind. The lies seem to be always awaiting a ripe opportunity to jump back in and make themselves at home." Their reports convey the arduous battle entailed in taking one's life permanently back from anorexia nervosa. It requires much diligence and patient support which must continue long after formal counseling is terminated.

Having anorexic thoughts or even lapses back into anorexic behavior is not evidence of a lack of recovery. Such lapses offer opportunities, as Caitlin said, to "get back to the basics and continue in the fight." Dr. Carmen put it this way,

> If there is a lack of surrender at any point, the anorexia will come back; so they must learn to be proactive against the lies that will come. They can never go into neutral, but rather they must learn to prepare their mind according to the Scriptures so as to be ready for the spiritual warfare. They must learn to pronounce truth when the temptations come and come under the authority of what God says, not anorexia.

Jennifer shared that she notices that when she gets isolated, the anorexic thinking re-surfaces. She said,

> The thoughts re-emerged a lot at first, but now less. But now, especially since I broke up with my fiancé, they try to emerge. But I have a very supportive group of friends and family. I still struggle because I am somewhat isolated. It did resurface, but I said no, I made my decision, I made my decision I am done. It was not even an option. I have not allowed myself to go back to anorexia for four years. I kicked it out through the Lord's strength. I really attribute my recovery to the Lord and the walk I now have with Him.

Sondra also expressed this sense of ongoing battle, and used language from her Christian faith to express her experience:

> Satan tries to make me feel bad about my years in anorexia. But when I feel guilty, I pray and I know, again, that I am forgiven totally. I pray when I feel fat or guilty and I ask God to take it away and immediately I feel better. I know now that I am more than my weight. I have the power of the Holy Spirit now to help me fight. It doesn't mean that thoughts don't come up about my weight anymore,

> just that I am not consumed with thoughts about my inadequacy. I have a joy in life now that pulls me to do the right things. Basically I think the deeper you get into the eating disorder, the harder it is to get out of it. Perhaps that is why it took me so long. I know that I cannot go back to that place. I choose to live in the joy of my healthy life. When I do struggle, I seek help fast, in God, in others, and I forgive myself. I still need to avoid certain situations that cause me to stumble. I still need to fight. But now I know that I am worth it and I think that is what true recovery is. God is my stronghold in the fight now. The battle is His, so the victory is assured.

Rosalind, Jennifer and Caitlin also shared that there are times that are hard. Helping others in their recovery has supported them in the ongoing post-treatment battle. According to Rosalind, "Now I co-facilitate a group for eating disorders at church and this is really good accountability for me." As she teaches, she is ever reminded of the necessity to continue to be vigilant in the fight. Jennifer put it this way,

> I am being honest with you when I say that I finally have resolved my dealings with anorexia. This doesn't mean that I don't have thoughts about anorexia; I'm not trying to hide from it or forget that I ever struggled with the disorder. The difference is how I think about anorexia. When I say that I am completely free from the disorder, I mean that I now have the confidence and determination to deal with anorexic thoughts and behaviors in a healthy manner rather than being consumed and controlled by them. I still hear the lies, but the difference is now I can counteract them with the truth that I've determined I'm going to live by. I know what is true and I am going to act on it constantly. I have chosen to obey and please the Lord in the way I think and act about anorexia. After I could honestly claim a full recovery, the Lord provided me with the vital accountability He knew I would need. Over the following year, I spoke at several groups and meetings which not only kept me honest with myself and the Lord, but also it was my earnest desire to expose the truth that freedom is attainable! The accountability was crucial to fortify my mind for times when I was lonely or weak or felt the need to slip back. I choose to constantly be thankful for His clearing me of the multi-faceted disorder of anorexia. I choose to keep the perspective of what the Lord's love, acceptance, and graciousness can heal.

Caitlin, who uses skills learned in recovery to help others, also discussed the importance of staying on guard for the lies that re-emerge when the guard goes down, even long after recovery is complete. She shared that she continues in the battle "because I don't ever want to go back to it. I'm not going to be one of those people who make a

little progress and then go back." For Caitlin, the pushing for truth that occurs during recovery "is just something that must be maintained for the rest of my life."

According to the co-researchers, persisting in recovery after treatment is terminated entails continuing to take captive one's thoughts, with a resolute attitude against anorexic thinking, along with the support of healthy and encouraging people. A journal entry from a recovered patient of Dr. Jessie's portrayed how freeing it was to realize that the things she had heard in her head since she was little (that she was too fat, too ugly, people thought she was weird, too loud, not normal, disgusting, and so on) were just lies that she had never questioned. When Dr. Jessie framed this internal struggle as a "spiritual battle" she was able to let go of much shame and guilt. In her journal she wrote about how freeing it was to learn that she wasn't just picking these thoughts; and that she wasn't sick or weak for having them. When she started to discern how the thoughts were contrary to her values and her faith and she was encouraged to choose to believe thoughts in keeping with her identity and values instead, strength for the fight grew. Even though now recovered, she has found the need to continue to watch over her thinking. She said,

> I am no longer ashamed of this obsessive-compulsive problem I have had. I know that I cannot help the thoughts that fire off in my mind, some of which are influences that I have no control over, some are just the way my brain has managed to deal with the trauma I've endured. What I can help, however, is how I respond to these thoughts. I can choose what to listen to, to obey. Sometimes I still need help in the fight, but I have people I trust now to help me along. But more than that, I have God and He has said, "My sheep listen to my voice, I know them and they follow me" (John 10:27). I am God's beloved, little lamb. Although there are false shepherds and voices that abound, if I know what my Shepherd says about me, about my worth, about my safety, I do not need the false shepherd of anorexia to keep guard over me. I have a real lover of my soul now and I will not be rejected or forsaken ever again. This is the truth I must continue to focus on.

Maintaining recovery is a process that entails incessant vigilance over the mind. This assiduous battle, according to the co-researchers, is aided by spiritual integration in counseling, and has the potential to promote congruence, joy and maturity in one's spirituality. As Paige said, "As terrible as anorexia was, I wouldn't trade the closeness with the Lord that came about as a result of the battle."

Lessons from the Suffering

Woven throughout the co-researchers stories was the belief that a vital lesson was learned as a result of the recovery process. This lesson was related to the profound spiritual transformation that came out of the suffering and the great value they now place on the spiritual life. Jennifer, for example, wrote this testimony for her therapist to share with others in treatment, hoping to impart the important place God's love had in her recovery.

> At the risk of sounding cliché, my heart truly is at rest. I have eagerly agreed to write this in hopes that those who read will see the truth and the hope that can come of a war with anorexia. Through the Lord's love and acceptance and the guidance of Counseling Services, I believed there was hope, and fiercely pursued this determination to be free of anorexia until I was writing pages like this about my recovery. That's where I've been with anorexia and where I am now on the other side, the side of freedom.

Jennifer feels that as a result of anorexia nervosa, and, in particular, the addressing of distortions in her faith in treatment, she learned about "true Christianity" which is now the cornerstone of her identity and security.

Rosalind shared that "the biggest thing I learned was that recovery is a journey and not a destination; recovery is a process. Just because you mess up, it doesn't mean you start back over. I don't have to be perfect. The eating disorder has to be perfect but

not me." Rosalind, like the others, believes that as a result of the recovery journey, she has come to know and be loved by the God of her faith, and for her "nothing else really matters."

Caitlin shared,

> Now, I am probably healthier than I would have been if I hadn't gone through it because I know I had to deal with a lot of junk. I know that now, and I don't ever want to be in bondage again. I realized that I had been deceived and that I needed to get rid of that deception. I didn't want to just change behaviors; I wanted to get to the core. I didn't want to just pull weeds and grass. I wanted to go down deep and pull it all out. I knew that for me, that is what the process had to be.

As a result of her willingness to go deeper, Caitlin learned that she could trust God, be guided by God, and get what she needed from God. "These were big lessons that I needed to learn."

Paige and Sondra, speaking almost the same words, shared that as a result of the illness and subsequent Christian-based treatment, they discovered who they and the God of their faith truly are. As a result, they experienced the reality of the God of their faith, internalized His nurture and protection, and, as Paige put it, let go of the "hell-hole" that is anorexia nervosa. Also from Paige,

> Anorexia forced me to look deeper at my faith, to change my misunderstandings about God, and to really live in relationship with Him. Once I learned to trust, I found recovery, but it was something much more than even that, as big as that was. It was through the process of fighting anorexia with the truth, that I learned who I am and the joy of living in and through the One who loves me. My mind might slip backward from time to time, but never will I live apart from Him again.

The clinicians shared that they have also all learned much in the process of facilitating recovery with this deeply wounded population. They have learned that they can rely on and trust in God to work in and through them, and their patients, as they call

out to Him each day. All discussed their joy and wonderment over "the things I've seen God do." Dr. Jessie shared,

> I always think of an anorexic as someone who found a lifeboat on a sinking ship and it is keeping her from drowning, it is keeping her alive. Now, if you look at someone whose only safety is this lifeboat and you say, "Give me that lifeboat," they are going to look at you like a deer in the headlights and cry, "what in the world are you talking about?! I'll drown without that! I would be totally out of control if I didn't have this lifeboat!" So there is a lot of really intense defensiveness and guardedness that goes into being anorexic and it all gets focused on the food. All those fears get funneled down onto the food thing. So, how do we help someone who has no trust? Well, we have to build a relationship. We have to have patience, incredible patience, and I think that is what is so hard. But I have come to appreciate their time table; I have to appreciate the damage they come in with. I have to appreciate the dynamics of what caused this to happen and just meet them where they are. Just keep meeting them where they are which is just what God does with us. I have to work knowing that building trust, building rapport, building safety just takes time. You and I know that sometimes we are the first person this person ever trusts in their life and so we have this incredible need to have the consistency and the patience that God has with us with them. That is why our modeling how God wants to relate to them is so important because when they finish therapy with us, they should have transferred a lot of that rapport onto God. So when they are not with us any more they have a proper image of who God is and how they can relate to God and to see that as a partnership and not as a manipulating controlling thing that they saw it as before they came in. Experience has taught me that that is really the most powerful and effective way to do it. You can't just say, here take this other lifeboat [God] and ride on it for a while, it just doesn't work that way.

Summary

In this chapter, my collaborators, the co-researchers, were described and the themes that emerged from a phenomenological analysis of their narratives were given. The themes reflect a procession of recovery that is impacted by a focus on the spiritual in treatment. This process involves movement from a state of "spiritual disconnection," through "reconnecting to the spiritual," and, finally, "sustaining spiritual connection." Appendix C contains a list of themes and sub-themes. In the next and final chapter,

conclusions, implications, and recommendations based on these findings will be provided.

CHAPTER FIVE: DISCUSSION

Overview

This study has examined participant's perspectives on Christian spirituality, counseling practice, and recovery from anorexia nervosa. Document, interview, and observation data was collected from recovered individuals, clinicians, and a residential eating disorder treatment facility. Results from an analysis of this data were presented and summarized in the previous chapter. This chapter presents the significance of these findings by relating them to the initial research questions: (a) What role, if any, does Christian spirituality play in recovery from anorexia nervosa? and (b) What specific Christian spiritual interventions, if any, support recovery from anorexia nervosa? First, the findings will be compared and contrasted with those found in the literature. Next, the implications of the findings will be related to the development of spiritually integrated treatment models. Subsequently, recommendations for further research will be provided. Finally, the researcher will locate herself in reference to the findings.

Significance of the Research Findings

In this section of the chapter, the findings from this study will be compared and contrasted with conclusions from the literature review of Chapter Two. In keeping with the spiritual integration model introduced in this study (Figures One & Two), the discussion examines the progression of treatment relative to the current standard of practice, spiritual integration, and Christian spiritual integration in the treatment of anorexia nervosa. Each of these levels of care will be discussed in relation to the treatment process, that is, prior to, during, and after treatment.

The Current Standard of Practice in the Treatment of Anorexia Nervosa

Prior to Treatment

The findings from this study corroborate with the literature regarding the bio-psycho-social "brokenness" of the anorexic patient prior to treatment, as well as the recalcitrant nature of the illness once in treatment. The research participants confirmed previous findings that anorexia nervosa is a devastating, debilitating illness (e.g., Birmingham et al., 2004; Lamoureux et al., 2005; Lowe et al., 2001) which develops on the heels of suffering (e.g., Cooper, 2006; Levenkron, 1997/2000) and is often resistant to treatment (e.g., Bloom et al., 1994; Halmi, 2005b; Rushford, 2006; Vitousek et al., 2005; Yager, et al., 2006) and chronic (e.g., Allen, 2001; Herzog et al., 1999).

Then too, the literature and the study findings concur regarding the development of anorexia nervosa as a means of coping with intolerable internal states and interpersonal situations (e.g., Allen, 2001; Cooper, 2006; Claude-Pierre, 1992; Levenkron, 1997; 2000). The participants in this study confirmed that prior to the development of anorexia nervosa they experienced incessant anguish and suffering. This pain related to failures in secure attachment, unmet core developmental/emotional needs, the presence of relational trauma, and/or the experience of a malicious and relentless internal "voice" that demanded perfection. According to Allen (2001), the psychological outcome of these experiences is the continual and frequent triggering of "unbearable emotional states, including extreme stress, intense fear, feelings of helplessness, and a sense of being overpowered and out of control" (p. 17), which are now being controlled,

coped with, and managed via the anorexia nervosa. As Dr. Jessie said, “Anorexia is their lifeboat and the world, their sinking ship.”

Although the co-researchers and the spiritual integration literature are consistent with one another regarding the important role of spirituality in the etiology, maintenance of and recovery from anorexia nervosa, the current standard of practice does not reflect recognition of this. Findings from this study corroborate with conclusions found in the integration literature that treatment for anorexia nervosa should be considerably more focused on patient spirituality (e.g., Garrett, 1996; Lewis, 2001; Marsden et al., 2007; Mitchell et al., 1990; Rorty et al., 1994; Richards et al., 2007; Smith et al., 2003) because “religious and spiritual issues are frequently intertwined with the pathology of eating disorder patients, religious issues can contribute to, exacerbate, and help maintain eating disorders, and religious and spiritual resources and interventions are frequently instrumental in patient’s healing and recovery” (Richards, 1997, p. 277). Participants in this study substantiated these conclusions when all of them revealed that prior to treatment, in addition to biological, psychological and interpersonal suffering, they also experienced a profound sense of spiritual disconnection [e.g., “feelings of spiritual unworthiness and shame; fear of abandonment by God” (Richards et al, 1997, p. 264)] which impacted their choice to take control of their brokenness through the defensive mechanisms of anorexia nervosa.

During Treatment

This study's findings substantiated the clinical consensus found in the literature that treatment must incorporate the current standard of practice for the treatment of eating disorders including comprehensive assessment, medical evaluation and treatment, psychological assessment, nutrition evaluation and treatment, an emphasis on the person of the therapist and the therapeutic relationship, a variety of therapeutic approaches as needed, psycho-education, long term therapy, after care, and relapse prevention (e.g., Corstorphine, 2006; Costin, 2007; Crisp, 2006; Cumella, 2005; D'Abundo et al., 2004; Hinz, 2006; Marsden et al., 2007; Rushford, 2006; Waller et al., 2007). The clinical research participants all reported the vital need for treatment to address the whole person within the context of a comprehensive treatment model and treatment team. As Dr. Benjamin put it, anorexia nervosa is a "bio-psycho-social-spiritual illness and treatment must address the whole person."

The findings from this study and the literature also corroborated regarding the pivotal role of the person of the therapist and the therapeutic relationship in the treatment of anorexia nervosa (e.g., Berrett, 2003; Geller et al., 2006; Manley et al., 2003; Santucci, 2007; Yager, et al., 2006). Almost all of the co-researchers and some of the literature highlighted the "nurturing-authoritative therapeutic relationship" (Levenkron, 2000) as the most important factor associated with recovery (e.g., Anderson, 2001; Beresin et al., 1989; Button et al., 2001; Hsu et al., 1992; Kelly, 2001; Lamoureux et al., 2005; Weaver et al., 2005).

After treatment

The findings from this study confirm previous conclusions relative to the difficulty of maintaining recovery and the ongoing efforts required to sustain the gains made in treatment (e.g., Deter et al., 1994; Lowe, et al., 2001; Pike, 1998; Solitis, 2001; Steinhausen et al., 2000). Additionally, these findings verify that becoming completely asymptomatic is not likely. According to the co-researchers not only is it, as Caitlin put it, "a grueling battle to recover from anorexia," but maintaining recovery entails "continuing in the battle."

The clinicians and the literature also support one another on the recommendation that counselors encourage patients to continue to utilize the tools learned in treatment, to normalize the continuing nature of the struggle after treatment, and to accept the possible need for intermittent and ongoing types of support to maintain recovery after treatment is terminated (Waller et al., 2007; Yager, et al., 2006). Co-researcher clinicians and those speaking from the literature create detailed after care plans that take into consideration the high rates of recidivism common to anorexia nervosa.

Finally, the co-researchers and the literature corroborated regarding an emphasis on the important lessons learned while recovering from anorexia nervosa (e.g., Beresin, et al., 1989, Cooper, 2006; D'Abundo et al., 2005; Garrett, 1996; Jacobsen, 2001). In keeping with the conclusions of Fernandes, Papaikonomou, and Nieuwordt (2006),

> When the individual is able to find and experience meaning in his or her suffering, he or she has achieved the freedom to rise above conditions that were once so debilitating. Moreover, finding meaning in terms of personal suffering is not something one can create or invent, but something that is instead discovered, discerned, and experienced. As individuals, we find meaning by discerning what each situation requires of us and what we are called upon to do or be. Only when

> an individual is able to find that meaning can he or she be freed from self-destruction and self-preoccupation. The individual is then able to experience a sense of self-worth, a sense of being a responsible, spiritual individual, a sense of having a unique destiny to fulfill, and a sense of sufficient power to strive towards living his or her life more fully. (p. 873)

Spiritual Integration in the Treatment of Anorexia Nervosa

Prior to Treatment

The findings from this study are consistent with the conclusions in the literature that prior to treatment individuals who are religious/spiritual often experience acute spiritual struggles that play a part in the etiology and maintenance of anorexia nervosa (e.g., Marsden et al, 2007; Nilson et al., 2006; Richards et al., 2006; Weaver at al., 2005). In particular, participants' narratives confirm the conclusions of Richards and associates (1997) that patients with eating disorders often have "negative images of God, feelings of spiritual unworthiness and shame, fear of abandonment by God, and difficulty surrendering and having faith" (p. 3). Research participants clarified that prior to treatment the patient with anorexia nervosa does not make use of her faith as a resource in recovery because, as Dr. Carmen relayed "the concept of God is so skewed: distant, uninvolved, He is displeased with me. Their view of God is a complete distortion." According to the literature and findings, this population's faith prior to treatment is, in fact, intertwined with and contributing to the maintenance of the disorder. These triangulated findings point to the need for counselors treating this population to formally assess patient spirituality to determine co-morbidity of clinical and spiritual features prior to the development of the treatment plan.

During Treatment

This study substantiates the spiritual integration literature confirming the importance of including a thorough spiritual assessment at intake (e.g., Darden, 2005; Hartz, 2005; Richards, et al., 2007; Sperry, 2001, 2003; Wall, 2003; Weld et al., 2007). Also corroborated by the co-researchers and the literature is the need for counselors to recognize that the patient's spiritual struggles are likely to hinder her ability to draw on her faith as a resource in recovery (e.g., Hardman, et al., 2004; Jersild, 2000; Joughin et al., 1992; Morgan et al., 2000; Newmark, 2001). Although the addressing of spirituality in treatment has been shown to support recovery from anorexia nervosa (e.g., Abel, 2005; D'Abundo et al., 2004; Garrett, 1996; Marsden et al, 2007; Nilson et al., 2006), findings from this study suggest that such integration should proceed cautiously, ethically, in keeping with empirically based recommendations, and only after trust is established in the therapeutic bond. As Dr. Jessie reported, "everything you'd do in treatment with Christians with other disorders you can't do right away with anorexics. They'll drop right out of treatment. It's real counter-intuitive." However, in their caution, clinicians must not "throw the baby out with the bath water," as Paige put it. Findings from this study corroborate with those in the literature reflecting that spiritual integration becomes a powerful resource in recovery from anorexia nervosa when introduced with proficiency and prudence (e.g., Marsden et al., 2007; Richards, et al., 2001; Rorty, et al.,1993; Ruskay-Rabinor, 1999; Smith, 2004; Smith et al., 2003).

Also substantiated by the literature and the findings is that certain spiritual integration tools, when utilized in the context of the current standard of treatment, help facilitate recovery for individuals who consider themselves spiritual and consent to spiritual integration in their treatment. Of the intervention tools reported in the literature (see Chapter Two) spiritual education, prayer, and forgiveness were all mentioned by some of the co-researchers as supportive of recovery.

After Treatment

As previously stated, the literature and the findings from this study confirm the need for a relapse prevention plan after treatment termination (Waller et al., 2007; Yager, et al., 2006). Although the continued use of spiritual interventions and perspectives post treatment is not specifically addressed in the literature, if these have been helpful in treatment, as verified by the participants in this study, it is reasonable to suggest including them in the after care plan. Such a plan is implemented at the observation site and was strongly recommended by the clinical staff there as well as the clinician co-researchers. Participants in this study, who found that their spirituality played a significant role in their recovery, also reported that their faith continued to play a major role in both recovery maintenance and overall wellness once treatment was complete.

Christian Spiritual Integration in the Treatment of Anorexia Nervosa

Prior to Treatment

The study findings corroborate with the literature regarding the relationship between spiritual issues and concerns and the development and maintenance of anorexia nervosa for the Christian patient (e.g., Braem, 2004; Cooper, 2006; Darden, 2005; Eberly et al., 2003; Eberly, 2005; Rogers, 2004; Wall et al., 2005). In particular, this study confirms the existence of painful emotional states related to the patient's experience of and relationship with God, including feeling abandoned and disconnected from God and having feelings of inadequacy, shame, and fear associated with God. Consistent with the literature and the research participants, these painful spiritual experiences directly relate to the development and maintenance of the disorder and are rooted in distorted interpretations and perspectives of the patient's Christian faith as well as her tendency to process spiritual information through pre-existing, ego-dystonic internal working models of God, self and others. These internal templates, or "schemas" (Cecero, 2002), confirm the painful feelings and lend to the already unbearable emotional states that precede the anorexic coping strategies.

During Treatment

The present study upholds the findings from the one empirical study that also explored eating disorders and the Christian faith (Abel, 2005), as well as the discourse (e.g., Braem, 2004; Cooper, 2006; Darden, 2005; Eberly, 2005; Rogers, 2004; Wall, 2003; Wall et al., 2005) regarding the important role of Christian spirituality and spiritual

interventions in treatment with this population. The co-researchers substantiated the literature conclusions regarding the potential for the patient's faith, once distortions are addressed and corrected in treatment, to play a significant role in recovery. This role especially relates to the faith's provision of unconditional love and protection in the context of a secure attachment with God and other people who share her faith.

The role of consistent and unconditional love and security in healthy development is documented in the literature as promoting secure attachment, trust, identity formation and solidification, affect management, boundary development, empathy, and love for others, among other important developmental milestones (e.g. Bowlby, 1988; Campbell, 1979; Clinton et al., 2002; Miller, 2002; Sperry, 2003). According to the findings, when recovering Christian anorexics discover in their faith a secure provision of love and security; and learn to turn to God and a healthy faith community, instead of anorexia to meet their needs, significant recovery takes place. As Paige put it, "It (recovery) all came down to Jesus Christ providing me with the love and truth I had been looking to anorexia to provide."

But how does a person who experiences her faith as "toxic" (Arteburn et al., 2001) or uses her faith to verify her "badness" learn to turn to her faith to meet her emotional needs? According to this study, in order for faith to become a resource for recovery, the patient must experience a human relationship wherein she can (a) encounter a person, "with skin on," who provides the kind of nurture and security that the Christian faith describes God does; (b) be given the opportunity and patient encouragement to explore her faith and correct distortions in it; and (c) be given spiritual tools that enable her to solidify her identity and disregard faulty perceptions about

herself, God, and others. According to the co-researchers and the literature cited above, when God's love is internalized, it responds to the unmet needs behind the anorexia nervosa while also "mending" the patient's faith. As Dr. Benjamin revealed, "this is the foundation of our self-worth and ultimate healing."

The tools pointed out in the literature as promoting recovery from anorexia nervosa (see Chapter Two) were mentioned by some of the research participants. However, in this study, an "incarnational" relational experience, CCBT, and the Christian perspective of "fighting the good fight," were unanimously mentioned by the co-researchers as being significantly helpful in the process of recovery.

"Incarnational" Relationship

The co-researchers and the literature corroborated regarding the importance of the therapeutic relationship in recovery. According to the literature, the healing of anorexia nervosa entails the development of the kind of relationship that was lacking prior to the emergence of the illness (e.g., Bloom et al., 1994; Bruch, 1978; 1995; Levenkron, 2000; Weaver et al., 2005; Zerbe, 1993). Such a connection responds to the unmet core needs that are behind both the illness and the distorted faith. According to the research participants, as these needs were addressed and provided for in the context of the therapeutic relationship, the patient's perception of others, herself and God were reevaluated and modified. This revision of "internal working models" paved the way for faith to be utilized in recovery and to provide her with the secure attachment she was hungering for. Dr. Benjamin called the kind of connection provided by the therapist an

“incarnational relationship” and it is akin to what McMinn (1996) calls “redemption in counseling” (p. 259).

Although there is an important place for explicit integration, or the direct use of spiritual interventions and tools in treatment with this population, the research participants corroborated with each other and with some of the literature (Cooper, 2006; Cumella, 2002; Eberly, 2005; Wall et al., 2005) that such integration, as previously stated, is not indicated until the patient has come to trust in and bond with the therapist. Even when such a bond is established, findings indicate that counselors need to process with patients their experience and interpretations of such interventions. This is particularly important with this population, according to Dr. Jessie, because the anorexic patients’ desire to please the therapist and maintain secure attachment prevails over their need to develop an authentic identity and spirituality.

Christian Cognitive-Behavioral Therapy (CCBT)

The findings from this study also substantiate previous research conclusions regarding the effectiveness of CCBT in the treatment of Christians with anorexia nervosa (Abel, 2005, Anderson et al., 2001; Corstorphine, 2006; Eberly et al., 2003; Eberly, 2005; Wall, 2003; Wall, 2005). Participants in this study reported that second to the therapeutic relationship, CCBT principles and tools play a primary role in recovery.

"Fighting the Good Fight"

Findings from this study also confirm previous research conclusions that anorexia nervosa is not only dangerous, but it is tenacious and inordinately resistant to treatment and recovery (e.g., Birmingham et al., 2005; Crisp, 2006; Fairburn, 2005; Le Grange et al., 2005; Wilson et al., 2007; Yager, et al. 2006). According to the co-researchers, utilization of the Christian concept of "fighting the good fight" validates the intensity of the struggle, the functionality of the disease, and the kind of strength, support, and energy required to differentiate from the anorexic internal construct (Claude-Pierre, 1997). As one sufferer cited in Hautzig (1999) put it, "the hell never stops; the dictator never eases up" (p. 126).

In keeping with some of the discourse literature (Cooper, 2006; Eberly et al., 2003; Wall et al., 2003), the research participants all reported that the "battle" perspective supported them in the difficult process of either differentiating their authentic identity from anorexia nervosa or helping their patients to do so.

After Treatment

In addition to the post-treatment recommendations discussed in the current standard of practice and general spiritual integration sections (above), although not found in the literature, several of the research participants also reported that after treatment termination, sharing with others about how their spirituality positively impacted their recovery, providing presentations, or helping to run spiritually integrated support groups

aided recovery maintenance. Additionally, according to participants, after treatment was completed, continuing to turn to and grow in their faith was helpful.

Summary of Implications

In this section of the chapter, the triangulated research findings were discussed in reference to current standards of practice, spiritual integration, and Christian spiritual integration before, during and after treatment for anorexia nervosa. These findings provided answers to the research questions and have several implications for counseling practice. According to the research participants, and in collaboration with the literature, Christian spirituality can play a significant role in recovery from anorexia nervosa when counselors who work with this population:

- Understand the internal world of the anorexic individual, the psychological necessity of her symptoms, and the time it most likely will take for her to become emancipated from the anorexic state.
- Recognize that without something formidable in position to replace what the anorexia nervosa is providing for the patient, such release from symptoms may not be possible without the prospect of psychological decomposition and fragmentation (Allen, 2001; Levenkron, 2000). Such an appreciation for the function of anorexia nervosa may also help counselors appreciate and respect why these patients cling so tenaciously to their symptoms.
- Appreciate that although patients' Christian faith has the potential to address and provide for what the anorexia nervosa is supplying, it is necessary to proceed cautiously with

spiritual integration due to the “broken” condition of her faith as well as her undeveloped sense of identity.

- Understand the profound spiritual struggles that are often implicated in the etiology and maintenance of anorexia nervosa.
- Include a spiritual assessment in the comprehensive diagnostic evaluation and consider assessment findings when developing a comprehensive treatment plan.
- Utilize empirically based treatment strategies that recognize the biological, psychological, social, *and* spiritual needs of the Christian patient during treatment.
- Include the ethical integration of empirically supported spiritual interventions as indicated, with special attention to the person of the therapist and the therapeutic relationship, CCBT and the Christian perspective of “fighting the good fight.”
- Recognize the therapist and the therapeutic relationship as having the potential to play *the pivotal role* in treatment related recovery.
- Establish the importance of clinical training and supervision that focuses on the (a) spiritual development *of the counselor*; (b) ethical and appropriate spiritual integration with Christian patients; and (c) effective spiritual integration with Christian, anorexic patients. Guidelines provided in this document as well as those cited in the references provide direction in these areas.
- Draw on the CCBT resources cited in this publication that directly relate to work with this population (Eberly, 2003, 2005; Jantz, 2002; Wall, 2005), from the CCBT integration literature at large (Hardy, 2000; Hawkins et al., 1999; Jones, 2001; Johnson, 2001; Kaiser, 1991; Miller, 1988; Tan et al., 1996; Propst, 1996; Propst et al., 1992), and from the CBT focused eating disorder literature in general (e.g. Anderson et al., 2001;

Corstorphine, 2006; Fairburn, 2005; Foreyt, et al., 1998; Garner, 1997; Geller et al., 2006; Leung et al., 1999; Manley et al., 2003; Waller et al., 2005; Waller et al., 2007; Williamson et al., 2004; Wilson et al., 2007). It is also suggested that clinicians and researchers further delineate effective and empirically based CBT and CCBT protocols, including manual based options, for Christians and individuals of other faith orientations suffering with anorexia nervosa.

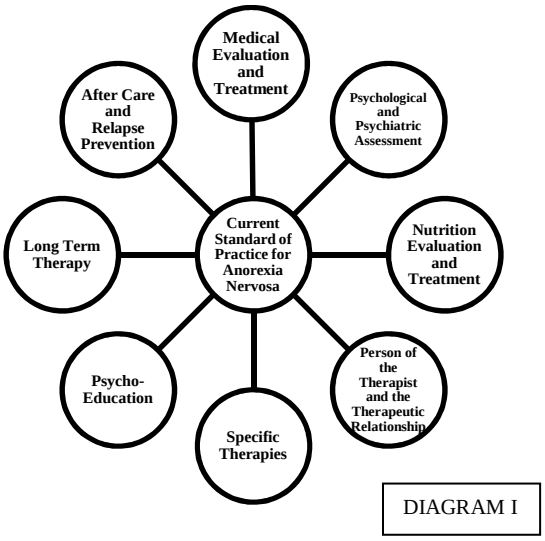
- Facilitate the Christian patient's understanding of God's love toward them personally, in keeping with their faith, first through the therapeutic relationship and then through the use of the various empirically based spiritual intervention tools presented in this document.
- Acknowledge the often chronic nature of anorexia nervosa and encourage patients to continue to utilize the "bio-psycho-social-spiritual" (Wall et al., 2002) tools they learned in treatment after termination.

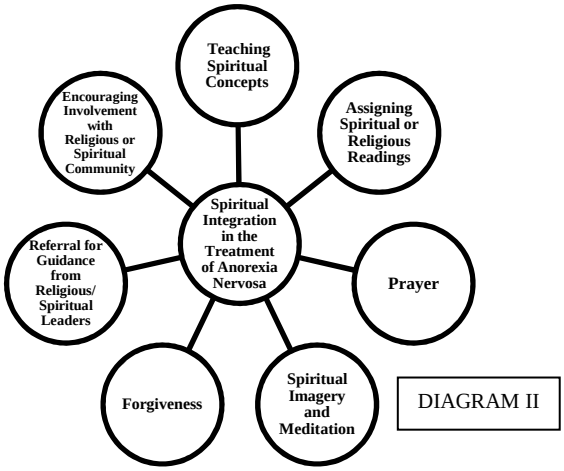
In the next section, the importance of developing spiritually integrated treatment models will be discussed.

Developing Spiritually Integrated Treatment Models

In the previous section the triangulated findings from this study and the literature were presented. These highlighted the significant role of spirituality and spiritual interventions in the treatment of Christian anorexic women. One way of applying these conclusions to clinical practice is to use the spiritual integration treatment model that emerged from the literature review in Chapter Two. This model is depicted in Figure Two with the addition of the Christian spiritual interventions that emerged from this

Figure 2. Spiritual integration in the treatment of Christian women with anorexia: Completing the model





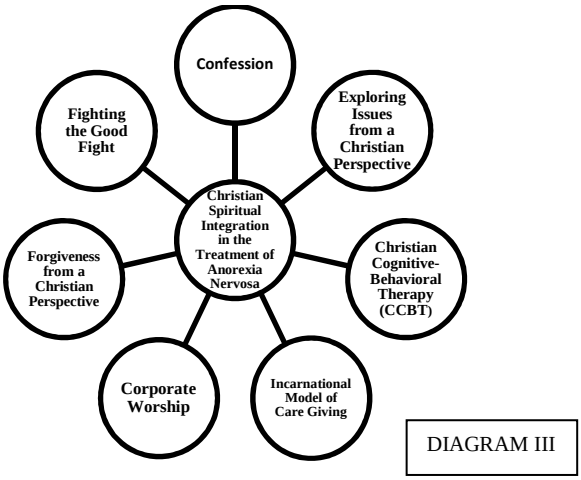
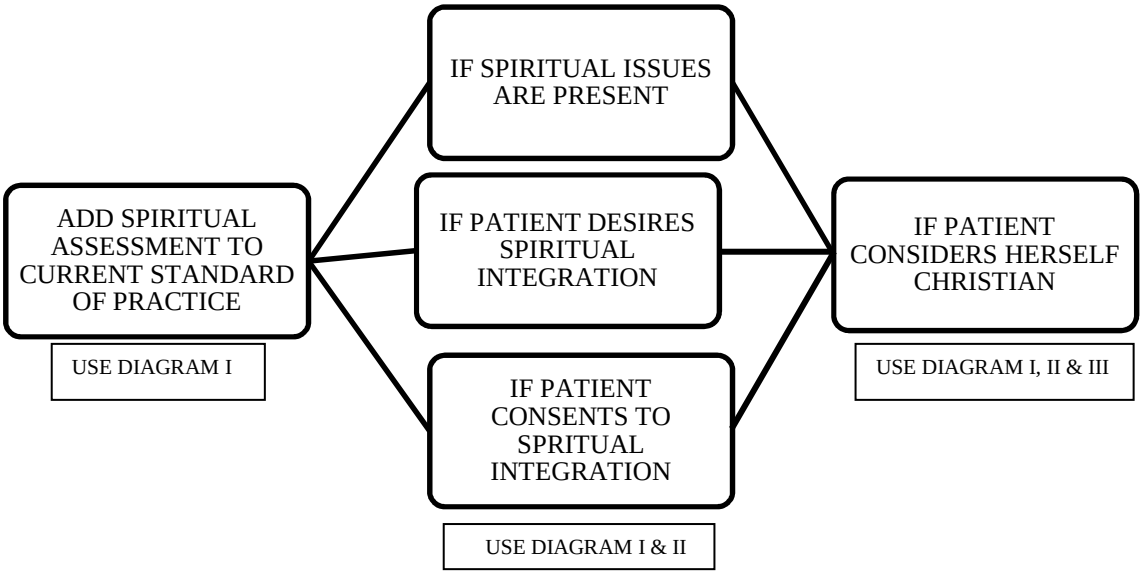


Figure 3. Spiritual integration in the treatment of Christian women with anorexia: Decision tree



study. A decision tree for determining an appropriate level of intervention is depicted in Figure Three. Use of this model entails adding a spiritual assessment to the comprehensive diagnostic evaluation recommended in the current standard of practice, and then employing the empirically supported spiritual interventions as indicated. Although the proposed model is only one way of addressing the spiritual needs of this population, it does provide an embarking point for further investigation. The comprehensive nature of the model, its simplicity, its grounding in empirical research, its relevance for this population, and its ability to address a dire need on the clinical horizon give weight to its potential usefulness in treatment.

This study's findings also point to the need for clinicians and researchers to consider focusing on developing spiritually integrative treatment models, especially for hard to treat conditions like anorexia nervosa, wherein faith has the potential to play such a vital role in recovery. It would seem likely that individuals of faith would benefit from integrative models, such as the one presented here, that address all of the diagnostic conditions. If, as stated by Miller and Thoresen (1999), "about 95% of Americans say that they believe in God," "for many spirituality and religion are important sources of strength and coping resources," and "many people name them as the most important aspects of their lives, central to their meaning and identity" (p. xviii), it seems incongruent that "consideration of spirituality remains the exception rather than the rule in [mental] health care" (Miller et al., 1999, p. xix).

One way clinicians and researchers interested in answering the call for further research attention to the incorporation of spiritual perspectives into empirically based treatment (Miller et al., 1999) is to follow the method found in this study. This would entail completing a comprehensive literature review to determine (a) the current standard of treatment for a particular disorder; (b) what is known about spiritual integration in the treatment of the particular disorder; and (c) what is known about Christian (or whatever faith is being explored) spiritual integration in the treatment of the particular disorder. Then research can be implemented that is designed to confirm and extend the model.

Another method of extending spiritually integrated, scientific methodology in this area is to ask the questions posed by Miller et al. (1999) including, "What is already known from scientific research about spirituality in relation to this area of [mental] health? What do we need to know-what are the pressing questions to be asked next?

What scientific methods could be used to answer these questions? ” (p. 11). Whatever the means, the findings from this study and the literature suggest the need for the development of spiritually integrative treatment models.

This section of the chapter has discussed the importance of developing spiritually integrated models for the treatment of various mental health conditions. The Christian spiritual integration model that emerged from this study was visually portrayed in its completed form, including a decision tree for use by clinicians working with this population. The model was also presented as a potential template for subsequent research that focuses on delineating spiritually integrative models for other disorders. In the next section recommendations for further research based on the findings will be provided.

Recommendations for Further Research

In this section recommendations for further research will be provided that relate to the findings from this study. First, suggestions that relate to the current standard of practice in the treatment of anorexia nervosa will be provided. Next, suggestions for research that relate to spiritual integration will be given. Finally, recommendations for research on Christian spiritual integration in the treatment of anorexia nervosa will be presented.

The spiritual integration model that emerged from this study is based on the current standard of practice in the treatment of anorexia nervosa. At this level of the model a tremendous amount of research opportunity exists. Although a devastating illness with the highest mortality rate of any other mental disorder (Crisp, 2006), there still remains a serious deficiency in research attention to anorexia nervosa (LeGrange et

al., 2005). In terms of general research recommendations, studies that respond to the American Psychiatric Association's research agenda for anorexia nervosa, as summarized here, are encouraged. These include

> Studies about biological and psycho-social risk factors for eating disorders, developmental issues in eating disorders, influence of co-morbid conditions on eating disorders, the effects of exercise and food restriction on the onset of eating disorders, women's athletics and eating disorders, family influences on the onset and maintenance of eating disorders, primary prevention of eating disorders, and outcome studies of various interventions for eating disorders (Richards, et al., 2007, p. 207).

In addition to these, the findings from this study point to the importance of further research efforts that explore spiritual issues and interventions relative to anorexia nervosa. In this study several issues directly related to spirituality and anorexia nervosa were revealed. The co-researchers, confirmed that (a) distorted religious beliefs helped to maintain the disorder; (b) religious meanings were attached to the disorder; (c) the anorexia nervosa undermined personal faith; (d) faith recovered along with general recovery, when it was addressed in treatment; (e) participants found that faith was helpful in treatment and recovery, in particular via the person of the therapist along with CCBT and "fighting the good fight" tools; (f) the model introduced in this study may help professionals implement spiritual perspectives and interventions with this population; (g) the recovered participants all preferred that their faith be incorporated into their recovery; (h) the participants felt that the use of spiritual interventions enhanced the effectiveness of treatment; and (i) the participants found that their faith helped prevent relapse and promote long-term recovery.

Consistent with the implicit model of spiritual integration (Tan, 1996), findings from this study reflect the importance of the therapist's own spirituality and

“incarnational” stance in the initial stages of treatment with later explicit integration occurring once the therapeutic relationship is solidified. Additionally, because this population has often had “toxic faith” (Arteburn et al., 2001) relational experiences, avoiding a legalistic or controlling stance in treatment is indicated (McMinn, 1996).

Finally, research that confirms and expands on the findings from this study regarding Christian spiritual integration, research that focuses on the development of Christian spiritual integration models for other disorders, and research that explores diverse faiths and spiritual orientations relative to etiology, maintenance and recovery of anorexia nervosa and the various other disorders is recommended. The last section of this chapter locates the researcher in reference to this study’s findings.

Locating the Researcher in Reference to the Findings

During these months of research immersion a song has been reverberating and rising in the recesses of my mind. It started tenuously and quietly, barely recognizable at first. Looking back, I can see how the tune was gently prodding and encouraging me all the while. It was playing when the reverie, referred to in Chapter One, occurred and I “saw” the bastion, the dungeon and the prisoner. It rang out softly when the veil fell from my eyes and I discovered that I too had become captivated by “the voice;” and it fueled and empowered me as I took back my freedom. By degrees the song arose, during the course of the literature search, in and through the plane ride and visit to the observation site, during the interviews, and in the course of the writing.

The song was playing at the observation site, amidst the starving women. I saw shackles; even then, falling as faith poured out through the hands and hearts of the staff and took hold of the prisoners. I heard inklings of it as I pondered captive's faces and could see the rebirth of a tentative hope, the hiding turning into queries. These emaciated women conducting their own forms of research: "Is it possible that love is real? Can I be safe apart from this dungeon? Can I connect with God and others and not be consumed?"

The melody, like a summer breeze, was rising as I sat with the victorious, yet battle-wounded recovered co-researchers. With Caitlin, who taught me the importance of fighting with *everything* you've got; and to keep doing so because it's never really over. While looking into the tear filled eyes of Paige, with her message that recovery is a process; and that "God has *every* answer." With Jennifer, who spoke of the power she found in using the words of scripture to fight "the horrible voice." A voice I too have known so well, that though still threatening, can no longer smother the song. And Sondra, who tutored me on the brightening of hope, the naissance of trust, and the emergence of authenticity born in the context of the therapeutic relationship and culminating in a mature and congruent faith. And finally with Rosalind, who, filled with the wisdom acquired from years of torment and of triumph, gave me this gift: "We can make the choice to give up control."

I heard the melody warmly rising, and discovered it a fighting song, a song of hope, a song of true deliverance as I sat with these amazing women who, although ever bearing the scars of their battles, now stand as beacons of light, shining to others who dare to resist this menacing darkness. They have taught me the pivotal role that faith can

play in recovery and the necessity of being helped to find in faith what anorexia nervosa can never provide: love, security, hope, and peace.

The poetic words of the hymn gently broke through as I sat at the feet of the masters, the clinician co-researchers. Dr. Carmen, who showed me how to *really* bring faith into the treatment; Dr. Benjamin, who demonstrated how faith works throughout the model; and Dr. Jessie, who exemplified how faith is born in the process of relationship. I am indebted to them all.

My mind's eye turns now from the participants' faces, my mentors and teachers, back to the reverie of the bastion (Chapter One). Back to what I sensed I was called to do. I can hear the melody leading me as I stand before the looming citadel and prepare to re-enter its' darkness. I am ready now to face my fears. I descend the endless stairways, unlocking gates and pressing through. Though the 'voice' tries to deter me with images reflecting my deepest fears, I am steady and not alone. Down and down I descend until I enter the abominable dungeon and see her withered form.

Gently I take up the unchained captive and carry her through the opened door; notes of music—like luminaries around us. He is with us and we are ascending the multitude of stairways, passing through the dank, black fortress, winding and winding upwards. As we do, the music strengthens and a stray beam of sunlight makes its way into our midst. I carefully let her down to stand on her own two feet. I wipe her forehead. She is gaining strength as her trust begins to grow. She may be crying but I feel her hope, as upwardly we travail together now walking hand in hand.

Then in an unexpected moment, while the song breaks through with joy, she pauses and looks past me, finally seeing Him and His loving gaze. She drops my hand and walks beside me able now to stand on her own.

Finally, we break through the last barred doorway; leaving behind the final locked gate. The sun's dazzling brightness falling upon us; behind our backs the bastion breaks. And above its crashing comes resplendent, now the song with loudest praise:

> In these days of confused situations, in these nights of a restless remorse, when the heart and the soul of a person, lay wounded and cold as a corpse.
>
> From her dungeon a rumor is stirring, she has heard it again and again [that God loves], but this time the cell keys are turning and outside there are faces of friends.
>
> And though her body lay weary from wasting; and her eyes show the sorrow she's had, the love that her heart is now tasting; has opened the gates BE GLAD!
>
> So, [counselors] be like lights on the rim of the waters, giving hope in this storm sea of night; be a refuge amidst the slaughter, of these fugitives lost in their flight.
>
> [Show her that] she is timeless and part of a puzzle, she is winsome and young as a lad, and there is no disease or no struggle that can rip her from God, BE GLAD!
>
> (Blanchard, undated)

Summary

This chapter provided a discussion of the implications of the research findings. First, the findings were compared and contrasted with the conclusions in the literature. The two research questions were answered regarding the role of Christian spirituality and the specific Christian spiritual interventions that support recovery from anorexia nervosa. Next, recommendations for further research were provided. Finally, the researcher was located in the research findings.

Final Summary

This study provided a preliminary look at the important role spirituality may play in the etiology, maintenance, and treatment of Christian women with anorexia nervosa. First the purpose of the study, research questions, definitions and description of the researcher were provided. Next, a review of the literature and a proposed model of spiritual integration were introduced. Subsequently, the research method was presented, including a description of the case study method, a definition of the case, a presentation of the research questions, an explanation of data collection and data analysis procedures, and a discussion regarding trustworthiness. Next, the findings were provided, including an introduction to the co-researchers and a presentation of the relevant results. Finally, a discussion of the findings was presented, including the significance of the research findings, the importance of developing spiritually integrated treatment models, recommendations for further research, and closing comments from the researcher. It is my hope that this exploratory study has provided a springboard for further research in the important area of spirituality and recovery from anorexia nervosa.

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APPENDIX A: INFORMED CONSENT

CONSENT FORM

Christian Spirituality and Recovery from Anorexia Nervosa

Lisa S. Sosin, LLP

Liberty University

Department of Counseling

You are invited to be in a research study on Christian Spirituality and Recovery from Anorexia Nervosa. You were selected as a possible participant because of your history or expertise. I ask that you read this form carefully and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Lisa S. Sosin, LLP

Background Information

The purpose of this study is to understand and further the research knowledge base on this subject.

Procedures:

If you agree to be in this study, I will be asking you to do the following things:

- Sign this consent form after asking any questions you may have.
- Write a brief outline of your recovery from anorexia nervosa and the impact Christian spirituality had on your recovery (or your experience as a therapist facilitating recovery from anorexia nervosa and the impact Christian spirituality has had on your recovering clients).
- Participate in a sixty to ninety minute interview which will be audio-taped and transcribed or telephone interview in which notes will be taken by the researcher and sent to you for clarification and/or correction.
- Be available for follow-up questions if needed for the purposes of clarifying data.

Risks and Benefits of being in the Study

The risks of participation in this study may include discomfort in reviewing and sharing aspects of your history that may be uncomfortable to share. It may feel uncomfortable or

awkward to share your history with me, a stranger. You may feel a sense of shame or exposure. You are giving of your time, your emotional resources, and your priceless experience as a clinician or a recovered individual and this giving can exact from you an emotional cost.

The steps taken to minimize those risks include my efforts to make you as comfortable sharing with me as possible, your preparatory outline writing and prayerful consideration prior to participation, the confidentiality practices listed below, your informed consent, the availability of debriefing with me or another therapist, and the ability to revoke your participation at any time.

The benefits to participation include knowing that sharing your story may help others, furthering the knowledge base for researchers and clinicians, and glorifying God by displaying His power in what He has done for you in your recovery or your work with those in recovery.

Confidentiality:

The records of this study will be kept private. In the dissertation report or any subsequent journal publications or presentations, I will not include any information that will make it possible to identify you as a subject.

All transcribed and audio taped data or notes will be coded in such a way that your identity is protected. The audio taped data will be immediately erased after the transcription is complete and all transcribed data or notes will be destroyed within three years of the study's completion. Until that time data will be stored in the office of the researcher in coded format and inaccessible to outsiders.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the Liberty University or with Lisa Sosin, LLP. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is: Lisa S. Sosin, LLP. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact me at 248 872- 2824 or lssosin@sbcglobal.net .

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Human Subject Office, 1971 University Blvd, Suite 2400, Lynchburg, VA 24502 or email at irb@liberty.edu.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature: _____Date: _____

Signature of Investigator:_____ Date: _____

APPENDIX B: INTERVIEW PROTOCOL

Project Title: *Christian Spiritual Integration in the Treatment of Anorexia Nervosa: An Exploratory Study and Proposed Model Based on the Literature*

Lisa Sosin, Principal Investigator
Liberty University

1. Contact potential participant by telephone and explore interest level and appropriateness of candidate by asking screening questions:

    - Determine if candidate is recovered from anorexia nervosa, or is a PhD level counselor with specialization in treating anorexia nervosa, as defined in Chapter One of this document.
    - Determine if candidate is Christian, as defined in Chapter One of this document.

2. Mail a description of the study and the consent form to candidates who meet the requirements for participation in the study.

    - Receive consent form back signed by participant
    - Answer any questions participants may have about the study and their participation in it
    - Set up an interview date and time
    - Request participant to send a detailed and comprehensive outline of their recovery, or treatment experiences as a counselor, including, but not limited to, the role of Christian Spirituality in recovery. Request participant to share any other documents they have written, or they suggest my reading, relative to recovery from anorexia nervosa and/or Christian spirituality and recovery from anorexia nervosa. Ask participant to send the outline and other documents to me in advance of the interview and to utilize the outline as an interview guide during the interview.

3. During the 60-90 minute interview, participant will elaborate on the outline. The researcher will utilize outline, if needed, to prompt for further, deeper or more focused explication on the subject of the inquiry.

    - Receive consent for participant to receive the transcript, or notes if not audio-taped, of the interview in order for participant to check for accuracy and expand on contents, if indicated, and for other clarifying contact, if needed, during the data processing.
    - Communicate researcher availability to receive additional documents or information on the subject of the inquiry, to answer any further questions, and to respond to any emotional/psychological needs that may arise as a result of participation in this study.

APPENDIX C: LIST OF MAIN THEMES AND SUB-THEMES

Theme One: Prior to Treatment: Spiritual Disconnection

- Suffering and Brokenness
- Taking Control of Brokenness through Anorexia Nervosa
- Her Broken Faith

Theme Two: During Treatment: Reconnecting to the Spiritual

- The Person of the Therapist
- The Mending of Her Faith
- The Tools

Theme Three: After Treatment: Sustaining Spiritual Connection

- The Battle Continues
- Lessons from the Suffering