Resiliency of Females Who Have Suffered From Eating Disorders

XXXXXXXX

Chapman University

This study explores the paths of resiliency females use to overcome the devastating consequences of eating disorders. Eating disorders can negatively affect the physical, psychological, social-emotional and academic well-being of students. Therefore, for those suffered from eating disorders, success in any of these categories should be considered a great accomplishment. This article examines the resiliency of three females who have suffered from an eating disorder and have gone on to lead heathy and productive lives.

Eating disorders are overwhelming illnesses that significantly impact the physical and psychological well-being of their victims. The two main types of eating disorders discussed in this article are Anorexia Nervosa and Bulimia Nervosa. Anorexia Nervosa is characterized by limiting food intake, fear of being fat and body image issues (American Psychiatric Association). A person suffering from anorexia nervosa is significantly underweight and unable to maintain a normal body weight because of the weight-loss behaviors. These weight-reducing behaviors include excessive exercising, vomiting, use of laxatives, and restricting food. Bulimia nervosa is characterized by binge-and-purge behaviors. Patients who suffer from bulimia consume large amounts of food followed by a fear of gaining weight or pain from consumption and purge the food out of their bodies by vomiting or using laxatives (American Psychiatric Association).

Eating disorders are widespread, affecting 30 million Americans, and 43.5% of American girls report signs of disordered eating during childhood (Gicquel, 2013). A concern, however, is that many cases are being overlooked and not receiving necessary help. Through revisions to the clinical definition and updates on symptoms of eating disorders, the DSM-V has allowed for more women to be diagnosed with an eating disorder who were previously undiagnosed because they did not satisfy the criteria (Mustelin et al., 2016). The new classification has increased the population prevalence by 60% (Mustelin et al., 2016). This change in diagnosis criteria has

identified more people as having an eating disorder and has allowed more people to receive services and treatment earlier than with the previous DSM-IV. This improvement is important because early identification is crucial for recovery.

Although extremely dangerous on their own, eating disorders are especially devastating because they are commonly attached to other serious mental illnesses, most commonly, depression, anxiety, mood disorders, and substance abuse. Between 51-93% of individuals diagnosed with an eating disorder report a comorbid psychiatric diagnosis (Rojo-Moreno et al., 2015), meaning eating disorders can be the 'tip of the iceberg' for these children.

Because the peak of onset for developing an eating disorder is between 14 and 18 years of age (Volpe et al., 2016), school age children are suffering from these mental illnesses that can cause life-threating consequences. Recovery, however, is possible. While studies vary greatly on recovery rates, one study has shown that of the patients who suffer from anorexia nervosa, 37% recover within 4 years after disease onset. This increases to 47% by year 10 and finally increases to 73% after 10 years post onset (Zerwas et al., 2013). A successful recovery can be influenced by factors such as early intervention, social support and the resilient nature of the patients themselves.

Resilience

Resilience is the ability to self-correct and display a positive version of oneself despite experiencing adversity (Masten, 2011). This dynamic process is of interest to scientists because the phenomenon is both common and difficult to define. The study of resilience started in the field of medicine when scientists started examining human development and how humans recover from pathological disorders (Zolkoski, 2012, Masten, 2011). Then the field of resilience moved toward studying children. Despite growing up in extreme difficulty, children were able to

succeed beyond their adversity (Zolkoski, 2012; Masten, 2011). Children who experience adversity are commonly expected to never recover due to their experiences. There are, however, countless examples of children enduring aversive experiences who manage to not only survive, but prosper and thrive (Condly, 2006).

Many wonder if resiliency is embedded in the DNA of certain children and not in others. This is a common misconception of resiliency. In fact, it is believed that every person has the innate ability to be resilient (Zolkoski, 2012). Resiliency is a process that is fostered by common protective factors and personality attributes. The protective factors that contribute to resiliency are individual personality characteristics, family dynamics, and community support (Condly, 2006; Zolkoski, 2012). The common attributes found in resilient children are social competence, problem solving skills, critical consciousness, autonomy and a sense of purpose (Zolkoski, 2012; Bernard, 1993). This article examines three females who have experienced an eating disorder and have overcome it by demonstrating resiliency through numerous protective factors and personality characteristics.

Challenges of diagnosing and overcoming an eating disorder

In order to understand the difficulty of overcoming an eating disorder, it is important to know the challenges females with eating disorders face. Information shows that the percent of relapse in eating disorders can range anywhere from 6% - 50% (Berends et al., 2016), but multiple credible studies have shown that full relapsing rates average between 35%-41% (Berends et al., 2016; Carter, Blackmore, Sutandar-Pinnock, Woodside, 2004; Carter et al., 2012; McFarlane, Olmsted, Trottier, 2008) and that the first year out of treatment is the most common time for relapse (Herzog et al. 1999). Because the rate of relapse can be so high, Keski-Rahkonen, Raevuori, Bulik, Hoek, Rissanen, Kaprio, (2014) studied what made recovery likely.

In their unique study involving twins and multiple surveys at different ages, they found that recovery is less likely if patients had a diagnosis of major depressive disorder or premorbid depressive symptoms that were not prevalent enough to be fully diagnosed, but clearly observed by the researchers. In addition, they found that unrecovered patients in the study reported perfectionistic tendencies. This is an important study to recognize because it has been reported that more than half of patients diagnosed with an eating disorder display comorbid diagnoses (Rojo-Moreno et al., 2015), making recovering from an eating disorder difficult.

Another difficult aspect of eating disorders is the high likelihood of comorbidity with other serious mental disorders. Comorbidity is the condition of multiple diagnoses happening simultaneously (Hughes et al., 2013). The comorbidity of eating disorders is of interest because it complicates the severity of the disease, the diagnostic procedure, and the recovery process.

When researching the relationship between eating disorders and anxiety, Rojo-Moreno et al. (2015) found that by testing close to 1,000 teenagers from five different schools, 62.9% of individuals with an eating disorder had a comorbid diagnosis, 51.4% of which were anxiety disorders. To further understand the magnitude of the effect of comorbidity, Hughes et al. (2013) compared patients with eating disorders who have no comorbid associations with patients who have comorbid mood and anxiety disorders. They found that when compared to patients who did not have comorbid associations, patients with a comorbid mood or anxiety disorder had more complex and severe symptoms. Patients with a comorbid mood disorder had the highest levels of both dietary restriction and depression symptoms, as well as the poorest self-esteem (Hughes et al., 2013). The combination of anxiety and mood disorders compounds the effects of eating disorders.

Comorbidity further complicates the severity of eating disorders when researching the connection between it and suicide risk. Johnson, Weiler, Barnett and Pealer (2016) found that after assessing over 4,000 students in various states for extreme weight controlling behaviors and suicide risk, a significant amount of students who were thinking about, planning or considering attempting suicide had also engaged in unhealthy weight controlling behaviors. Goldberg, Werbeloff, Shelef, Fruchter and Weiser (2015) studied the reverse relationship and found that patients who experience a moderate-severe eating disorder have a greater risk of suicide than those who are not experiencing an eating disorder.

Finally, one of the biggest challenges patients face with overcoming an eating disorder is being diagnosed early enough. Countless studies have shown that an early diagnosis is crucial for recovery. Although changes to the DSM-V have allowed for more people struggling with an eating disorder to be clinically diagnosed (Mustelin et al., 2016), there are still difficulties diagnosing an eating disorder because symptoms of an eating disorder can look like symptoms of other diagnoses. The comorbidity of eating disorders creates a complication with diagnosing as well. For example, lack of appetite, lethargy, poor concentration, and guilt are all signs of major depressive disorder (American Psychiatric Association, 2017), and of eating disorders (Hughes et al., 2013). This adds to the difficulty of understanding the signs and symptoms of eating disorders.

Paths to resiliency

One path to resiliency and overcoming eating disorders is the avenue of social support systems. Because positive social support is linked to healthy coping strategies for other physical and emotional stress, it is most likely a significant factor of recovery for people who have suffered from eating disorders (Linville, Brown, Sturm & Mcdougal, 2012; Stice, Ragan &

Randall, 2004). To study this effect, Linville et al. (2012) interviewed 22 female recovered patients to examine if social support was helpful or hindering to their recovery. Many themes emerged from this study, including positive feelings towards social support systems. Of the 22 participants, 17 reported reconnecting to supportive people in their life, such as family and friends, as crucial to their recovery. Although a theme of unsupportive families was also found from the interviews, most felt the social support of families is helpful. Even though families are important for recovery, the acceptance, attentiveness, and emotional support from friends allowed for 12 participants to fully recover because it eliminated the feeling of isolation and allowed for recovery. In addition, 12 interviewees discussed the compassion they felt from health care providers and seven interviewees credited their positive experiences with therapy as an essential part of their recovery.

The work of Nilsson and Hagglof (2006) echoes this point while studying the effect of turning points in a follow up study with patients who suffered from anorexia nervosa 16 years prior. Their findings showed that of the 68 participants, each of them could recall a turning point in their recovery process. The turning points were categorized as either sudden or gradual events. The study found that most of the turning points reported were associated with the realization that illness/starvation would lead to death and that their illness was affecting their own lives as well as the lives of their significant others. The interviews also involved examining who was most important to the patients during their recovery process. Of the participants, 43% mentioned friends and 38% mentioned family as the most useful support system during recovery. This furthers the research on the importance of support systems to promote the resilience against eating disorders.

Arthur-Cameselle and Quatromoni, (2014) further confirmed this point when they examined collegiate female athletes and the factors that promoted their recovery. In their study, 28% of participants expressed that support from others aided in their recovery. Another important finding showed that 34% of the athletes used their drive to get healthy enough to return to their sport as their primary source of resilience. This shows that in addition to support systems, internal factors are another substantial avenue of resilience.

According to Levallinus, Roberts, Clinton, and Norring (2016), internal factors such as extraversion and assertiveness have emerged as personality traits that predict recovery and symptom improvement. This was found by studying 130 females who fulfilled the DSM-IV diagnostic criteria for an eating disorder. Using structured interviews, the Eating Disorder Inventory-2, Clinical Impairment Assessment and the NEO Personality Inventory Revised, researchers found that a take-charge type of personality, particularly the positivity, sociability and leadership aspect of assertiveness was statistically significant in relation to recovery.

Las Hayas et al. (2016) studied the resilience of women who suffered eating disorders to find why some women recover and some do not. Their study composed of ten semi-structured interviews and focus groups with patients and caregivers of patients suffering from eating disorders. Through these interviews and focus groups, the reason for everyone's resilience appeared. Main themes were gathered from the interviews. The first theme was having a deep dissatisfaction with life, meaning individuals were depressed and frustrated with their lives. Another theme individuals experienced was that major turning points initiated the recovery process, because they had a sudden realization of the severity of their disorder. Seeking out social support was another part of the resilience process for many of the participants. Other participants mentioned understanding the dangers of their eating disorder and gaining knowledge

about the disease sparked the need to recover. Finally, participants reported that identifying their hopes, dreams and goals for their life showed them that they needed to change because the goals they were setting went beyond their current situation with the eating disorder, making it clear that they needed to change in order to achieve these dreams.

Method

Research was conducted by using the ERIC-EBSO Chapman Library website and searching for articles using keywords such as "eating disorders," "resiliency," "recovery," "relapse." Additional articles were retrieved by using references from previously found articles. Interview participants responded to a posting on Facebook requesting individuals who fit the criteria and were willing to participate in an interview. Two interview participants privately responded to the researcher and agreed to an interview. The third interview participant was referred by a mutual friend of the researcher. All participants were contacted by phone to set up interviews. The semi-structured interviews lasted between 50 and 75 minutes, were conducted in a quiet public place, and recorded by hand.

Participants

"Morgan"- Morgan is a 23 year old Caucasian female living in Anaheim, California who suffered from two eating disorder episodes during her adolescence. Morgan grew up in a family that abused drugs and she was referred to Orangewood Children and Family Center. After being placed with another abusive family, she was removed and placed with her current family. Her first episode occurred when she was 14 and her second episode occurred when she was 18. When she was 14 years old, she experienced severe body dysmorphia and started restricting food so much that she started to eat nothing at all. At the age of 16, she lost one of her best friends to suicide. This event made her realize she wasn't invincible and made her want to stop hurting

herself and her body. When she was 18, she was in an unhealthy relationship with a boyfriend who was cheating on her. After constantly comparing herself to the other girl, in an attempt to control her life, she began restricting food again, lost a significant amount of weight, and was extremely unhealthy. Her family helped her start seeing a therapist who addressed many aspects of her mental health including diagnosing her with bipolar disorder, chronic depression and the eating disorder. She was prescribed medication, which helped get her on a healthy path. She is currently living with her boyfriend and working after studying photography at Santiago Canyon College.

"Madison" - Madison is a 22 year old half Hispanic, half Caucasian female living in Redlands, California who comes from a close-knit family and was heavily involved in sports during her childhood and adolescence. She suffered from disordered eating thoughts at the age of 16 that manifested to anorexia nervosa at the age of 18. In her freshman year of college while involved in athletics, her eating disorder began to spiral out of control. She was then diagnosed with anorexia nervosa, depression and anxiety. With the help of her best friends and family, she was placed in a residential treatment center where she received the help she needed to learn about her eating disorder, why it affected her, where her anxiety and depression came from, and necessary coping mechanisms to continue recovery. After finishing a collegiate sports career and graduating from her undergraduate university, she is continuing her education in order to pursue a teaching career. She is now 3 ½ years passed her eating disorder and has a much healthier relationship with food. Although there are still days she struggles, she is so much happier with her life because she has accomplished so many goals and her relationship with her family is stronger than it has ever been.

"Courtney"- Courtney is a 24 year old Caucasian female living in Orange, California. She was born in the U.S., but at the age of nine, her family moved to Singapore. Her disease started in high school during the same time her twin brother began showing signs of major depression disorder. In order to be "the perfect child," she began putting immense amounts of stress on herself. When her mother and brother left Singapore to get him help for his depression and her father would travel for business, she was living alone for long periods of time. Courtney wanted desperately to "fix" her family, but felt completely out of control. The one thing she was in control of was what and how much she was eating. When she went to college in southern California, she began to realize how alone she was and her disease began to take over her life. A voice in her head, which began in Singapore, grew to be so loud and so negative that she couldn't concentrate on anything else, but she didn't care because she loved the voice since "it was there when everyone else left." She fell into a major depression and began restricting food more than ever. At the lowest weight she has ever been, her body was so weak and her depression had worsened so much that she began to contemplate suicide. After a major turning point, she found the strength she needed to live and obtain the help she needed. After five years, post onset, she continues using skills she learned in therapy to help continue her journey to recovery. She is now getting her MFT from Chapman University and has written a book about her life experience and suffering from her eating disorder.

Findings

Theme One: Lack of support in Schools

It is known that eating disorders are hard to diagnosis properly because of their tendency to be comorbid with other mental health disorders and common relapse rates. In addition, early diagnosis is very important for a successful recovery. Because the average onset for the disease

is during high school, school personnel could be the first to identify adolescents who are suffering. Schools are a refuge that provides a protective shield for students (Bernard, 1993) and if students are suffering from mental health problems, they should be given support from school programs aimed at helping them. Mental health programs in schools need to reduce risk factors, symptoms and onset without increasing the stigma or identifying the individuals. These requirements make prevention programs hard to implement successfully and therefore many schools do not implement programs at all. If mental health programs are implemented, the likelihood of them being focused on eating disorder is small. It has been reported that school psychologists do not feel trained or competent assessing for an eating disorder (Carney & Scott, 2012; Stachowitz, Choi, & Schweinle, 2014). This combination creates a lack of support from schools for adolescents struggling with eating disorders. This is consistent with the findings from interviews with Morgan, Madison and Courtney when asked about the amount of support they received in school during their struggles.

When discussing the difficulties of going through this during high school, Morgan expressed that there wasn't anyone near her who could or wanted to help her. She also expressed how she wished eating disorders were discussed in schools because she was not aware of the extensive damage she was doing to her body. Although she cannot be sure, she feels this could have made her recognize and decrease the severity of her actions, as Las Hayas et al. (2016) insinuated. She also added that she believes that mental health should be embedded into the curriculum and discussed because "children go through terribly hard real-life issues in high school and pretending that it doesn't happen is not helpful. It makes us feel even more alone than we already do."

Even though Madison experienced her disorder in college, she found the same lack of support.

> "My university did not have great programs when it came to eating disorders. There were no support groups and it was a taboo thing to talk about. There were three counselors in the on-campus counseling center, but none of them had an eating disorder background. Other mental health disorders had a lot more emphasis put on them, but nothing for eating disorders. It made it seem like I had even more of a problem."

Courtney stated that she "just wished someone noticed and cared." She also said how pivotal it would have been if someone just asked, "Are you OK?" Because this did not happen, she was forced to try to handle it on her own. "I was a young girl who had been picked up and moved to an entirely new culture and then my parents left me. I was alone and trying to handle all of this."

Because all three participants did not receive adequate support in schools, they needed to rely on other paths of resiliency to overcome their eating disorders.

Theme Two: Friends and Family for Support

As it has been pointed out, there is evidence showing that support systems are a major opportunity that fosters resilience. Support systems commonly include families, friends, health care professionals or other members of a person's recovery team. The family dynamic provides physical, emotional and spiritual needs that serve as one of the main protective factors of child resilience (Masten, 2014; Condly, 2006; Zolkoski, 2012). Friends can provide emotional support that also serves as a protective factor during adversity. The combination creates a powerful social support system that is ideal for facilitating resilience. Social support helps patients suffering from

eating disorders to seek advice, moral support, sympathy, energy and understanding (Las Hayas et al., 2016).

When asked what promoted their resilience in overcoming their eating disorders, Morgan, Madison and Courtney all spoke of their supportive friends and family and how essential they were during the recovery process. Although conflicts did arise between the three participants and their own social supports during the peak of the disorder, their support systems were a source of positivity during the recovery process. Morgan mentioned a supportive family and friends, but commented that her biggest source of support was from her therapist. Similar to Linville et al. (2012) research, Morgan credited her positive experience in therapy and her supportive relationship with her therapist as a main source of support saying "I don't know if I would be alive today if it wasn't for him."

Madison also credits her social support system for being essential for her recovery. She praises her best friends who didn't let her continue to hurt herself and initiated her recovery journey. Her friends were also "there for her" for emotional support and accountability on her tough days during recovery. She also spoke highly of her family for being understanding and accepting of her disease. Her family helped her get into a treatment center and took part in family counseling sessions. There, they learned about the triggers and causes of her disordered eating thoughts and actions. Before the onset and after recovery of her eating disorder, similar to findings by Condly (2006), Madison was close with her family and had parents who were involved in her life, creating a healthy relationship with them. This could have contributed to her ability to overcome and be resilient against the eating disorder.

Courtney furthered the finding about the importance of social support when she commended her sorority sisters for "taking care of her" when it felt like she was completely

alone. Her friends would ask what she needed, made sure one of them was eating with her at every meal, ate "scary" foods with her and kept her accountable during her recovery. This is similar to the findings by Las Hayas et al. (2016) who found social supports helped patients seek sympathy, understanding, assistance and moral support. Courtney also credited her team of doctors, nutritionist and psychologist who worked together and communicated to discuss her recovery and keep her on track to a healthy life.

Theme Three: A Turning Point toward a Sense of Purpose

One of the main attributes found in resilient children is a sense of purpose (Zolkoski, 2012; Bernard, 1993). A sense of purpose is the motivation or drive to reach a successful future. Morgan, Madison and Courtney all discussed finding their sense of purpose again after a major turning point occurred in their lives. These turning points led to the realization that they needed to get help and start the recovery process. Then, additional turning points in the recovery process led to all three participants finding their sense of purpose. Turning points can be a gradual accumulation of realizations or a sudden instance of clarity (Nilsson & Hagglof, 2006). For Morgan, her turning point was therapy. But, in order to get into therapy, she had to experience a mini-turning point. This occurred when she was in the bathroom of a restaurant and her sister had barged in on her throwing up the little dinner she had just eaten with her family. Her sister was mortified at what she was witnessing and yelled "Stop this. You are killing yourself!" The words "killing yourself" instantly brought back the pain she had endured over losing her friend to suicide in high school. Similar to findings by Nilsson and Hagglof (2006), Morgan's sudden insight that she was hurting her body so much that she could be killing herself made her realize that she didn't want to hurt herself like that anymore. This brought her to therapy. While in therapy, she had a gradual turning point toward a sense of purpose.

> "Therapy was definitely a turning point for me because I got to work with someone who showed me that my life matters. He helped me see life differently because I was coming from such a negative place. I wondered all the time if I should even continue living. My therapist opened my eyes that I need to be healthy in order to complete my mission in life."

A sense of purpose can be something as simple as having goals for the future (Zolkoski, 2012; Bernard, 1993) and when asked what Morgan's mission in life is, she shared that therapy allowed her to realize that many people go through terrible experiences in their lives and she wants to help people by sharing her experiences to let them know that they can get through it too. She remembers asking herself "Who is going to help the people like me, if I am not here?" Realizing that she needed to be healthy herself to do this was a major turning point in her recovery and she is forever grateful that she experienced it because she doesn't know if she would be here today without that.

Madison's turning point of recognizing she had a problem and needed to get help occurred in the back seat of a car on the way to the hospital. She had passed out in a bar from lack of food and her friends made the decision to take her to the hospital.

> "I was in the back seat of my own car and I remember one of my best friends hovering over me trying to keep me awake. I was going in and out of consciousness and she began doing compressions on my chest. It was the closest thing to an out of body experience, I've ever experienced. I felt like I was looking down on us in the car and realized I have a problem and my friends have been offering help for a long time and I need to start taking it."

Madison's experience echoes a theme in Las Hayas et al. (2016) that patients need a realization that sparks determination to change. Once in a residential treatment center, she was determined to start her recovery journey. In her room at the facility, she kept pictures of her friends and family around a calendar with a countdown to the next major softball tournament marked as a goal to get healthy for. She had found that her sense of purpose was to get healthy and realized that she could have a successful athletic career and a healthy future. Similar to findings from Arthur-Cameselle and Quatromoni, (2014), Madison's drive to recover came from her desire to get back to her teammates and to the sport she loved.

Courtney's sudden moment of clarity was "a clear act of God" and similar to a finding by Las Hayas et al. (2016) who found that many patients suggested that hope and faith is what allowed them to begin the recovery journey.

> "It was September 11, 2012 and I was sitting on my bed in my apartment while no one was home. My depression had worsened so much and the voice inside my head was so loud that I couldn't take it anymore. I got off my bed and got on my knees – all 75 pounds of me- and began to pray for the first time in a very long time. I said, very clearly, God, if you are listening and want me to live, you have to show me because today is the day I am going to kill myself. Two minutes later, I hear a knock on my door and I go answer it. A girl from two floors above me is there and says 'Hey I don't know why, but I just wanted to come down and see how you are doing today.' I immediately drop to the floor and start crying because I realized that God wanted me to live."

From that moment on, Courtney knew that faith could get her through anything and her sense of purpose in the world is to follow God and continue living.

Masten (2014) suggests that systems of belief are particularly important for resilience when faced with feelings of loss of control. Consistent with that thesis, all three participants stated on multiple occasions feelings of being out of control and unaware of how much their eating disorder was taking over. Likewise, all three mentioned their sense of purpose helping them during their recovery. Las Hayas et al. (2016) concluded this further in her findings of resiliency and eating disorders and reported that people who suffer from eating disorders and recover accept their illness and decide to change their way of life. Experiencing hope is a vital part of the process to overcome an eating disorder. This experience of hope echoes Masten's (2014) findings that hope, faith and the belief that life has meaning are associated with resilience. This was confirmed by Morgan, Madison, and Courtney, who all reported having a strong feeling that their lives have meaning, and all three are living healthy lives trying to give back and help others as much as they can.

Limitations

This study has explored the resiliency of three females who suffered from eating disorders as adolescents and overcame them. There are obvious limitations of this research. One limitation is that only three individuals were interviewed and all three suffered from anorexia nervosa. This leaves out two of the other common eating disorders, bulimia and eating disorder not otherwise specified (EDNOS). Another limitation is that all participants were female. Although this is what the study called for, males experience eating disorders as well. Studies on males suffering from eating disorders are a potential future research opportunity which could help find other sources of resiliency. Because of the small sample size and commonality in gender and age, more research is necessary in order to further understand the resiliency in overcoming eating disorders. Although common themes were found through the participants in

this study, more themes could be uncovered if the sample included more diverse individuals. This could lead to an even greater understanding of how adolescents overcome and show resilience against eating disorders.

Implications

Because the average onset of anorexia nervosa and bulimia is between 14 and18 years old, individuals who are suffering from these disorders are students in high school. Students spend between seven or eight hours each day on a school campus. This puts school counselors or school psychologists in a position of being on the front lines and having an excellent opportunity to help identify students who may be struggling (Carney & Scott, 2012). Because of this, school psychologists need to be aware of the dangers and severity of eating disorders and, additionally, identify any students who are showing signs of disordered eating.

The National Association of School Psychologists characterizes school psychologists as facilitators of change who develop, implement and promote mental health policies that support the education and mental health of all students (National Association of School Psychologists, 2015). Although these mental health programs can encompass many things, eating disorders are not specifically mentioned. This could explain the study that surveyed school psychologists and found that school psychologists commonly do not feel comfortable handling students with eating disorders (Carney & Scott, 2012; Stachowitz, Choi, & Schweinle, 2014). This highlights an opportunity for school psychologists to begin to further understand eating disorders and how best to help students who are suffering.

One way school psychologists can help students is by implementing programs that directly address eating disorders. As this study highlights, this is an important need that is not being met. By understanding the themes outlined in this paper, programs can be created to foster

resiliency in others who are also suffering from eating disorders similar to the three participants in this study.

References

American Psychiatric Association. "What Are Eating Disorders?" *American Psychiatric Association,* Jan. 2017, www.psychiatry.org/patients-families/eating-disorders/what-are-eating-disorders.

Arthur-Cameselle, J. N., & Quatromoni, P. A. (2014). Eating Disorders in Collegiate Female Athletes: Factors That Assist Recovery. *Eating Disorders, 22*(1), 50-61. doi:10.1080/10640266.2014.857518

Berends, Meijel, Nugteren, Deen, Danner, Hoek, & Van Elburg. (2016) Rate, timing and predictors of relapse in patients with anorexia nervosa following a relapse prevention program: a cohort study. *BMC Psychiatry 16*(1). doi:10.1186/s12888-016-1019-y.

Bernard, B. (1993). Fostering resiliency in kids. *Educational Leadership, 51*(3), 44.

Carney, J. M., & Scott, H. L. (2012). Eating issues in schools: Detection, management, and consultation with allied professionals. *Journal of Counseling & Development 90,* 290-297.

Carter, J. C., Blackmore, E., Sutandar-Pinnock, K., &Woodside, D. B. (2004). Relapse in anorexia nervosa: A survival analysis. *Psychological Medicine 34*(4), 671-679. doi:10.1017/S0033291703001168.

Carter, J. C., Mercer-Lynn, K. B., Norwood, S. J., Bewell-Weiss, C. V., Crosby, R. D., Woodside, D. B., & Olmsted, M. P. (2012). A prospective study of predictors of relapse in anorexia nervosa: Implications for relapse prevention. *Psychiatry Research 200*(2-3), 18-23. doi:10.1016/j.psychres.2012.04.037.

Condly, S. (2006). Resilience in children: A review of literature with implications for education. *Urban Education, 41*, 211-236. doi:10.1177/0042085906287902

Gicquel, L. (2013). Anorexia nervosa during adolescence and young adulthood: Towards a developmental and integrative approach sensitive to time course. *Journal Of Physiology - Paris, 107*(Special issue on Time perception), 268-277. doi:10.1016/j.jphysparis.2013.03.010

Goldberg, S., Werbeloff, N., Shelef, L., Fruchter, E., & Weiser, M. (2015). Risk of suicide among female adolescents with eating disorders: A longitudinal population-based study. *Eating And Weight Disorders, 20*(3), 295-300. doi:10.1007/s40519-015-0176-1

Herzog, D. B., Dorer, D. J., Keel, P. K., Selwyn, S. E., Ekeblad, E. R., Flores, A. T., & ... Keller, M. B. (1999). Recovery and relapse in anorexia and bulimia nervosa: A 7.5-year follow-up study. *Journal Of The American Academy Of Child & Adolescent Psychiatry, 38*(7), 829-837. doi:10.1097/00004583-199907000-00012

Hughes, E. K., Goldschmidt, A. B., Labuschagne, Z., Loeb, K. L., Sawyer, S. M., & Le Grange, D. (2013). Eating disorders with and without comorbid depression and anxiety: Similarities and differences in a clinical sample of children and adolescents. *European Eating Disorders Review, 21*(5), 386-394. doi:10.1002/erv.2234

Johnson, E. R., Weiler, R. M., Barnett, T. E., & Pealer, L. N. (2016). Extreme Weight-Control Behaviors and Suicide Risk among High School Students. *Journal Of School Health, 86*(4), 281-287

Keski-Rahkonen, A., Raevuori, A., Bulik, C. M., Hoek, H. W., Rissanen, A., & Kaprio, J. (2014). Factors associated with recovery from anorexia nervosa: A population-based study. *International Journal Of Eating Disorders, 47*(2), 117-123. doi:10.1002/eat.22168

Las Hayas, C., Padierna, J. A., Muñoz, P., Aguirre, M., Gómez del Barrio, A., Beato-Fernández, L., & Calvete, E. (2016). Resilience in eating disorders: A qualitative study. *Women & Health, 56*(5), 576-594. doi:10.1080/03630242.2015.1101744

Levallius, J., Roberts, B. W., Clinton, D., & Norring, C. (2016). Take charge: Personality as a predictor of recovery from eating disorder. *Psychiatry Research, 24*(6), 447-452. doi:10.1016/j.psychres.2016.08.064.

Linville, D., Brown, T., Sturm, K., & McDougal, T. (2012). Eating Disorders and Social Support: Perspectives of Recovered Individuals. *Eating Disorders, 20*(3), 216-231. doi:10.1080/10640266.2012.668480

Masten, A. S. (2011). Resilience in children threatened by extreme adversity: Frameworks for research, practice, and translational synergy. *Development and Psychopathology, 23,* 493-506.

Masten, A.S. (2014). *Ordinary Magic: Resilience in development*. New York, New York: The Guilford Press.

McFarlane, T., Olmsted, M. P., Trottier, K. (2008). Timing and prediction of relapse in transdiagnostic eating disorder sample. *International Journal of Eating Disorders 41*(7), 87-93. doi:10.1002/eat.20550.

Mustelin, L., Silén, Y., Raevuori, A., Hoek, H. W., Kaprio, J., & Keski-Rahkonen, A. (2016). The DSM-5 diagnostic criteria for anorexia nervosa may change its population prevalence and prognostic value. *Journal Of Psychiatric Research, 77,* 85-91. doi:10.1016/j.jpsychires.2016.03.003

National Association of School Psychologists. (2015). Position Statement: Mental and Behavioral Health Services for Children and Adolescents. Retrieved from

http://www.nasponline.org/research-and-policy/professional-positions/position-statements

Nilsson, K., & Hägglöf, B. (2006). Patient Perspectives of Recovery in Adolescent Onset Anorexia Nervosa. *Eating Disorders, 14*(4), 305-311. doi:10.1080/10640260600796234

Rojo-Moreno, L., Arribas, P., Plumed, J., Gimeno, N., García-Blanco, A., Vaz-Leal, F., & ... Livianos, L. (2015). Prevalence and comorbidity of eating disorders among a community sample of adolescents: 2-year follow-up. *Psychiatry Research*, 22752-57. doi:10.1016/j.psychres.2015.02.015

Stachowitz, A. L., Choi, H., & Schweinle, A. (2014). The Use of the BASC-2 for the Identification of Female Adolescents at Risk for Developing an Eating Disorder. *Psychology In the Schools, 51*(10), 1063-1075. doi:10.1002/pits.21804

Stice, E. Ragan, J., & Randall, P. (2004). Prospective relations between social support and depression: Differential direction of effects for parent and peer support? *Journal of Abnormal Psychology, 113,* 155-159. doi:10.1037/0021-843X.113.1.155.

Volpe, U., Tortorella, A., Manchia, M., Monteleone, A. M., Albert, U., & Monteleone, P. (2016). Eating disorders: What age at onset?. *Psychiatry Research, 225*. doi:10.1016/j.psychres.2016.02.048

Zerwas, S., Lund, B. C., Von Holle, A., Thornton, L. M., Berrettini, W. H., Brandt, H., & ... Bulik, C. M. (2013). Factors associated with recovery from anorexia nervosa. *Journal Of Psychiatric Research, 47*, 972-979. doi:10.1016/j.jpsychires.2013.02.011

Zolkoski, S.M. & Bullock, L. M. (2012). Resilience in children and youth: A review. *Children and Youth Services Review, 34*, 2295–2303.

Appendix A

Sample Interview Questions

1. Tell me your story about your experience with your eating disorder.
    - Be sure to obtain basic demographics, age onset, diagnosis, treatment, etc.
2. Who was supportive of you during your struggle?
3. Was it difficult to go through this while in school? How so? What was most difficult? What would have been helpful?
4. What were some of the factors that allowed you to overcome your eating disorder?
5. What was a turning point for you?
6. Tell me about your life now.
7. Do you still have challenges today with regards to your eating disorder? How do you cope with those challenges?
8. What do you think contributes to your success?
9. Where do you think your source of inner strength and resilience comes from?
10. Any information or advice you would pass on to others who are going through what you went through?

Reflection

I felt so honored and privileged that these three participants wanted to share their story with me. The experiences they went through were incredibly personal, so it was touching that they volunteered to share such a private story. I thought their stories were particularly inspiring when they discussed the turning points they went through to begin the recovery process. Each of the turning points sparked emotion out of the participants when they were describing the moment. When this happened, it was hard not to feel incredibly moved by their stories. Courtney's story about her turning point when she asked for God to give her a sign, was a truly emotional and uplifting story that I couldn't help but be amazed by.

One of my favorite moments during the interviews is when I asked them to tell me about their life now. Each of them lit up instantly and had the biggest smile on their faces. They were so happy to share all their accomplishments. I could tell they were proud of how far they've come in their recovery process. My other favorite part of the interview was when I asked them about giving advice to other people struggling with what they went through. Each of the women thought hard about this and took it very seriously, even though it was just me they were telling. This made me realize how serious they are about recovery and helping others, which is an incredible outcome for these women.

I haven't suffered from an eating disorder or disordered eating habits myself, but I have a close friend and an aunt who have suffered from one. This inspired me to do this topic because I saw how resilient they have been. When listening to Morgan, Madison and Courtney's story, I couldn't help but make connections back to people close to me who have also suffered. I really connected with the theme about social supports because I was a part of my friend's support system and saw how important we were to her.

Some of my strengths during the interview process were my listening skills and my use of the "power of wow!" I also found my skills of not knowing to be very helpful during these interviews because it allowed the participants to share lots of details about their story. Another skill I utilized is open-ended questions because it allowed Morgan, Madison and Courtney to share as much of their story that they wanted to. Then I would ask more specific questions, so they could elaborate further.

Another aspect of interviewing that I tried to be aware of was, my facial expressions and body language. Even though I had to actively think about it, I think it was a strength of mine because I was able to stay neutral and provide non-verbal cues that I was listening and understanding their stories.

A challenge I faced during these interviews was thinking of people in my own life who have gone through similar situations. In order to be the most help to my clients, I need to refrain from bring unnecessary personal feelings into counseling sessions or take emotions from counseling home with me. This is something I would like to work on in future courses.

Although I was nervous for my first interview, I got more comfortable the more I completed interviews. Even though I was nervous, my participants were very helpful in making me feel comfortable while sharing their emotional story with me. This allowed me to relax and become less of a "robot" which allowed for more of a conversational dialogue between us. This is something I want to keep working on as I look ahead to the next semesters of counseling courses.

I really enjoyed listening to these three women and their stories because hearing how amazing these women are, made me excited for my future as a school psychologist and my counseling career. I am excited to help more amazing people and hear more incredible stories.