"Learning to live your life again":

An Interpretative Phenomenological Analysis of weblogs documenting the inside experience of recovering from Anorexia Nervosa

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Abstract

Objective: This study aimed to explore the construct of recovery from Anorexia Nervosa (AN) through the medium of weblogs, focusing on the benefits and barriers to the recovery process.

Method: Data was extracted from female (*n*=7) and male (*n*=1) participants' textual pro-recovery weblogs, all of which were posted between 2013 and 2015 in the public domain. Data were analysed using Interpretative Phenomenological Analysis (IPA).

Results: Three superordinate themes were identified: (1) barriers to recovery, (2) factors increasing the likelihood of recovery, and (3) support.

Discussion: Results suggest supportive relationships, re-gaining control and recognising the consequences of the eating disorder benefit recovery, whereas public perceptions, the AN voice, and time act as barriers to recovery. Out of eight participants, four described seeking professional help as part of their recovery, of which three believed their professional therapy experience helped aid recovery.

Conclusion: Implications for AN treatment are discussed in detail.

Key words: Anorexia Nervosa, Recovery, Benefits, Barriers, Treatment.

Introduction

An estimated 725,000 individuals are affected by an eating disorder in the UK (B-eat, 2015), with a lifetime prevalence of 0.9% for women, and 0.3% for men (Hudson et al., 2007). Anorexia Nervosa (AN) is characterised by restrictive behaviours, such as low calorie intake, leading to severe weight loss due to having a distorted-body image and obsessive fear of gaining weight (American Psychiatric Association, 2013). Due to the complex diagnostic criteria of AN, it is a difficult disorder to treat, and there is a severe lack of literature investigating treatment effectiveness. Researchers suggest that less than half of those affected ever seek treatment for the disorder (Hudson et al., 2007), with a mere 2.9% seeking help immediately after recognising the symptoms of Anorexia Nervosa (B-eat, 2015). This low rate of help-seeking suggests current treatment routes available for this group are insufficient.

Treatments with the best evidenced outcomes show limited success for full recovery from AN. Cognitive behavioural therapy (CBT) and enhanced CBT have limited effectiveness for individuals with AN (Fairburn et al., 1993, Agras et al., 2000) (Dalle Grave et al., 2013), whereas family-based therapy appears more effective (le Grange et al., 2007). Accordingly, it is important to understand the factors that contribute to help-seeking to improve treatment outcomes. Recovery from AN is often seen as a choice, and findings suggest many individuals feel ambivalent regarding whether to maintain the harmful

behaviours or to recover (Williams and Reid, 2007). This may explain why AN has the highest premature termination of treatment across eating disorders (Zeeck et al., 2005).

Recovery is an ongoing process which requires internal motivation, emotional regulation and support (Federici and Kaplan, 2008). Recovering from an eating disorder engages mental, physical and social factors. Even those who receive extensive medical observation, pharmacological intervention, and psychological treatment may not fully recover without the desire and internal motivation to change (D'Abundo and Chally, 2004), and many barriers to recovery exist. For example, an individual's sense of self tends to be defined by an AN diagnosis (Tierney and Fox, 2010), however there is little research investigating AN self-identity, despite the importance of considering the difficulty of detachment from one identity (i.e., the non-AN identity) to another (i.e., the AN identity). The relationship between the individual and their 'anorexic voice' (conducive to AN identity) often explains the ambivalence to change, as it is often described as their 'best friend', giving them control to build a sense of self and identity (Dignon et al., 2006, Weaver et al., 2005). Yet this critical, irreconcilable and unreasonable AN identity controls and confines the individual's rational, true self (Williams and Reid, 2012). However, individuals with AN may realise that the 'voice' lied to them about its ability to alter their lives for the better, increasing the likelihood of choosing recovery (Tierney and Fox, 2010) . Recovery allows the individual to regain control over the self, place the self back into society, and modify irrational thinking patterns (D'Abundo and Chally, 2004). Additionally, recognising the consequences of the eating disorder (D'Abundo and Chally, 2004), support can act as a catalyst for recovery (Nilsson and Hägglöf, 2006), and imminent death or increased physical harm (Weaver et al., 2005) are important in the decision to choose and maintain recovery. Experiencing these factors can be viewed as "turning point".

Another form of support for individuals with AN is documenting the recovery process via the Internet. New technologies have led to the availability of vast amounts of information and supportive online communities (Rheingold, 1993). The ubiquity of the Internet has raised concerns with regards to online communities, which actively promote harmful behaviours, such as pro-anorexia ("pro-ana") websites (Norris et al., 2006, Brotsky and Giles, 2007). Pro-ana websites disseminate advice regarding acquiring or maintaining eating disorders by providing 'tips and tricks' for starvation (Dias, 2013, Mulveen and Hepworth, 2006). Search engines such as 'Yahoo' have previously sought censorship of such websites, due to their encouragement of self-injurious behaviour. However, there is no nationwide enforceable legislation that can control and set limits to such potentially dangerous websites (Christodoulou, 2012).

Due to the increased use of Internet-mediated communication (e.g., weblogs), the Internet presents an opportunity to understand individuals in naturalistic online settings. Weblogs, i.e., personal online diaries, are increasingly used to document an individual's experience of recovering from AN (e.g., Dley et al., 2014). Weblogs ("blogs) are highly attractive to individuals with mental disorders due to their ease of access, 24-hour availability and wide reach, providing the perfect mode of communication, as self-disclosure barriers are lowered (Joinson, 2001). Being an anonymous blogger allows freedom of expression without fear of consequences (Hookway, 2008). Moreover, pro-recovery weblogs allow the writer to relive their recovery, document their thoughts and opinions about the recovery process, and encourage others to begin their journey into recovery.

Although recovery weblogs seem predominantly positive and encouraging, little relevant research is available regarding such blogs. For example blogs of this kind could be useful in helping to identify a sufferers' experience of recovery and what sufferers found helpful (and not so helpful) in their recovery process. Few studies have been conducted

within natural settings investigating both positive and negative aspects of treatment for AN. Accordingly, the present study aimed to fill this gap by investigating the lived experiences of recovering from AN and endeavoured to understand the individual within a naturalistic environment (i.e. personal weblogs). This study's objective was to identify the main events and experiences described by individuals which increase and decrease the likelihood of effective AN recovery. It also addressed the importance of gaining insight into whether bloggers were satisfied with their treatment in order to understand the relationship between treatment and recovery to aid in developing more effective treatments.

Materials and Methods

Participants

Data were obtained from online weblogs as pre-existent, documented accounts of individuals' experiences of recovering from AN. The term "weblog" used throughout is a representation of numerous blog entries written by one participant. Data were sourced from eight separate weblogs. Smith et al. (1999) state that a sample size of between 4-10 participants is ideal for Interpretative Phenomenological Analysis (IPA) which was used in the present study, and therefore the present authors decided to include a sample of eight participants. The blogs were written by both females (n=7), and males (n=1), aged between 19 and 29 years old (M=23.9, SD=3.6). The unequal gender distribution echoes the larger AN prevalence in females with a ratio of 10:1 (American Psychiatric Association, 2013). In addition to this, females are more likely to write blogs than males, update their blogs, and talk about sensitive and emotional topics (Liu and Chang, 2010). Using small sample sizes is appropriate when employing IPA due to the investigation's idiographic nature (Shaw, 2010). Weblogs met the following inclusion criteria: (i) the website only focuses on pro-recovery of AN (and accordingly encourages healthy eating and lifestyle choices) and not pro-ANA weblogs. Pro-ANA weblogs, the writer consciously promotes the maintenance of AN, encouraging unhealthy eating behaviours and providing tips for the self-management of extreme starvation. (ii) the blogger is 18 years or above, (iii) the blog is written in text (rather than videos, pictures, etc.) in English language, (iv) the individual has written four or more weblogs between 2013 and 2015, and (v) the weblog is accessible in the public domain without registration.

Procedure

Data collection took place between April and June 2015. Key terms were entered into the Google search engine (e.g., "eating disorder recovery blog", "pro-recovery", "pro-ana recovery", "anorexia recovery weblogs"). Weblogs that did not meet the inclusion criteria were excluded. Subsequently, several weblog entries were scrutinised for relevance to recovery, and four entries were chosen from each website. Relevant content was compiled for each participant. Informed consent was then sought from each participant to abide by the Internet-mediated communication ethical guidelines (British Psychological Society, 2013).

Data Analysis

Interpretative phenomenological analysis (IPA) was employed to investigate individuals' experiences of documenting their recovery from anorexia nervosa through weblogs on the Internet. IPA explores subjective experiences in order to assign meaning to these experiences within the context of their naturalistic environment (Smith et al., 1999). The interpretation of collected data is the joint reflection of both the participant and the researcher, resulting in 'double hermeneutics' – i.e., the researcher interpreting the participant's interpretation of their experience (Osborn and Smith, 2015).

IPA is most commonly used for interpreting spoken communication such as semi-structured interviews; few examples of using IPA to explore weblog data exist. However, any texts created by participants (such as personal diaries or other personal accounts) are a cross between written and spoken communication, therefore are amenable to IPA analysis (Mann, 2000, Smith et al., 1999). To assure reliability and validity in the current research, notes and researcher reflections about what the sections portrayed, researcher questions and comments on the language used (Biggerstaff and Thompson, 2008) were documented in the margin of each case. These were referred back to during the interpretation phase that identified superordinate themes which captured the essence of the varying subordinate themes (Bradley

and Simpson, 2014). Peer-agreement with the second author was sought about the interpretation of each weblog to enhance the validity of the results

Results and Discussion

From the data, three super-ordinate themes emerged, 1) Barriers to recovery, 2) Factors increasing the likelihood of recovery and 3) Support. Each was associated with subordinate themes (presented in Table 1). Main findings and an in-depth analysis of each subordinate theme are outlined below.

Table 1

Super-Ordinate and Subordinate Themes

Super-ordinate themes	Subordinate themes	Sub-categories
1. Barriers to recovery	1.1. Perceptions of others	1.1.1. Society's ideal 1.1.2. Others' behaviour
	1.2. Time/patience	
	1.3. AN identity	1.3.1. AN voice 1.3.2. AN as a person influencing behaviour
2. Factors increasing recovery likelihood	2.1. Regaining control	
	2.2. Reclaim self-identity	2.2.1. Increased self-worth 2.2.2. Changed values/perspective
	2.3. Recognising the consequences of the disorder (AN)	
3. Support	3.1. Professional help	
	3.2. Interpersonal connections	3.2.1. Family 3.2.2. Friendships

Barriers to recovery

Throughout the weblogs, the participants described several unhelpful aspects that may act as barriers to recovery, or triggers for relapse. These were conceptualised in three main subordinate themes: *Perceptions of others, time/patience* and *AN personified*.

Perceptions of others.

Society's ideal.

Several of the participants documented the effects which society's idea of perfection may have on their recovery.

> "*We live in a society that is rampant with ideas of beauty, false, unattainable, unrealistic standards of beauty*" (Participant 5).

This statement suggests the participant understands the unrealistic nature of society's ideal, however, mass media and the culture in which they live make it difficult to disconnect themselves from the mindset of "*thinner is better*" (Participant 6). Additionally, one participant documented that society believes "*losing weight is good and gaining weight is bad*" (Participant 6). This belief is generally accepted and hinders recovery because to recover, individuals must gain weight, which is stigmatised.

Participant 6 suggests individuals in recovery feel other people cannot understand what they are going through as they have not been through the experience themselves.

The majority of participants regarded society valuing slim body shapes in order to live a better life with more opportunities (i.e., like Barbie) (Jambor and Robert-McComb, 2001) as unhelpful aspect of recovery. These descriptions echo sociocultural models emphasising 'Western' culture's beauty ideal of extreme thinness as risk factor for eating disorders (Striegel-Moore and Bulik, 2007). All participants' statements regarding public perceptions did not provide evidence for causing such restrictive behaviours. However, exposure and internalisation of Western culture's beauty standards may lead to body dissatisfaction (Moradi et al., 2005, Striegel-Moore and Bulik, 2007), and may act as trigger to lapse back into the disordered eating. Moreover, individuals are more prone to relapse if they feel misunderstood by their support system (Federici and Kaplan, 2008).

Other's behaviour.

Participants also described how others perceive their recovery as potential trigger for relapse. Although significant others try to be supportive throughout recovery, "*people run the risk of feeling triggered when people comment on their body*" (Participant 7). Participant 7 describes several scenarios that ED sufferers may be presented with during recovery, e.g. *"...someone tells you 'you look healthy!' Your mind reads that as 'you look fat*". Being able to cope with such thoughts relies on having the motivation to continue recovery, yet if the individual cannot ignore the negative voice, it may act as a trigger for relapse.

> "*...the fact that [people without AN] are looking at [AN] with such an objective view can also mean that it makes it more difficult for them to understand why the person in recovery does not always feel the same way*" (Participant 6).

Time/Patience. The need for patience was also a theme running throughout the participants' accounts of recovery, emphasising the process of recovery as lengthy. Internal motivation and perseverance is needed for successful recovery. Participant 1 states that individuals cannot "*let go of these [anorexic behaviours] overnight*" and "*it may take many years and include multiple relapses – but this is to be expected on a recovery path*". This excerpt highlights the difficulty faced within recovery and the time and patience needed for individuals experiencing AN to let go of their restrictive eating behaviours as it is difficult to recognise small achievements throughout recovery (such as periods of healthy eating and weight gain), contributing to relapse.

The reported lengthy process of change reflects previous research. In a 12-year follow up study of 69 hospitalised AN patients, AN symptomology did not improve until six years

after first inpatient treatment in 50% of the sample (Herzog et al., 1997). This suggests that it takes "*...weeks, months, years for things to change*" (Participant 2). Conversely, some participants in the present study did not seek professional help, yet still believe themselves to be 'recovered'. Accordingly, requiring six years of inpatient treatment to achieve full recovery may reflect treatment programmes' insufficiency and therefore points to an important clinical perspective, namely that treatment needs to support relapse episodes by decatastrophising them

AN personified. All participants personified about eating disorder in some way, often suggesting the AN voice (described by one participant as "ANA" and another as "Ed") overrode their own voice and influenced their behaviour. Participant 1 documented that her AN voice "*values things that are the complete opposite to what I... value*", and participant 8 stated "*ANA also 'says' I was never thin enough to shock you anyway*". The presence of this anorexic voice underscores the sufferer's experience of the separation between the individual and their eating disorder.

> *"When Ed [the eating disorder] and I were still best friends there were certain things that I was "not allowed to do" as mandated by Ed* [such as eating particular foods]... *Those were just a few of Ed rules*" (Participant 5).

Having two separate identities (i.e., personal and AN identity) may also allow the individuals to avoid taking responsibility for their disordered eating, as shown by Participant 5, who adhered to someone else's rules, and this meant blame could be placed elsewhere (i.e., outside of the individual themselves). Participant 8 also believed that she was "*restricted by*

anorexia and her rules" (Participant 8). Accordingly, the participants had diminished control of their behaviours during their eating disorder phase as the ED dictated how they should behave.

When faced with removing the eating disorder from their lives, a sense of loss was felt, even after the participants had realised the negative life effect. Participant 6 acknowledged that her "*eating disorder is also a coping mechanism, and so losing that coping mechanism can be hard*". Coping mechanisms are often used to reduce stress and anxiety, which are common symptoms in AN. The loss of the AN coping mechanism can trigger further maladaptive coping mechanisms, which can maintain and strengthen the disorder (e.g., restrictions other than food, such as restrictions regarding their everyday behaviours). The individuals' ambivalence to change often stems from the 'anorexic voice' giving them a sense of control and identity (Dignon et al., 2006, Weaver et al., 2005). Therefore, the individuals may experience a loss of identity when undergoing recovery, placing a barrier on change.

Factors increasing recovery likelihood

The second super-ordinate theme *factors increasing recovery likelihood* which related to the benefits of the recovery process was subcategorised in *regaining control, reclaiming self-identity,* and *realising the consequences of AN.*

Regaining control. One of the beneficial aspects of recovery was the realisation that recovery was a choice that the individuals must make to regain control over their actions.

> *"... things I realised during my recovery were that a) my recovery was in my hands, and b) that I was not helpless."* (Participant 3)

During recovery, it was clear that the individual gained a sense of empowerment over their disordered behaviours, and realised that to fully recover, they were the only ones who could take back control of their own mind and body.

> *"... when he [the anorexic voice] tries to speak up I know why and can tell him to go away and it happens..."* (Participant 5)

> *"Usually, I do the exact opposite of what it [the anorexic voice] is telling me to do, just show it how much it is not going to affect me."* (Participant 6)

Several participants recalled realising their life was out of control because of the eating disorder. To regain the control they once had, they had to abandon the disordered eating behaviours and exchange them for healthier behaviours. Participants' 5 and 6 ability to let go of the control their ED had over them allowed them to regain a sense of control, increase self-efficacy and decide how they wanted to live their lives.

> *"This is a struggle for me right now – hovering between relapse and wellness, deciding which path to take"* (Participant 1)

Individuals can regain control by choosing healthier behaviours (Patching and Lawler, 2009). In previous research, of 20 female participants who had recovered from AN, BN or both, once they realised their eating disorder hindered their self-actualisation, they discontinued the behaviours and engaged in behaviours more likely to give them a sense of

control over their lives. Once the individual has gained control over their eating disorder's commands, the eating disorder loses its power over them (Jenkins and Ogden, 2012).

Reclaiming self-identity. Becoming a healthy self separate from the eating-disordered self was a crucial step toward full recovery. During recovery, many of the participants recalled an increase in self-worth and belief that they were entitled to the life they wanted to live. Participant 5 ends several of her blogs with the statement "*YOU are LOVED and YOU are WORTH it!!"* which not only serves as encouragement to the reader, but seems to be a self-motivating statement repeated to remind herself of her self-worth. This is reflected in the statement of another participant:

"So, my self-esteem and body image is probably the best its ever been" (Participant 7)

Since being in remission, Participant 7 also recognised her self-worth, increased confidence and ability to live a better life. As AN is characterised by a distorted body image, the fact that Participant 7 had seen an increase in body image satisfaction also suggested her old non-disordered self was returning, and reassured the reader that gaining weight does not mean becoming fat, but instead results in increased confidence.

All participants documented a change in values once in recovery. For example, Participant 2 stated, "*It is now about learning to live your life again... To do fun things. To do things you enjoy".* Participant 1 also wrote about her values: "*mulling over what it is that is most important to me, the things in my life that I love and treasure...*", and how having an ED restricted her in fulfilling her ideals. However, being in recovery allowed the individual to re-evaluate what her ED did to her values and encouraged her to "*think about what it is that you care about mos*t" and to not forget that "*you DESERVE to live a life that illustrates your values, because you are INFINITELY important*" (Participant 1).

Self-evaluation is vital to mental health and psychological wellbeing because it can lead to better health, increased social inclusion, and self-efficacy. Low self-esteem can be a contributing factor in the development of several mental disorders, including AN (Mann et al., 2004). Positive self-worth is therefore important to individuals with eating disorders as it can buffer the impact of stressors during recovery (Lazarus and Folkman, 1984). Of six AN-recovered individuals, their increased self-confidence was vital for their recovery and maintaining healthy eating (Hsu et al., 1992).

Recognising the consequences of the disorder (AN). Whilst in recovery, most participants communicated recognition of the social disadvantages to having an eating disorder: *"... essentially I've ditched bible study / ditched spending time with people whom I care about deeply so I can sit at home feeling sorry for myself..."(*Participant 1). Exclusion from friends, family and activities was often described throughout weblogs. For example, Participant 4 mulled over the downside he felt during recovery:

> *"... my mind goes towards the missed opportunities, the friendships that got beaten up, the experiences that went unshared, the gratitude that went unshown, the untasted food with a lover...".*

Expressions of guilt for excluding and isolating themselves highlights the individual's realisation that having an eating disorder stopped them from achieving happiness, and from creating memories and these missed opportunities could never be revived. Mulling over such missed opportunities however often had a positive effect as it became the motivation for the individual to start creating the memories they wanted to have whilst they were in recovery. One of the most significant consequences of having an eating disorder is isolation and exclusion from others (Treasure et al., 2011). Isolating the self from a friendship group

becomes part of a vicious cycle during AN, as social exclusion leads to further low self-esteem and anxiety (Lee and Robbins, 1998), which maintains AN behaviours. Previous findings (Maner et al., 2007) show that the individual experience of social exclusion may increase a recovering sufferer's with AN's desire to affiliate and reconnect with friends and family. This is known as the *reconnection hypothesis* (Maner et al., 2007).

Physical consequences of AN recovery were also documented. For instance, for participant 2 it was something as simple as sitting down for longer than two minutes: "*I would never sit if I was on my own, I just couldn't physically do it (…) the anxiety would take over and I would have to get up and do things". Recognising that such thought processes were irrational took the participant* some time, but once she realized this cost of AN, it became easier to change her behaviour. It allowed her to appreciate that "*living a life being scared of something such as sitting will hold you back a lot in life!!".*

Support

The final superordinate theme *Support* encompasses the types of support each individual used during the process of recovery and whether this facilitated or hindered recovery. *Professional help* and *interpersonal connections* were subcategorised under this theme.

Professional help. There appeared ambivalence among the sample regarding whether professional help assisted or hindered recovery. Participant 1 believed that "*With a proper treatment team (dietician, psychologist, doctor)... recovery is possible*", suggesting she had a positive experience with her treatment team which allowed her to recover from AN.

In contrast, when talking about tackling her fears related to eating during recovery, participant 3 suggested that she was never told by her therapist how she could aid her own recovery apart from writing diet plans:

> *"No therapist had ever told me this [she can help her own recovery] (if anything, my therapists were of the "count your calories and weigh yourself religiously" variety)".*

It was only later as a result of her own reflections on her illness that this participant understood that tackling her fears was related to her recovery. No therapist she stated had ever told her about this.The tone adopted in this weblog is therefore one of dissatisfaction with therapy, suggesting that therapists can often contribute to establishing new disordered or obsessive behaviours even during the process of recovery. Partaking in therapy nevertheless supported recovery as it allowed individuals to recognise the extent of the damage they had done to their bodies(Jenkins and Ogden, 2012). However, where treatment had a focus on weight gain, female treatment seekers tend to express frustration and dissatisfaction (Kordy et al., 2002).

Interpersonal connections. Interpersonal connections, such as friends and family, also played a crucial role in starting recovery, and maintaining healthy eating.

> *"You need to face the problems. And find a way to cope with whatever it is you are feeling... DO TALK TO SOMEONE. OR WRITE A LETTER OR SOMETHING, But communicate your feelings to someone. They can help you, they can support you. They cant [sic] do the fighting for you, but they can support you. Help you set up a strategy...."* (Participant 2).

"I was ready to go on hiatus, but my wife brought me back to sensibility" (Participant 4).

Participant 2 acknowledges her support system could not ensure that she maintained recovery. However, as stated by Participant 4, personal support systems in the form of family and friends can provide the care needed to help cope with the anxieties, sadness and guilt that may arise in the context of AN to prevent relapsing into unhealthy AN behaviours.

Social support allows an individual to believe they are cared for, loved and have available assistance from others if needed (Goldsmith, 2004). Such perceived social support acts as protective factor against health consequences and life-stressors (Cobb, 1976). Support networks are now included in treatment as they produce better treatment outcomes than individual treatment alone (Eisler et al., 2003). There is also an increased likelihood of relapse if the individual does not have an adequate support system, and holds the belief that asking for help is weak and shameful (Federici and Kaplan, 2008).

Conclusion

The present study investigated the experience of recovering from AN using an IPA of individual weblogs. To summarise, the factors contributing to participant recovery were regaining control over their behaviour and life, recognising increased self-worth, realising the costs of having an eating disorder, and perceived and actual social support. In contrast, public perceptions, the time it took to fully recover and trying to dissociate themselves from their anorexic voice were identified as barriers to recovery. Perceptions of professionals were ambivalent as several participants believed recovery was achievable with a treatment team,

while others expressed negative emotions towards AN treatment, suggesting a need for improved treatment programmes.

This study has implications on both theoretical and practical levels. Theoretically, the findings lend support to preceding literature investigating lived experience of AN recovery (e.g., D'Abundo and Chally, 2004, Nilsson and Hägglöf, 2006). In the current study similar feelings regarding factors increasing the probability of choosing and maintaining AN recovery and recovery barriers were identified as those observed in the studies by the above authors.Findings suggesting Western culture's beauty ideal is a potential obstacle to recovery need to be addressed further. Reducing the stigma toward gaining weight in today's society would not only help those in recovery not feel ashamed (and pressured to stay thin), but it could also reduce the likelihood of more individuals developing eating disorders. Several strategies are needed to contest stigma associated with weight, including education and large media campaigns depicting healthy but heavier individuals more positively (Puhl et al., 2008).

Pro-recovery weblogs have proven to be markedly different to pro-ana websites, providing no cause for concern regarding encouraging dangerous behaviours (as do pro-ana sites). Regarding AN treatment this study provides evidence for how low treatment success and satisfaction can be improved. The present findings indicate participants chose and maintained recovery via supportive relationships, as this allowed them to feel assistance was available, as and when it was needed. Therapists should therefore ensure they provide the individual with the support necessary to allow their clients to disconnect from their eating disorder, increase their self-confidence and discover healthier ways to express their emotions.Incorporating the individuals' support systems in treatment was beneficial regarding reducing AN symptomology more effectively than individual therapy (Eisler et al., 2003).

Investigating the experience of recovery from the individual's personal weblogs is a main strength of the present study, as this perspective provided an accurate representation of what the individual wanted to document, free from researcher bias (Hookway, 2008). Interview-based studies, which are more commonly utilised for investigating AN experience, may not enable research participants to articulate their experiences regarding such a sensitive subject fully.

Limitations of the present study must also be noted. Although the male to female ratio corresponds to that of AN (American Psychiatric Association, 2013), having used one male participant only in this study limits the generalisability of the findings to the male AN population. Limitations of qualitative research also apply, particularly in relation to the subjective nature of the interpretation of the findings. However these were addressed through peer review of the results.It is recommended that future research focuses on contact with recovering individuals, investigating specific treatment experiences and ways the individuals themselves suggest would improve low treatment uptake. Also, closed weblogs that require registration should be used to investigate whether these differ from publicly available weblogs with regards to disclosure. This may help to produce a more detailed view of recovery and treatment from the perspective of individuals with anorexia nervosa, and expand the body of knowledge.

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